STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435049	A. BUILDING _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SALEM	500 COLONIAL DRIVE SALEM, SD 57058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 41895 An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/19/21 through 10/21/21. Avantara Salem was found not in compliance with the following requirements: F554, F565, F658, F677, F684, F725, F812, and F880.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (34) had been assessed for self administration of medications per facility policy. Findings include: 1. Review of resident 34's medical record revealed: *He had a self-administration of medication assessment completed on 5/29/21. -The assessment determined he was safe to self-administer medications and they could be left in his room. -There had been no other self-administration of medication assessments completed. *His care plan stated "Staff will administer medications as ordered." -His care plan did not address self-administration of medication.	F 554	1. Self-Administration Assessment completed on resident 34. Revised care plan states leave medications at bedside. 2. All residents have potential to be affected. 3. Audit all residents to ensure self-administration assessments and care plans are completed upon admission, quarterly, and with significant change. All nurses and medication aides educated by DON on 11/10/2021 on each resident's preference of self-administration. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. DON or designee will audit self-administration of 5 random charts weekly x4, biweekly x 2, monthly x 3. All audits will be reviewed and monitored through QAPI.	11/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	11/15/2021

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

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F 554	Continued From page 1 *His physician orders had indicated a medication self-administration evaluation was to have been completed every three months, ordered on 05/29/21, to ensure the resident was able to self-administer those medications appropriately. Interview on 10/21/21 at 7:30 a.m. with registered nurse (RN)/director of nursing (DON) C and RN/regional nurse consultant (RN/RNC) A confirmed: *Another self-administration of medication assessment should have been completed three months after the 5/29/21 assessment. *The assessments were to have continued quarterly and with any significant change of condition for resident 34. *RN/RNC A stated: -There was a problem with staff understanding the need to complete a quarterly assessment. -Education was needed for the nursing staff. Review of the provider's January 2020 Self-Administration of Medications policy revealed: *"Policy: Each resident has the right to self-administer medications should they desire, unless this practice is determined unsafe." "2. Evaluations will be completed quarterly, with change of condition, annually and prn [as needed]." "4. Nursing is to get an order from the clinician for self-administration of medications." "6. Documentation of the ability to self-administer medications will appear on the resident's plan of care."	F 554		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		

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F 565	Continued From page 2 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, policy review, and resident council meeting minutes review, revealed the	F 565	1. Administrator interviewed residents 3, 8, 15, 21, 29, and 38 for bathing preferences. Resident 3's preference is a bath 3x week, Monday, Wednesday, Friday. Resident 8's preference is a bath 2x week, Mondays and Thursdays. Resident 15's preference is a shower 3x week, Tuesday, Thursday, and Saturdays. Resident 21's preferences is a shower 2x week, Tuesdays and Fridays. Resident 29's preferences is 1 bath a week and had no preference of day. Resident 38 no preference for bath vs. shower, would like 2x week on Sunday and Wednesdays. Scheduled and Care Planned baths per preferences. Unable to rectify previous call light complaints. All C.N.A.'s and Dietary staff educated that snack pass is to occur at 2pm and 8pm. 2. All residents have potential to be affected. 3. Administrator interviewed remaining residents for bathing preference ensure scheduled and care planned per preference. Continual education with all staff of importance of call light response time. Continual education with all staff on importance of offering snacks. Initial education provided by DON on 11/10/2021. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Resident council grievances will be reviewed Monday-Friday at morning meeting. The grievances will be delegated to respective department or designee, returned to morning meeting within 48 hours with resolution, and reviewed with Resident Council President prior to resident council meeting with grievance responses. IDT team and resident council president educated on process. Administrator B attended Resident council Meeting and reviewed previous resident council grievances and resolutions 11/4/2021. If not in attendance of resident council 11/4/21 personally reviewed with resident regarding grievances. DON or Designee will audit 5 random residents for completion of baths and preference x4 weeks, biweekly x2 months, Monthly x3 months. Social Services or Designee will Audit 5 random call lights for various shifts x4 weeks, biweekly x2, monthly x3. DSM or Designee will audit snack pass weekly x 4 weeks, biweekly x2, monthly x3. Activities Director or Designee will audit resident council grievances monthly x6 months. All audits will be reviewed and monitored through QAPI.	11/20/2021

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F 565	Continued From page 3 provider failed to: *Follow-up and investigate concerns for seven of seven (3, 8, 15, 21, 29, 38, and an anonymous resident) interviewed regarding cares and services not being performed. *Fully document responses to resident council members concerns identified in the January 2021 through May 2021 resident council meeting minutes. Findings include: 1. Resident council interview on 10/20/21 at 10:05 a.m. revealed: *Six of seven residents said they did not receive baths on a timely basis. *Three of seven residents said they did not always receive a bath every week. -Resident 3 said he usually gets one bath per week, "But, sometimes have to wait one or two days due to short-handed [not enough staff], it feels good when I do get a bath." -Resident 8 said she used to get two baths per week but has now been only getting one. She preferred two baths per week. -Resident 15 said she used to get two baths per week but has now been only getting one. She preferred two baths per week. -Resident 21 said she has had to wait up to three weeks to get a bath and preferred two baths per week. -Resident 29 said she has had to wait up to two weeks to get a bath and would like "A whirlpool, as it helps with my back pain, but I only get a shower." --She stated the provider should hire a bath aide. -Resident 38 said she had to wait up to two weeks to get a bath and preferred two baths per week. *One resident who wanted to remain anonymous	F 565		

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F 565	Continued From page 4 said: -Her roommate often smelled of urine for hours at a time. --The odor gave her a headache. -She: --Often smelled urine in the hallways. --Asked staff what that smell was to prompt them to provide care to others. --Did not think there was enough staff in the mornings to provide care. *Two of seven residents (8 and 38) said they had waited more than fifteen minutes for their call lights to be answered. -Resident 8 stated, "They [staff] told me not enough aides." *One resident who wanted to remain anonymous reported she had to wait up to one-half hour for her call light to be answered. *Three of seven residents felt there was not always enough certified nursing assistants to ensure they received snacks in the afternoon and evening. 2. Review of resident council minutes from January 2021 through May of 2021 revealed: *On 1/13/21 four residents reported call lights took too long to answer in the evening. -The department response was to "Educate staff to answer call lights in a timely manner." *On 2/3/21 old business showed call lights were still taking too long to answer after 6:00 p.m. with no resolution. *On 3/3/21 one resident had a concern of call lights not being answered with no resolution. *On 4/7/21 two residents had concerns of wrong food being received [per diet or requested food] with no resolution. *On 5/6/21: -Four residents had concerns of not getting	F 565		

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F 565	Continued From page 5 enough towels, wash clothes, or fresh water unless they specifically asked for it. -One resident had concerns of their call light not being answered. -Three residents had concerns of bed linens not being changed. -Three residents had concerns of no religious services being conducted in the facility. --There had been no resolution to these concerns. *On 5/25/21: -Three residents had concerns of wheelchairs and walkers not being cleaned. -Three residents had concerns of showers or baths not consistent. -Four residents had concerns of waiting up to an hour for call lights to be answered or not answering call lights at all. -Three residents had concerns of their laundry being lost. -Two residents had concerns that their rooms were too hot, ranging from 78 to 81 degrees. --These concerns had been addressed by the provider. 3. Interview on 10/21/21 at 11:02 a.m. with administrator B regarding resident council grievances revealed: *They used the "Same process as a regular grievance." *When the resident council had a grievance there was a form to be filled out at resident council. -This completed form would have been discussed at the next manager's meeting and assigned to the appropriate department manager. --Manager meetings were held on a daily basis. --The manager was to have investigated the issue and provided the resident council a response, and filled out a "department response	F 565		

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F 565	Continued From page 6 form." --This form would then be attached to the resident council minutes each month. *She confirmed a department response form had been completed for the 1/13/21 resident council meeting concerns. *She could not find any other department response forms completed for all other resident council grievances. *The provider had done call light audits in May 2021, the response time did improve. *She was not sure if the department response from 5/25/21 had been discussed with the residents during the next resident council meeting. -The activity director assisted the residents with their meetings, but he was not available during this survey to confirm if it had been discussed. 4. Review of the provider's updated 1/5/21 grievance policy revealed: *"Policy: It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident....." *"Procedures:" -"2. The facility Administrator or Administrator Designee, referred to as the grievance official, has been designated to receive all grievances." -"4. Any resident or representative or member of the resident's family or the resident council may present a grievance to the grievance official orally or in writing giving rise to the grievance." -"8. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not	F 565		

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F 565	Continued From page 7 confirmed, any corrective action taken [, or] to be taken by the facility as a result of the grievance, and the date the written decision was issued. 9. If the grievance is confirmed, the facility will take appropriate corrective action." *"Purpose: To provide a system that allows residents, families, staff and others to bring comments of grievances and satisfaction to the attention of the grievance official which allows the team to investigate and bring resolution in a timely manner. *"Process:" -"Grievance Official: .....All Grievances and Satisfaction Forms will come to the stand-up meeting and are reviewed by the grievance official who will determine what actions need to be taken and who will follow up on the Grievance. --The grievance official should actively participate in the investigation and resolution but may delegate portions of the tasks to the appropriate individuals. --The grievance official will make contact with the concerned party within 24 hours of being made aware of the grievance to let them know you are aware, that an investigation is being conducted, and to ask any additional questions that may help you come to a resolution and will keep in frequent contact until a resolution is obtained."	F 565		
F 658 SS=E	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:	F 658	1. Unable to rectify notification and following orders for resident 26, 38, and 39. Unable to educate LPN L as Agency contract ended prior to end of survey. Physician orders notification education provided to nursing staff on 11/25/2021. RN K was educated on appropriate administration of inhaler, and medication cart left unlocked and unattended by DON on 10/25/2021. Obtained distilled gallon of water from kitchen 10/19/21. Automatic order of distilled water on weekly order.	11/20/2021

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F 658	Continued From page 8 Surveyor: 45383 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Notification to a physician about a change in condition for one of one sampled resident (26) who was transferred to the emergency department (ED). *One of one sampled resident (26) had physician's orders followed for low blood sugar. *Documentation was completed for one of one sampled resident (26) who had gone to the ED. *Medications and medication-related items on and within the north hallway medication cart had been secured by one of one registered nurse (RN) (K). *Inhaler medication had been administered in accordance with the manufacturer's instructions for use for one of one random resident (38) by one of one RN (K). *Distilled water had been available for one of one random resident (39) for use with his continuous positive airway pressure (CPAP) machine. Findings include: 1. Review of resident 26's medical record revealed: *On 9/26/21 at 4:20 a.m. licensed practical nurse (LPN) L was notified of the resident's condition. -The resident's skin was cool and clammy to the touch. -She was unresponsive to verbal commands. -She had "coffee ground emesis on her cheek and in her mouth." -She had abnormal labored breathing. -Her blood sugar was 41 mg/dL (milligrams per deciliter) - LPN L had administered IM (intramuscular) Glucagon 1 mg. -Resident 26 had an as needed order for	F 658	2. All diabetic residents and residents utilizing C-PAP are potentially at risk. 3. Educated all nursing staff regarding blood sugar orders and parameters by DON on 11/10/2021. All diabetic resident's physician orders were reviewed, and parameters in place. All nurses educated for appropriate medication administration and inhaler administration by DON on 11/10/2021. Educated staff regarding who will be ordering distilled water, location of storage, and who to contact if not available by DON on 11/10/21. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. DON or Designee will review all diabetic residents weekly x4, biweekly x2, monthly x3 to ensure accuracy of diabetic orders being followed. DON or Designee will complete medication administration audits with 5 random alternating medication passes weekly x4, biweekly x2, monthly x3 ensure meds are stored correctly and inhalers are administered appropriately. DON or designee will Audit C-pap and distilled water for resident 39 weekly x4, biweekly x2, monthly x3 to ensure filled appropriately and ensure distilled water is available. All audits will be reviewed and monitored through QAPI.	

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F 658	Continued From page 9 Glucagon 1 mg IM for a blood sugar less than 60 mg/dL. -Her vital signs were: blood pressure 147/62, pulse 72, oxygen saturation 86% , temperature 94.7, and respirations 12 per minute. *On 9/26/21 at 4:31 a.m. 911 was called for transfer. *On 9/26/21 at 4:48 a.m. the family of resident 26 was notified of her transfer to the ED. *The physician or on call physician had not been notified prior to transferring resident 26 to the ED. *The resident was transferred to the ED that morning. *There was no provider's Skilled Nursing Facility/Nursing Facility (SNF/NF) to Hospital Transfer Form completed for resident 26. Review of resident 26's interdisciplinary progress notes dated 10/3/21 revealed: *On 10/3/21 at 4:30 a.m. RN M had: -Been called to assess resident 26 who had clammy skin and was lethargic. -Checked the resident's blood sugar and it was 37 mg/dL. -Attempted to give orange juice by and the resident had spit it out on every try. -Attempted to give a house supplement orally and the resident had spit it out. *On 10/3/21 at 4:45 a.m. RN M had: -Rechecked the resident's blood sugar and it was 38 mg/dL. -Tried giving yogurt orally and the resident spit it out as well. *On 10/3/21 at 5:00 a.m. RN M had: -Rechecked the resident's blood sugar and it was 38 mg/dL. -Given the resident a packet of sugar orally and the resident tried spitting it out. *On 10/3/21 at 5:15 a.m.:	F 658		

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F 658	Continued From page 10 -RN M had rechecked the resident's blood sugar and it was 44 mg/dL. -The resident was more alert and was given sips of sugar water. *On 10/3/21 at 5:45 a.m.: -RN M rechecked the resident's blood sugar and it was 58 mg/dL. -The resident was responding to verbal commands. -RN M had not given prn Glucagon 1 mg intramuscularly as ordered. Interview on 10/21/21 at 10:00 a.m. with administrator B, RN/regional nurse consultant A, and director of nursing (DON) C regarding the treatment RN M and LPN L had provided to resident 26 revealed: *Resident 26 had a PRN (as needed) physician order for Glucagon 1 mg intramuscularly for blood sugars less than 60 mg/dL. *RN/DON C stated RN M should have given Glucagon 1 mg intramuscularly to resident 26. *The provider did not have a policy on treating low blood sugar for a lethargic resident. *The provider did not have a policy for transferring a resident to the ED. *Administrator B stated the steps to take when transferring a resident to the ED included: -Notify the resident's physician or on call physician prior to transfer. -Notify 911. -Notify family. *They all agreed that LPN L had not notified physician with resident 26's change in status. -Had not obtained an order to transfer resident 26 to the ED. Surveyor: 41895 2. Observation on 10/20/21 at 7:40 a.m. of the	F 658		

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F 658	Continued From page 11 north hallway medication cart in the north hallway revealed: *When the cart was checked, it was unlocked. *There were four medication cards on top of it, that contained medications. *There was a piece of paper on top of the cart that had a list of residents and included how they took their medications and what type of assistance some of them needed with transfers. *RN K had walked out of a resident room and back to the medication cart. Observation on 10/20/21 at 8:10 a.m. of RN K administering a Dulera inhaler to resident 38 revealed: *She had asked resident 38 if she usually administered the medication herself and resident 38 replied "no." *She handed the inhaler to resident 38 without giving her any directions on how to use it. *Resident 38 took two puffs from the inhaler. -She did not instruct her wait thirty seconds between taking the two puffs. *She did not have resident 38 rinse her mouth after using the inhaler. Interview on 10/20/21 at 12:56 p.m. with RN K regarding the above observations revealed she: *Did not know she should have waited 30 seconds between puffs of the inhaler. *Should have had the resident rinse her mouth after using the inhaler. *Should have locked the cart, put her paper away, and locked the medication cards in the drawer. -She had stepped away from the cart quickly as a resident had been hollering for help and she needed to assist her. Review of the provider's 2007 Medication	F 658		

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F 658	Continued From page 12 Administration policy revealed: *"[Medication] Cart may remain unlocked only when in the direct line of sight and control by the nurse or medication aide who is administering medications." *To follow manufacturer's instructions product information for acceptable wait times between puffs of an inhaler. *A cup of water was needed to rinse mouth after a steroid inhaler. Review of the revised June 2021 Dulera Patient Instructions for use, found at https://www.organon.com/product/usa/pi_circulars/d/dulera/dulera_ppi.pdf, revealed: *"7. Breathe out as fully as you comfortably can through your mouth. Push out as much air from your lungs as possible. Hold the inhaler in the upright position and place the mouthpiece into your mouth (see Figure 4). Close your lips around the mouthpiece." *"8. Take a deep breath (inhale) in slowly through your mouth. While doing this, press down firmly and fully on the top of the canister until it stops moving in the actuator. Take your finger off the canister." *"9. When you have finished breathing in, hold your breath as long as you comfortably can, up to 10 seconds. Then remove the inhaler from your mouth and breathe out through your nose, while keeping your lips closed." *"10. Wait at least 30 seconds to take your second puff of DULERA." *"11. Shake the inhaler well again and repeat steps 6 through 8 to take your second puff of DULERA." *"13. After you finish taking DULERA (2 puffs), rinse your mouth with water. Spit out the water. Do not swallow it."	F 658		

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3. Interview on 10/19/21 at 2:59 p.m. with resident 39 revealed he had:
*Been out of distilled water for his CPAP machine for about a week so he could not use it.
*Told nurses, certified nursing assistants (CNAs), and administrator B he needed distilled water.
*Denied any adverse reaction from not using his CPAP machine.

Review of resident 39's medical record revealed:
*A 11/25/19 physician's order for resident to wear a CPAP machine at bedtime for obstructive sleep apnea.
*Documentation on his treatment administration record that he had not worn the CPAP on 10/12/21, 10/16/21, or 10/17/21 due to not having distilled water.
*There had been no other documentation as to what was done about it or if someone else had been notified.

Interview on 10/20/21 at 11:08 a.m. with CNA J revealed he did not know where the distilled water was stored.

Interview on 10/20/21 at 11:00 a.m. with administrator B, RN/DON C, and RN/regional nurse consultant A revealed:
*Distilled water was delivered on Tuesdays by US foods and was kept in central supply for staff to access.
*Nurses had been told where to get the distilled water.
*They had not been aware he did not have distilled water.
*He was usually accurate with his description of events.

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F 658	Continued From page 14 Observation on 10/20/21 at 11:12 a.m. with administrator B revealed there had been distilled water in the central supply room on the counter in a box. Interview 10/21/21 at 10:05 a.m. with dietary director H revealed: *Someone had told her to order distilled water on 10/15/21. *She had ordered it on 10/18/21 and it had came in on 10/19/21. *She did not know they had been completely out or she would have bought some. A respiratory care/CPAP policy had been requested from administrator B on 10/20/21 at 1:45 p.m. A policy on cleaning the CPAP machine was provided. The policy did not address the supply of distilled water.	F 658		
F 677 SS=F	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, internal bathing audit forms, policy review, facility assessments, and performance improvement project review, the provider failed to ensure: *Nineteen of twenty-three sampled or random residents (2, 3, 4, 6, 8, 10, 15, 18, 19, 21, 22, 23, 24, 25, 27, 29, 34, 35, 36, 37, 38, 39, and one resident who wanted to remain anonymous reviewed for personal hygiene had received a	F 677	1. Administrator interviewed residents 2, 3, 4, 6, 8, 10, 15,18, 19, 21, 22, 23, 24, 25, 27, 29, 34, 36, 38, 39 for bathing preferences on 11/11/2021. Scheduled baths per resident preferences, and care planned per preference. Unable to rectify resident 35, 37 due to no longer in the facility. Oral Hygiene unable to rectify with resident 35 as no longer in facility. 2. All residents have potential to be affected. 3. All nursing staff educated on 11/10/2021 regarding bathing policy and oral hygiene policy. Those not in attendance due to vacation, sick leave prior PTO request will be educated prior to next shift. DON or Designee to review all residents to ensure all resident oral hygiene is being followed 2x day and prn per facility policy. Interviewed remaining residents for bathing preference ensure schedule and care planned per preference. DON or Designee Audit 5 random residents for completion of baths and preference x4 weeks, biweekly x2, Monthly x3. DON or Designee to audit 5 random residents for oral care completion x4 weeks, biweekly x2,and monthly x3. All audits will be reviewed and monitored through QAPI.	11/20/2021

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shower or bath according to their preference.
*One of one sampled resident (35) had received oral care per physician orders.
Findings include:

1a. Interview on 10/19/21 at 3:15 p.m. with resident 2 revealed:
*He was supposed to have a bath on 10/19/21 but was told there had not been enough staff to provide the shower.
*In the past he had gone five to six weeks without a shower.
*He could only take a shower and not a bath because of his catheter.

Review of resident 2's bathing audits completed by the certified nursing assistants (CNAs) who had bathed him revealed:
*A bath/shower had been provided on 8/4/21, 8/19/21, 9/2/21, 9/10/21, 9/24/21, and 10/9/21.
*He had refused a bath on 10/18/21 due to a stomach ache.

Review of resident 2's revised 2/19/21 care plan revealed:
*He required physical assistance of one staff person for bathing.
*It did not indicate how often he preferred to have a bath.
*It did not indicate if he preferred a shower or bath.

b. Interview on 10/19/21 at 2:21 p.m. with resident 19 regarding her bathing revealed:
*She had not had a bath since 10/3/21, "it has been 16 days."
*She became teary eyed and explained how she felt like she had bacteria growing down there [perineal area] and was starting to smell bad.

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F 677	Continued From page 16 Review of resident 19's bathing audits completed by the CNAs who had bathed her revealed a bath/shower had been provided on 8/5/21, 8/12/21, 8/20/21, 9/1/21, 9/8/21, 9/18/21, 10/3/21, 10/13/21, and 10/19/21. Review of resident 19's revised 2/19/21 care plan revealed: *She required physical assistance from one staff person for bathing. *It had not indicated how often she preferred to have a bath. *It had not indicated if she preferred a shower or bath. c. Review of resident 37's bathing audits completed by the CNAs who bathe him revealed a bath/shower had been provided on 8/4/21, 8/19/21, 8/31/21, 9/8/21, 10/5/21, 10/12/21, and 10/18/21. Review of resident 37's revised 1/26/21 care plan revealed: *"Assist resident with shower/bathing per schedule." *It had not indicated what type of assistance was needed. *It had not indicated how often she preferred to have a bath. *It had not indicated if she preferred a shower or bath. d. Interview on 10/19/21 at 2:55 p.m. with resident 39 revealed: *He had not gotten a shower on a weekly basis. *There was not enough staff to provide his showers regularly. *When there was not enough staff to give him his	F 677		

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F 677	Continued From page 17 scheduled shower it does not always get made up and at times has had to wait until the following week. Review of resident 39's bathing audits completed by the CNAs who bathed him revealed a bath/shower had been provided on 8/2/21, 8/30/21, 9/10/21, 9/24/21, 10/7/21 and 10/18/21. Review of resident 39's revised 1/5/21 care plan revealed: *He required physical assistance from two staff members for bathing. *It had not indicated how often he preferred to have a bath. *It had not indicated if he preferred a shower or bath. Surveyor: 43844 e. Resident council interview on 10/20/21 at 10:05 a.m. revealed: *Six of seven residents said they did not receive baths on a timely basis. *Seven of seven residents said they did not always receive a bath every week. -Resident 3 said he usually gets one per week, "But, sometimes have to wait one or two days due to short-handed [not enough staff], it feels good when I do get a bath." -Resident 8 said she used to get two baths per week but has only been getting one now. She preferred two baths per week. -Resident 15 said she used to get two baths per week but has only been getting one now. She preferred two baths per week. -Resident 21 said she has had to wait up to three weeks to get a bath and preferred two baths per week. -Resident 29 said she has had to wait up to two	F 677		

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F 677	Continued From page 18 weeks to get a bath and would have liked, "A whirlpool, as it helps with my back pain, but I only get a shower." --She also thinks the provider should have hired a bath aide. -Resident 38 said she had to wait up to two weeks to get a bath and preferred two baths per week. -A resident who wanted to remain anonymous said: --Her roommate often smelled of urine for hours at a time. ---It gave her a headache. -She often smelled urine in the hallways. --She asked staff what that smell was to prompt them to provide care to others. -She did not think there was enough staff in the mornings to provide care. f. Observation on 10/19/21 at 11:59 a.m. of resident 18 revealed: *She had been laying in her bed. *The room had a very strong urine smell. *Her hair had an extremely greasy appearance. Review of resident 18's most current care plan revealed she: *Preferred a whirlpool bath and required the assistance of one staff member to complete. *Needed encouragement to participate in the bathing process. *Sometimes refused a bath. -Might take a bath if offered a candy bar. Review of resident 18's bathing audits revealed she had on: *8/11/21: Refused bathing twice. *8/17/21: A bath, had refused shaving, and her "hair was matted to scalp."	F 677		

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F 677	Continued From page 19 *8/24/21: The audit did not indicate if she had a bath, but did say her "hair was matted to her scalp - allowed staff to cut her hair." *8/31/21: A bath. *9/7/21: Refused a bath and had been educated. *9/14/21: A bath. *10/5/21: Refused. Two staff had attempted to give her one and they had offered snacks to do so. *10/19/21: Stated she had a bath on Monday, and refused three attempts to assist her with one. She had stated she would do it tomorrow. -She had not taken a bath on 10/19/21. g. Interview on 10/19/21 at 8:48 a.m. with resident 21 revealed she: *Believed she did not have a choice of when she could have a bath. *Wanted it on Wednesdays and it had been scheduled for Fridays. *Sometimes had not gotten a bath due to no staff. *"Gets sore in areas that I am unable to reach." Review of resident 21's medical record revealed her baths had been scheduled for Fridays. Review of resident 21's bathing audits revealed a bath/shower had been provided on: *8/9/21 and she had red areas in three areas, where the areas had been were unknown. -Bag balm had been applied and the nurse had been notified of the reddened areas. *8/18/21 and bag balm had been applied to her reddened areas, where the areas had been were unknown. *9/2/21, 9/10/21, 9/17/21, 10/5/21 and 10/16/21. h. Observation on 10/19/21 at 4:29 p.m. of resident 34 revealed he had:	F 677		

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F 677	Continued From page 20 *A full beard. *Hair that had been greasy in appearance and was at shoulder length. Interview on 10/20/21 at 8:46 a.m. with resident 34 revealed he: *Preferred to have a bed bath rather than a shower as it is easier for him. *Received a bed bath on 10/19/21 and stated, "That bed bath surprised the hell out of me, the one [staff] who used to do it is gone and it is the first bed bath I have had in well over one year. They wipe me up here and there, but not a full bed bath." Review of resident 34's medical record revealed: *He had a current brief interview of mental status (BIMS) with a score of 15 which indicated he was cognitively intact. *His care plan stated he refused baths at times, and was to have had a bed bath weekly if he refused his scheduled shower. Review of resident 34's bathing audits revealed he had a bed bath on: *8/4/21, 8/24/21, 9/7/21, 9/14/21, 9/23/21, and on 10/19/21. There had been no other documentation of a shower or bath. i. Confidential interview on 10/20/21 at 8:42 a.m. with a resident who wanted to remain anonymous revealed she: *Was mostly independent with her cares. *Seldom used her call light. *Did not feel there had been enough CNAs to care for the residents. -Felt this was an ongoing problem. *Would find someone to help her roommate when staff did not respond timely to her roommates call	F 677		

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F 677	Continued From page 21 light being activated. *Received a shower once per week. -Stated, "'Everyone used to get one [bath] twice a week, but they do not have enough staff for this any longer." j. Review of resident 36's care plan regarding bathing revealed she required physical assistance from one staff member to bathe. Review of resident 36's bathing audits revealed she had received a bath or shower on 8/2/21, 8/18/21, 8/25/21 , 9/2/21, 9/6/21, 9/13/21, 10/2/21, 10/9/21, and 10/16/21. k. Review of resident 22's bathing audits revealed he had received a bath or shower on 9/1/21, 9/7/21, 9/14/21, 10/12/21, and 10/19/21. l. Review resident 25's bathing audits revealed she had received a bath or shower on 8/12/21, 9/3/21, 10/8/21, and 10/17/21. Surveyor: 16385 m. Review of resident 23's bathing audits revealed a bath/shower had been provided on 8/5/21, 10/11/21, and 10/18/21. The resident had refused on 8/20/21, 9/6/21, and 9/13/21. Review of resident 23's revised care plan revealed the following bathing interventions: *9/15/21 - He required physical assistance with bathing. He often declined showers/baths. He sometimes called his sister to assist with directing him. *9/16/21 - He at times would refuse his bath. He would have liked staff to reach out to his sister and have her remind him how important bathing was.	F 677		

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F 677	Continued From page 22 n. Review of resident 10's bathing audits revealed a bath/shower had been provided on 8/20/21, 8/25/21, 9/1/21, 9/8/21, 10/6/21 and 10/13/21. Review of resident 10's revised care plan revealed the following 11/5/21 bathing interventions: *He required physical assistance from one staff member to assist with weekly WP (whirlpool) bath. *He needed encouragement to assist with the bathing process as he was able. o. Review of resident 4's bathing audits revealed a bath/shower had been provided on 8/5/21, 8/9/21, 8/20/21, 8/25/21, 9/1/21, 9/8/21, and 10/20/21. Review of resident 4's revised care plan revealed a 7/28/21 bathing intervention for the bath aide to give him a bath weekly versus a bed bath. p. Review of resident 6's bathing audits revealed a bath/shower had been provided on 8/5/21, 8/10/21, 8/16/21, 8/25/21, 9/1/21, 9/10/21, 9/15/21, and 10/7/21. Review of resident 6's revised care plan revealed the following 10/2/21 bathing interventions: *He required physical assistance from one staff with bathing. *He required encouragement to participate with bathing. q. Review of resident 29's bathing audits revealed a bath/shower had been provided on 8/4/21, 8/9/21, 8/19/21, 8/25/21, 9/2/21, 9/6/21, 9/13/21, 9/23/21, 10/2/21, 10/11/21, and 10/17/21.	F 677		

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F 677	Continued From page 23 Review of resident 29's revised care plan revealed a 3/31/32 bathing intervention for physical assistance from one staff member with bathing. Surveyor: 45383 r. Review of resident 35's bathing audits revealed bath/showers had been provided on 10/3/21 and 10/8/21. Review of resident 35 revised care plan dated 9/8/21 revealed the resident required assistance with a shower/bath per schedule. s. Review of resident 24's bathing audits revealed her bath/shower had been provided on 8/11/21, 8/19/21, 9/2/21, 9/10/21, 10/7/21, and 10/17/21. Review of resident 24 revised care plan dated 9/21/21 revealed she required physical assistance from one staff person with bathing. t. Review of resident 27's bathing audits revealed her bath/shower had been provided on 8/2/21, 8/16/21, 8/24/21, 9/7/21, 9/14/21, 9/23/21, 10/2/21, 10/7/21, 10/9/21, and 10/16/21. Review of resident 27 revised care plan dated 9/4/21 revealed she required physical assistance from one staff person with bathing. 2. Observation on 10/20/21 at 7:55 a.m. of resident 35 revealed: -He was seated in recliner with oxygen on per nasal cannula. -He had white patches and dryness to his tongue. Interview on 10/20/21 at 10:10 a.m. with RN/DON	F 677		

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	435049	A. BUILDING _____ B. WING _____	10/21/2021

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F 677	Continued From page 24 C revealed oral care should have been provided in the morning and at bedtime. Record review of resident 35's oral care task revealed: -Oral care had been performed at 12:41 a.m., 1:14 a.m. and 4:11 a.m. on 10/20/21. *Oral care was to have been performed every two hours. Observation and interview on 10/20/21 at 12:35 p.m. with resident 35 revealed: -He had finished lunch. -Leftover food particles were noted in his teeth. Interview on 10/20/21 at 4:40 p.m. with LPN I regarding oral care for resident 35 revealed: *CNAs were responsible for completing oral care and documentation of the completion. *Oral care should have been completed as ordered. *Maybe the CNAs had not had time to document cares. Interview on 10/20/21 at 4:45 p.m. with CNA N and CNA E regarding resident 35's oral care revealed: *CNA N arrived at 6:00 a.m. and: -Had provided oral care to resident 35 after breakfast. -Had not provided oral care to the resident since that time. *CNA E had assisted with resident 35's cares this morning and had not provided any oral care for resident 35. Surveyor: 16385 3a. Interview on 10/20/21 at 3:00 p.m. with CNA E revealed:	F 677		

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F 677	Continued From page 25 *Most residents were scheduled for weekly baths. *Some residents refuse routinely. *Sometimes there were not enough staff to do weekly baths. Surveyor: 41895 b. Review of the facility assessment revealed: *It had been updated on 9/16/21. *It had been last reviewed with Quality Assurance and Assessment/Quality Assurance & Performance Improvement (QAA/QAPI) committee on 10/10/19. *There should have been a bath aide for one eight hour shift five days a week. c. Review of the provider's Performance Improvement Project (PIP) guide revealed: *A start date of May 2021. *Review dates of 6/15/21 and 7/20/21. *A completion date of 8/17/21. *The project leaders were the administrator and director of nursing. *The key area of improvement was completion of baths. *The goal was "All [residents] will receive the number of baths of their preference by 8/15/21." *The root cause of the problem was staffing and agency availability. *There had not been any documentation of possible solutions. *The plans had a start date of May 2021 and included: -"Bath list made to meet resident needs." -"Baths documented in PCC [point click care]." -"Weights documented appropriately in PCC." -"Skin assessments completed in PCC." --There had been no completion dates listed on the plans. *There had been no documentation of how	F 677		

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F 677	Continued From page 26 progress had been measured. *There had been no documentation of what was tried, what failed, or what succeeded. d. Interview on 10/20/21 at 2:45 p.m. and at 4:24 p.m. with RN/DON C revealed: *She had started working at the facility in September 2021. *She had worked in the facility usually seven days a week. *She was aware there was a problem with getting baths done for residents. *She had expected all resident to get a bath at least once a week. *It was the facility's policy to have bathing per resident preference. *She audited baths weekly. *She had been looking at different ideas to ensure bathing was done and refusals of baths had been handled. -She wanted to start having staff call residents responsible parties at time of the refusal and have them speak with the resident on the phone. *They had a problem in the past with two CNAs not doing baths as assigned. -Those CNAs no longer worked at the facility. *The provider had not had a bath aide since the COVID-19 pandemic started. -She was not aware the facility assessment had indicated they would have a bath aide. *CNAs were expected to give baths to the residents per the bath schedule. *Resident's had been asked what day of the week they preferred to have their bath on and it was entered into the POC (point of care) task charting. -It was not documented on the care plan. *Residents were able to have a bath or a shower whichever they wanted.	F 677		

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F 677	Continued From page 27 e. Interview on 10/21/21 at 11:54 a.m. with regional nurse consultant A, administrator B, and RN/DON C regarding resident bathing revealed: *A bathing schedule had recently been redone to follow what day resident's had specified they wanted a bath. *All CNAs working were responsible for all resident cares including baths and needed to work together to ensure all the baths on the schedule had been completed. *They had identified resident bathing as a systemic failure and had a performance improvement project (PIP) in place since July 2021. *Bathing was reviewed every weekday during a morning meeting. -If a bath had not been done it was put on the schedule to be done that day. f. Interview on 10/21/21 at 2:30 p.m. with administrator B regarding resident bathing revealed she had agreed residents had not received baths/showers on a consistent basis due to staffing shortages. g. Review of the provider's September 2019 Bathing policy revealed: *"The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin." *"The resident has the right to choose timing and frequency of bathing activity." *"Bathing preferences are asked upon admission and during quarterly care conference."	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 28 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview, observation, record review, and policy review the provider failed to ensure the care plan and physician orders had been followed for one of one sampled resident (36) with lymphedema. Findings include: 1. Observation on 10/19/21 at 8:18 a.m. of resident 36 revealed: *She had been sleeping in her wheelchair. *She had severely swollen feet and legs. *She had been wearing gray socks. -The right foot had the gray sock pulled up halfway up her foot. -The left foot had the gray sock pulled up to her ankle. -She had not been wearing any type of compression stocking or edema wear. Observation on 10/19/21 at 10:42 a.m. of resident 36 revealed: *She had been sleeping in her wheelchair. *Her feet and legs appeared to be severely swollen. -She was wearing gray socks and no compression stockings or edema wear. *The right wheelchair pedal was in the down	F 684	1. Primary Care Physician contacted regarding edema and medications reviewed and received new orders to increase Lasix. 2. Potential to affect all residents with Lymphedema. 3. Primary Care Physician to review orders monthly x6 months regarding Lymphedema to ensure appropriate regimen. All nursing staff educated on exacerbation of lymphedema and lasix by DON on 11/10/2021. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. DON or designee to audit resident 36 medication orders received continue to be effective or if changes need to be made weekly. DON or Designee to audit all potentially affected residents weekly x4, biweekly x2, monthly x3 to ensure care plan and PCP orders have been followed. All audits will be reviewed and monitored through QAPI.	11/20/2021

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F 684	Continued From page 29 position. -Her right foot was under the wheelchair pedal. -Her right leg was behind this wheelchair pedal and there had been a vertical piece of the pedal that had been pressing into her severely swollen leg. *The left wheelchair pedal was also in the down position. --Her left foot was resting on the wheelchair pedal. Observation and Interview on 10/19/21 at 12:03 p.m. with resident 36 revealed: *Her feet were "painful" and her right foot "busted out last night, no one was doing anything for it." -She thinks she should go to her doctor. -She stated her, "Foot leaking, it is busted open and draining hard." *Her right leg that had been pushing against the foot pedal had a two and a half inch by one-fourth inch red mark across it. Interview on 10/19/21 at 12:10 p.m. with registered nurse K revealed she had not been aware of any open areas on resident 36's feet and she would have to check into it. Observation on 10/20/21 at 7:46 a.m. of resident 36 revealed: *She was sitting in her wheelchair, eating breakfast. *Her feet and legs were severely swollen. *She had a red mark where her right leg that had been pushing against the foot pedal the previous day. *She had not been wearing edema wear or socks and her feet were bare. Observation on 10/20/21 at 8:56 a.m. revealed:	F 684		

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F 684	Continued From page 30 *She was asleep and sitting in her wheelchair beside her bed. *She had not been wearing edema wear or socks, and her feet were bare. -Her right foot was resting on the floor, and her left foot was resting on the foot pedal of the wheelchair. *Her right foot had: -A clear fluid filled blister across the top of her foot, above her toes, measuring approximately two inches wide by one inch. -An open area above her great toe on top of her left foot measuring approximately the size of a pencil top eraser. -A clear fluid filled blister above the 4th toe on her left foot measuring approximately the size of a dime. Interview on 10/20/21 at 9:52 a.m. with occupational therapist assistant P regarding lymphedema care for resident 36 revealed: *She was on a temporary assignment with the provider. *She was not certified in lymphedema care. *She was not sure if anyone in the facility was. *The occupational therapist (OT) did not physically come to the facility. -The OT had provided telehealth care only. --The OT would not have been able to provide lymphedema care. Interview on 10/20/21 at 11:08 a.m. with physical therapy assistant O regarding lymphedema care for resident 36 revealed: *The physical therapist comes two times per week to the facility. *They did not currently have anyone certified in lymphedema care for this provider.	F 684		

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F 684	Continued From page 31 Observation and interview on 10/20/21 at 11:10 a.m. with resident 36 revealed: *She had been sitting in her wheelchair beside her bed. *She had bare feet. *Her right foot was resting on the floor, and her left foot was resting on the foot pedal of the wheelchair. *She complained of pain in her feet. *She lies down and puts her feet up at night but not during the day. *She stated "Doc says my shoes were too strong and that I should be wearing a lighter shoe and that would take the pressure off with lighter shoe. The lighter shoe caused the blisters." Observation on 10/20/21 at 1:31 p.m. of resident 36 revealed: *She was sitting in her wheelchair, playing hallway Bingo. *Both of her feet had compression stockings on that started at her toes and extended up to the knees. -Over the top of them were black Velcro compression wraps on both of her lower legs and feet. Interview and record review on 10/20/21 at 2:53 p.m. with registered nurse/director of nursing C regarding resident 36's swollen legs and feet revealed: *The 10/16/21 internal bathing audit form had identified resident 36 as having had "lower legs swollen." *The 10/16/21 skin evaluation form, located in resident 36's electronic medical record, had not identified the lower swollen legs. -She was not sure why the skin evaluation form had not identified this issue. -She would have to follow-up with the nurse who	F 684		

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F 684	Continued From page 32 completed it and have her explain the discrepancy in documentation. Interview on 10/21/21 at 9:30 a.m. at with certified nursing assistant (CNA)/medical records G regarding resident 36 revealed she: *Was not sure when resident 36 had quit walking. *Had thought resident 36 walked sometime last week to the bathroom and back to her chair. *Said resident 36's feet often "swelled up", and she was often put in a recliner to help elevate her feet. -Thought resident 36 sat in a recliner daily. *Confirmed resident 36 had not sat in a recliner in approximately one week due to the construction that had been going on in the living room area and there had not been a recliner in her room for resident 36 to use. Review of resident 36's medical record revealed: *She had a diagnosis of lymphedema and general edema. *She had a current physician orders that had started on: -12/18/18 to, "Elevate legs above heart as able to decrease edema." -11/24/19 for, "Compreflex compression garments: apply stocking 1st, then ComperBoot snuggly, then Compreflex garment stretching flaps to 20-30 on Accutabs in the morning related to LYMPHEDEMA." *Documentation in the electronic medical record for resident 36 revealed there was no documentation of the physician orders had been followed on October 1, 12, and 17th at 6:00 a.m. *Her progress notes on: -10/5/21- "Shoes are not fitting well anymore. We will schedule podiatry appointment for assessment of footwear and if now [new] shoes	F 684		

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F 684	Continued From page 33 are needed." -10/16/21- "Noted she had "3+ pitting edema." -Her physician had not been notified of this until 10/19/21. *She had been on a walking restorative plan. -The last documentation of walking during restorative program was on 10/13/21. -The documentation showed she had refused on 10/14/21. -No documentation had been completed from 10/14/21 through 10/20/21 for her restorative walking program. Review of resident 36's current care plan regarding her feet and legs revealed: -"Encourage me to sit in the living room, not at the nurses station, so I am able to sit in a chair that will elevate my feet." -"I have Edema wear that I should have on in AM off at HS. I will take off the edema wear and just put on shoes." -"I have edema/lymphedema to my BLE; report any changes noted to my nurse/physician, including any significant or continued weight fluctuations, including increased difficulty walking." -"If I fall asleep in the living room or dining room, strongly encourage me to go to my room and lay in bed with my feet up, even for short periods during the day." -"Remind me not to take my wraps off my legs, and that they are supposed to be a bit tight, but if I am c/o [complaining of] too tight, please check them to be sure they are not too tight." -"I have the potential for pressure ulcer/injury development r/t [related to] Lymphedema, Obesity, mental disorders e/b [evidenced by] physical and cognitive limitations. -"My skin will remain intact without pressure	F 684		

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F 684	Continued From page 34 ulcers/injuries through the next review date." -"My nurse will assess my skin at least weekly for any actual or potential skin issues, and notify appropriate departments if actual impairments arise (dietary, wound nurse, physician), as needed." -"My nurse will monitor the skin on my legs when removing my specialized compression garments to my legs every night and inform my wound nurse of any skin changes as needed." -"Report any noted actual or potential skin impairments to my nurse that you notice with my BID [twice daily] cares, weekly bath and prn, as needed." Review of provider's April 2021 Skin Program policy revealed: *"Policy: To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they are unavoidable. -To provide care and services to prevent pressure injury development, to promote healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds. *The policy did not address fluid filled blisters. *No other skin policies were provided during this survey.	F 684		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725	1. Interviewed residents for bathing preferences, scheduled per preferences, and care planned per preference. 2. All residents have potential to be affected. 3.Administrator removed from floor to appropriately manage and maintain schedule. Administrator increased staffing through increased agency contracts.Interviewed remaining resident for bathing preference ensure schedule and care planned per preference. Resident council Grievances will be reviewed Monday-Friday AM meeting.	11/20/2021

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F 725	Continued From page 35 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, nursing schedule review, and facility assessment review, the provider failed to ensure sufficient staffing as evidenced by resident concerns with a lack of bathing and call light response times. Findings include: 1. Resident council interview on 10/20/21 at 10:05 a.m. with seven residents revealed baths were not getting done on a regular basis and call lights had not been answered timely due to what they perceived as staffing concerns. Refer to F565. 2. Review of 19 of 23 sampled resident bathing audits revealed baths had not been done on a	F 725	The grievances will be delegated to respective department or designee, returned to morning meeting within 48 hours with resolution, and reviewed with Resident Council President prior to resident council meeting with grievance responses. IDT team and resident council president educated on process. Administrator B attended Resident council Meeting reviewed previous resident council grievances and resolutions 11/4/2021. If not in attendance of resident council 11/4/21 will be personally reviewed with resident regarding grievances. All staff educated on Grievances and bathing policy by DON on 11/10/2021. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. DON or Designee will audit 5 random residents for completion of baths and preference x4 weeks, biweekly x2 months, Monthly x3 months. Activities Director or Designee will audit Resident council grievances x6 months. Results will be reviewed through monthly QAPI meeting with interdisciplinary team and medical director for further evaluation and monitoring.	

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F 725	Continued From page 36 regular basis. Refer to F677. Surveyor: 43844 3. Interview on 10/20/21 at 2:42 p.m. with social service designee D regarding staffing for the facility and bathing for residents revealed: *They could always use more staff. -She thought there was sufficient staff for the number of residents currently residing in the facility. -She thought the general feeling from residents was that the provider did not have sufficient staff. -"All open shifts are filled." *She thought residents had a difficult time when baths "needed to be shuffled." -"We have tried different things and maybe going to a block schedule seven days per week." *Resident 18 does not want help but she needs it. *Resident 34 had not told her of any concerns with bathing. -She had been trying to encourage him to have more personal cleaning. Surveyor: 16385 4. Review of the provider's October 2021 nursing schedule revealed management staff were regularly scheduled to work as nurses and certified nursing assistants (CNAs): *Administrator - seventeen days on the schedule. *Director of nursing - eleven days on the schedule. *Assistant director of nursing - thirteen days on the schedule. *Unit manager - seventeen days on the schedule. *Medical records - six days on the schedule.	F 725		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435049	A. BUILDING _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SALEM	500 COLONIAL DRIVE SALEM, SD 57058

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 37 §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: Surveyor: 45383 Based on observation, interview and policy review, the provider failed to ensure the: *Kitchen floor, cabinets, and vents were maintained in a sanitary manner. *Resident's personal food items had been stored appropriately. Findings include: 1. Observation on 10/19/21 at 8:20 a.m. and on 10/20/21 at 1:50 p.m. in the kitchen revealed: *Cabinet shelves that contained clean dishes had dust and dirt. *Tile floor throughout the kitchen was dirty. -Paper and other debris were along the base board and near workstations, and under dishwashing sinks.	F 812	1. Kitchen Floor, Cabinets cleaned 11/11/2021. Kitchen floor on daily cleaning at end of pm shift. Kitchen Cabinets on weekly cleaning schedule. Vents Replaced 11/11/2021 and added to weekly cleaning schedule. Deep clean of floor to be scheduled quarterly. Resident food items have been removed and stored appropriately 10/22/2021. 2. All residents have potential to be affected. 3. Education provided to DSM and Maintenance Director regarding sanitation policy by Administrator on 11/11/2021. Dietary staff educated that resident refrigerator needs to be checked daily to ensure resident's personal food items are stored appropriately by DON on 11/10/2021. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Non-dietary staff will audit that kitchen floor, vents, cabinets are being maintained weekly x4, biweekly x2, monthly x3. Administrator or designee will audit personal resident fridge weekly x4, biweekly x2, monthly x3. Audits and findings will be reviewed in monthly QAPI meetin with interdisciplinary team and medical director.	11/20/2021

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F 812	Continued From page 38 *Vents over the dishwasher had dirt and rust. *Vent and pipe above dish storage cabinet had a thick layer of dust. Continued observation and interview with dietary director H at the above time revealed she confirmed: *The vents above the dishwasher had dirt and rust and needed to be cleaned. *The vent above the dish storage cabinet needed to be cleaned. 2. Observation of the refrigerator in the dining room designated for resident use revealed: *An opened package of BBQ pork buns. -The package should have been kept frozen. -The package was not dated. *An applesauce bottle in the door of the refrigerator had not been dated. *Two opened jars of salsa with the resident's name on them. -Both jars were not dated. *Shredded cheese in the bottom left drawer in the refrigerator: -Had expired on 4/19/21. *Contents of the freezer in the resident refrigerator contained: -An opened box of corn dogs with the resident's name on it. -A frozen pizza with the resident's name on it. *The daily refrigerator temperature log posted on the side of the refrigerator had no documented freezer temperatures. Continued interview with dietary director H about the resident refrigerator revealed she: *Thought staff had been documenting freezer temperatures. *Was not aware of outdated and undated items in	F 812		

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F 812	Continued From page 39 the refrigerator. *Was going to speak with the activity director about refrigerator items. 3. Review of kitchen policy for food brought by the resident's family revealed: -Food should have been labeled to identify the date the food from the outside had been brought in by representative. -Perishable food items brought in by the resident's representative should have been discarded within 3-5 days after being brought in and refrigerated.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and 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 §483.70(e) and following accepted national standards;	F 880	1. Appropriate hand hygiene and glove uses along with procedural technique with dressing change. Appropriate maintenance of urinary catheter tubing. The Administrator, DON, and/or a designee in consultation with the medical director will review, revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services were educated on 11/10/2021 by DON. 2. All residents and staff have the potential to be affected if staff do not adhere to identified areas. 3. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks were provided by Admin/DON or designee on 11/10/2021. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Root Cause Analysis conducted answered the 5 Whys: Lack of structure for catheter care and monitoring. Lack of training in wound care, hand hygiene, PPE Donning/Doffing, Catheter Care. Lack of PCC prompts to complete catheter care. Lack of competencies in wound care, hand hygiene, PPE donning/doffing, catheter care. Lack of consistent placement of collection bag. Lack of monitoring/auditing. Administrator, DON, Medical Director and any others identified as necessary will ensure all facility staff responsible for assigned task(s) have received education/training with demonstrated	11/20/2021

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F 880	Continued From page 40 §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. §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.	F 880	competency and documentation. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 11/10/2021 and include conversation regarding hand hygiene, competencies, environment to allow more compliance with hand hygiene, catheter care supplies, wound supplies, and tools for education, tracking, and auditing. Administrator, DON, and/or a designee will conduct auditing and monitoring of area identified above. Monitoring of determined approaches to ensure effective implementation and ongoing sustainment include at a minimum 2-3 times weekly for 3 weeks, administrator, DON and/or Designee making observations across all shifts to ensure staff compliance with: Staff compliance in the above identified area. Any other areas identified through Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 41 §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: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to maintain proper infection control practices for: *Two of two resident (28 and 32) dressing changes by one of one licensed practical nurse (LPN) (I). *One of one resident (34) catheter bag replacement. Findings include: 1. Observation and interview on 10/21/21 at 7:40 a.m. of LPN I changing a wound vacuum-assisted closure (vac) dressing for resident 32 revealed she had: *Changed her gloves twice and had not performed hand hygiene. *Not used a clean barrier under her clean dressing supplies and had set them on the bedside table. *A piece of the gray foam dressing that was used on the wound had been on the bedside table touching the remote. *Scissors, that had been sitting on the bedside table, had been used to cut the dressing supplies. *When asked about her practice following the procedure LPN I stated she should have: -Performed hand hygiene between glove use. -Used a clean barrier under the dressing supplies and scissors. Interview on 10/21/21 at 8:20 a.m. with registered nurse/director of nursing (RN/DON) C revealed she had:	F 880		

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F 880	Continued From page 42 *Expected staff to perform hand hygiene between glove use. *Expected nurses to use a clean barrier under clean dressing supplies during a dressing change. A dressing change policy had been requested on 10/20/21 at 1:45 p.m. and the provider had provided the survey team with an undated Dressing Change Competency - Aseptic Technique form. Review of the provider's undated Dressing Change Competency - Aseptic Technique form revealed a barrier was to be used under dressing supplies. Review of the provider's October 2019 Hand Hygiene policy revealed: *"This facility considers hand hygiene the primary means to prevent the spread of infections." *An alcohol-based hand rub was to be used: -Before and after direct resident contact. -Before and after glove use. Surveyor: 43844 2. Observation and interview on 10/20/21 at 1:36 p.m. with resident 34 revealed: *His catheter bag had been full of urine, lying on the floor underneath his bed. *He had not been aware of this. *Due to his obesity, he was not able to roll over without assistance or to reach the catheter bag to move it himself. Interview on 10/21/21 at 8:25 a.m. with administrator/certified nursing assistant (CNA) B revealed resident 34's catheter bag should have been hanging from the side of the bedframe, and	F 880		

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F 880	Continued From page 43 not on the floor. Interview on 10/21/21 at 8:35 a.m. with CNA F revealed: *She had never provided catheter care. *Her training as a CNA was to hang the catheter on the side of the bedframe, so that the urine drained downward. Review of provider's September 2019 catheter care policy revealed: *"Policy: The purpose of this procedure is to prevent catheter-associated urinary tract infections." "General guidelines" -"Infection Control" --"2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag." ---"b. Be sure the catheter tubing and drainage bag are kept off the floor." Surveyor: 45383 3. Observation and interview on 10/20/21 at 8:00 a.m. of LPN I performing dressing change for resident 28 revealed she: *Removed a dressing from the medication (med) cart. *Opened the package and with her gloved right hand placed the dressing on her clean field on the med cart. *Moved all her dressing supplies to resident 28's room. Placing paper towel on resident 28's bed. *Had not performed hand hygiene before or after putting on the glove to her right hand. *Then removed the glove from her right hand. *Put on a new pair of gloves and removed the old dressing from the resident's left leg and foot. *Removed her gloves and put on a new pair of	F 880		

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F 880	Continued From page 44	F 880		

gloves.
*Put on a new pair of gloves then cleansed the wound with wound cleanser.
*Removed her gloves and washed her hands.
*Put on a new pair of gloves and redressed the resident's wounds.
*She removed her gloves and put on a new pair of gloves.
*Removed a dressing from the resident's right leg.
*Removed her gloves and went to the med cart to retrieve more dressing supplies.
*Put on a new pair of gloves and cleansed the wound on the resident's right leg.
*Removed her gloves, put on a new pair of gloves, and continued to redress the wound on the right foot.
*Replaced the resident's dirty socks over clean leg wraps.
*Then removed her gloves and washed her hands.

When asked about her practice following the procedure LPN I stated:
*That was normally how she performed dressing changes with this resident.
*She had missed performing hand hygiene between glove changes.

Interview on 10/20/21 at 10:15 a.m. with RN/DON C and administrator B regarding resident 28's dressing change revealed both had agreed that LPN I missed hand hygiene between glove changes.

Review of the facility's competency form revealed hand hygiene should have been performed between glove changes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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E 000	Initial Comments Surveyor: 41895 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 10/19/21 through 10/21/21. Avantara Salem was found not in compliance with the following requirement: E001.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	1. The following Policy/Procedures were added to the Emergency Preparedness Program: Sewage & waste disposal, Fire Alarms, Track Location of On Duty Staff and Sheltered Residents under facility during an emergency, Track location of staff & Residents during an Emergency Evacuation- including specific Name and Location of the receiving facility or other location and addition of communication plan that includes names and contact info for resident's physicians and a method to provide information about the facility occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center or designee. 2. All residents are at risk due to not having a thorough emergency preparedness program in place 3. Administrator to educate all staff on the above added policies 11/09/21. Those not in attendance at education due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. The administrator or designee will perform weekly audit of 5 staff per week to ensure they know where these policies and procedures are located within the emergency preparedness plan. Audits will be weekly x4, monthly x2 months. Results of audits will be discussed by the administrator at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	11/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	11/15/2021

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

NOV 16 2021

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	435049	A. BUILDING _____ B. WING _____	10/21/2021

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E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview and record review, the provider failed to establish a comprehensive emergency preparedness (EP) program that included policies, procedures, communication plan, and contact information. Findings include: 1. Interview on 10/20/21 at 4:10 p.m. and review of the provider's EP program documentation with registered nurse/regional nurse consultant A and administrator B revealed: *They did not have a comprehensive EP program. *They had not: -Addressed policies and procedures for sewage and waste disposal. -Addressed policies and procedures for a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains	E 001		

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E 001	Continued From page 2 availability of records. -Addressed the role of the facility in the provision of care and treatment at an alternate care site identified by emergency management officials. *The had not developed a communication plan that: -Included names and contact information for residents' physicians. -Included the contact information for the Office of the State Long-Term Care Ombudsman. -Addressed policies and procedures for an alternate means for communicating with: --The facility's staff. --Federal, state, tribal, regional, and local emergency management agencies. -Included a method of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 001		

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	435049	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SALEM	**500 COLONIAL DRIVE** **SALEM, SD 57058**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/19/21. Avantara Salem was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Nickel
TITLE: LNHA
(X6) DATE: 11/15/2021

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

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10674 S	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SALEM	500 COLONIAL DR SALEM, SD 57058

(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 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/19/21 through 10/21/21. Avantara Salem was found not in compliance with the following requirements: S130, S166, and S191.	S 000		
S 130	44:73:02:07 Food Service Food service shall be provided by a licensed facility or food service establishment that is inspected by a local, state, or federal agency. The facility shall meet the safety and sanitation procedures for food service in §§44:02:07:01, 44:02:07:02, and 44:02:07:04 to 44:02:07:95, inclusive, the Food Service Code. In addition, a mechanical dishwasher shall be provided in all facilities of 17 beds or more. The facility shall have the space, equipment, supplies, and mechanical systems for efficient, safe, and sanitary food preparation if any part of the food service is provided by the facility. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain an air gap for the vegetable preparation sink drain line in the kitchen. Findings include: 1. Observation at 9:15 a.m. on 10/19/21 revealed the vegetable preparation sink in the kitchen was not equipped with a one inch air gap in the drain line. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	S 130	1. Unable to rectify 2. Air Gap was placed in the vegetable sink on 11/05/2021 by Krohmer's Plumbing. 3.Administrator educated the Maintenance Director on 10/20/2021 to ensure an air gap is installed and maintained between the vegetable sink and plumbing. Maintenance Director will audit the functional status of the air gap installation 2 times per week for 4 weeks and then monthly for two months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	11/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Nickel — TITLE: LNHA — (X6) DATE: 11/15/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 166	Continued From page 1 S 166 44:73:02:18(1-2) Occupant Protection The facility shall take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents; (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to supply a working call system in one randomly observed toilet room (resident room 101 toilet room). Findings include: 1. Observation at 11:45 a.m. on 10/19/21 revealed the toilet room nurse call switch in resident room 101 was wired in the up position. The nurse call switch would not be able to be activated (pulled down) by the resident in that condition. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated the room had recently been changed from a staff office location into a resident room and the switch condition had been overlooked.	S 166 S 166	1. Unable to rectify the call light being wired in the up position preventing a resident from activating. All residents utilizing that room could be affected. 2. Call light was replaced by United Alarms on 11/09/2021. 3.Administrator educated the Maintenance Director on 10/19/2021 to replace the call light in room 101 and to audit the call light's functional status 2 times per week for 4 weeks and then monthly for 2 months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	11/20/2021

South Dakota Department of Health

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S 166	Continued From page 2 This deficiency has the potential to affect all residents who use that toilet room.	S 166		
S 191	44:73:02:21 Physical Plant Changes A facility shall submit any proposed change by new construction, remodeling, or change of use of an area to the department. Any change shall have the approval of the department before it is made. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to notify the department of room change of use for three rooms from offices to resident rooms (101, 113, and 213). Findings include: 1. Observation at 11:45 a.m. on 10/19/21 revealed the nurse call switch for resident room 101 toilet room was wired in the up position and was not usable by the resident in that condition. Interview with the maintenance supervisor at the time of the observation revealed the room had recently been converted from the DON office into a resident room. He stated he had overlooked the nurse call switch condition when the change happened. Further interview revealed he did not notify the department of the room change of use. He added room 113 (social services office) and room 213 (business office) had been converted into resident rooms at that same time.	S 191	1. Unable to rectify previous room conversions 2. Notification will be given to DOH Life Safety Department with any future room conversions prior to change. 3. Administrator or Designee will audit facility floor plan to ensure there have been no room change of use for facility weekly x4, biweekly x2, monthly x3. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	11/20/2021