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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/15/21 through 8/17/21. Avantara Pierre was found not in compliance with the following requirements: F561, F568, F578, F582, F584, F644, F661, F676, F812, and F880.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561	1. Resident's 18, 31, and 40 have had a smoking assessment completed and smoking privieges have been re-instated if they were deemed appropriate on August 30, 2021. 2. All residents are at risk of bein affected for the facility's failure to promote and facilitate resident self-determnation through support of resident choices. An audit will be conducteed of all other residents to ensure that they do not desire to smoke and if they do, a smoking assessment wil be completed to determine if appropriate no later than October 4, 2021. 3. The administrator or designee will educate staff on Resident rights to ensure the resident has the right to and facility promotes and facilitates resident self-determination through support of resident choices. The cited deficiency will be reviewed as well. Education will occur no later than September 16, 2021 and those not in attendance at ducation session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The Administrator or designee will interview 5 residents to ensure that the residents' rights are being supported by staff. Audits will be weekly for four 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. 5. October 4, 2021.	10/04/21

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

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.

Sharon Martin — Administrator — 09/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING Type text here B. WING	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 561	Continued From page 1 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on interview, record review, and policy review the provider failed to ensure three of three residents' (18, 31, and 40) right to smoke had been re-evaluated and re-instated if appropriate after COVID-19 quarantine restrictions had been lifted. Findings include: 1. Interview on 8/15/21 at 1:00 p.m. with director of nursing B during the survey entrance conference regarding resident smokers revealed: *At the onset of the COVID-19 pandemic in March 2020 all residents had been quarantined in their rooms. *All residents who formerly smoked had quit smoking during the COVID-19 quarantine. Record review related to resident 31 revealed: *Her admit date had been 12/14/18. *Her brief interview for mental status (BIMS) score had been 15 indicating she had no cognitive impairment. Interview on 8/15/21 at 1:49 p.m. related to resident 31 revealed: *She stated she wanted to be able to go outside to smoke. *She had been a smoker before a COVID-19 outbreak in the facility. -During that outbreak she had not been permitted to go outside and smoke. *Once the outbreak was over she had not been allowed to resume smoking. *She had discussions with administrator A about being able to resume smoking.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 561	Continued From page 2 *She stated administrator A told her two months ago she was working on it. Surveyor: 40788 A resident group interview on 8/16/21 between 10:30 a.m. and 11:30 a.m. revealed: *Resident 31 had not smoked since March 2020 when the COVID-19 pandemic began. -She wanted to resume smoking and had spoken to administrator A about that in March 2021. -She was still unable to smoke. *Residents 18 and 40 had not smoked since March 2020 and wanted to resume smoking too. Review of residents 18, 31, and 40s' care records revealed no care plans related to smoking. Interview on 8/16/21 at 3:35 p.m. with social services designee (SSD) F regarding resident smoking revealed: *She was aware in March 2021 resident 31 had voiced a desire to smoke again. *Administrator A was responsible for following up on that request. *She had not asked other former smokers if they had wanted to resume smoking too. Interview on 8/17/21 at 2:30 p.m. with administrator A regarding resident smoking revealed: *She confirmed resident smoking stopped in March 2020 when residents had been quarantined in their rooms due to the pandemic. -Smoking resumption had not been re-evaluated after quarantine restrictions had been lifted but should have been. *Resident 31 had asked to resume smoking in March 2021 and she had told her she would follow-up on that request.	F 561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 561	Continued From page 3 *Resident 31 had not asked again about smoking for several weeks to months after that time so she assumed resident 31 had not wanted to resume smoking and done nothing about it. *After resident 31 asked her again about smoking in July 2021 a quality assurance performance improvement plan (PIP) was initiated on 7/12/21. *Administrator A said no action had been taken on that PIP because a newly hired activities director starting the following week was expected to assume responsibility for that process. -Agreed another staff person could have been designated to assume responsibility for that PIP completion in the meantime, but was not. *Agreed five months from the time resident 31 had initially voiced her smoking concern until now was too long for her to wait for her concern to be addressed. Review of the July 2021 PIP related to smoking resumption revealed: *It was started on 7/12/21 and included a plan to talk with all former residents who smoked, complete smoking assessments for those interested in smoking again, establish smoking times, establish a smoking protocol, and provide resident education regarding smoking expectations. *The target date for completion of that PIP was 7/21/21. Review of the September 2019 Smoking policy revealed: *Policy: -"This facility shall establish and maintain safe resident smoking practices while protecting the rights of the individual resident." *Procedures: -"If the facility allows smoking, all residents who	F 561		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 561	Continued From page 4 smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the care plan." -"Any smoking -related privileges, restrictions, and concerns shall be noted on the resident's individual care plan."	F 561		
F 568 SS=F	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Surveyor: 42558 Based on interview, record review, and policy review, the provider failed to ensure 19 of 19 residents (2, 3, 4, 5, 9, 10, 14, 15, 16, 18, 20, 27, 28, 30, 32, 34, 40, 44, and 48) who had a financial trust account had received a quarterly statement. Findings include: 1. Interview on 8/16/21 at 3:30 p.m. with resident 5 revealed: *He had stated the facility kept a spending account for him and he had not received a statement in a long time. -He had not known his account balance.	F 568	1. Residents 2,3,4,5,9,10,14,15,16,18,20,27,28,30, 32,34,40,44, and 48 and/or the residents' representative will be provied a quarterly statement of their financial trust account by no later than October 4, 2021. 2.All residents wilth financial trust accounts being maintained by the facility are at risk for not receiving a quarterly satement of their funds. An audit will be conducted of all residents that have a financial trust to ensure a quarterly statement is provided no later than October 4, 2021. No other residents have a financial trust account maintained by the facility at this time. 3. The Administrator will educate the Business Officer Manager on the Resident Trust Acounts policy to include the requirement to ensure that the residents and/or the residents representative receives a quarterly statement of their funds. The cited deficiency will be reviewed as well. Education will occur no later than September 16, 2021. 4. The Administrator or designee will audit 5 resident turst accounts weekly to ensure a quarterly statement has been provided to the resident and/or the resident's representative. Audits will be weekly for 3 weeks, then monthly for 2 months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revisin of audits based on audit findings. 5. October 4, 2021	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 568	Continued From page 5 -Asked this surveyor, "Can you help me with this?" Interview on 8/16/21 at 4:06 p.m. with the business office manager E revealed: *She had been moved into the the business office manager position in December of 2020. *Stated her training for this position consisted of a few days with the prior office manager and a few days with a sister office in Rapid City. -She had no other facility training for this position. *She had also been responsible for: -Completion of resident admit paperwork. -Transferring residents to medical appointments. -Working on the floor as a certified nurse aid (CNA) and assisting with resident's care as needed. *She had been responsible for electronically updating financial trust accounts when there was a change to the residents' account balance. *She had viewed statements prior to December 2020, but had not been made aware she needed to provide a quarterly financial trust account statement to residents or their representatives. *Resident 5 had been responsible for himself and did not have a representative. *Supplied a list of 19 residents that had financial trust accounts. -Stated none of the 19 residents or their representatives had received a trust account statement since her taking over the position in December of 2020. Interview on 08/17/21 at 9:19 a.m. with Administrator A revealed: *On 8/16/21, office manager E had informed her quarterly resident trust account statements had not been provided to the residents or their representatives since December 2020.	F 568		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 568	Continued From page 6 *Agreed the office manager should have provided quarterly statements to residents or their representatives. Review of the provider's July 2019 'Resident Trust Accounts' policy revealed: **"Department: Business Office." **"Procedure: Accurate records will be kept of residents' monies and, a quarterly accounting of financial transactions will be given to the resident. A copy of the receipt given to the resident or authorized representative for monies received shall be kept with trust account records."	F 568		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578	1. An advanced directive has been completed for resident 7 on September 7, 2021 and resident 252 on August 17, 2021. 2. All residents are at risk of being affected by not having and advanced directive completed. An audit of all residents' medical records was conducted by the Admissions Coordinator to ensure an advance directive has been completed with the resident and/or the resident's representative no later than October 4, 2021. 3. The Director of Nursing (DON) will educate the Social Service Designee (SSD), Admission's Coordinator and the Clinical Care Coordinator (CCC) on the Advanced Directives policy to ensure an advanced directive is completed with the resident and/or the resident's representative upon admission. The cited deficency will be reviewed as well. Education will occur no later than September 16, 2021 4. The DON or designee will audit all new admissions each week to ensure an advanced directive has been completed with the resident and/or resident representative upon admission. Audits will be done weekly for 4 weeks and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with th eIDt and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 578	Continued From page 7 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Surveyor: 42558 Based on interview, record review, and policy review, the provider failed to ensure an advance directive had been completed for two of six sampled residents (7 and 252) who had been admitted to the facility within the last 90 days. Findings include: 1. Review of resident 7's medical record revealed: *She had been admitted on 5/19/21. *A 7/15/21 Brief Interview of Mental Status (BIMS) score of 0, indicating severe cognitive impairment. *She had a diagnosis of aphasia (the loss of ability to understand or express speech, caused by brain damage) and had been unable to make her needs known. *Her advanced directive form had been unsigned by her legal representative or by her physician.	F 578	1. An advanced directive has been completed for resident 7 on September 7, 2021 and resident 252 on August 17, 2021. 2. All residenseeeeddddare at risk of being affected by not having and adirective completed. An audit of all residents' medical records will be conducted to ensure an advance directive has been compled with the resident and/or the resident's represenative no later than October 4, 2021. 3. The Director of Nursing (DON) will educate the Social Service Designee (SSD), Admission's Coordinator and the Clinical Care Coordinator (CCC) on the Advanced Directives policy to ensure an advanced directive is completed with the resident and/or the resident's representative upon admission. The cited deficency will be reviewed as well. Education will occur no later than September 16, 2021 4. The DON or designee will audit all new admissions each week to ensure an advanced directive has been completed with the resident and/or resident representative upon admission. Audits will be done weekly for 4 weeks and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with th eIDt and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 578	Continued From page 8 *The electronic health record had a do not resuscitate (DNR) order entered on 6/9/21. -This had not been signed by the resident's physician. *This surveyor had attempted reach the legal representative by phone on 8/15/21 and 8/16/21. -The legal representative had not returned the phone calls by the end of survey on 8/17/21. 2. Interview on 8/16/21 at 11:33 a.m. with resident 252 revealed: *She informed this surveyor she had not signed an advanced directive when she had been admitted to the facility. *No one in the facility had talked with her about her wishes if she where to suddenly stop living. Review of resident 252's medical record revealed: *She had been admitted on 8/6/21. *An 8/9/21 BIMS of 11, indicating moderate cognitive impairment. *Her advanced directive form had been unsigned by the resident or her legal representative, or her physician. *The electronic health record had a DNR order entered on 8/15/21. Interview on 8/16/21 at 3:43 p.m. with business office manager E regarding advanced directives for resident's 7 and 252 revealed: *She had been responsible for completion of resident admission paperwork since September 2019. -This included the resident's advanced directives form completion. *If the resident or representative had been unable to sign the advanced directives at the time of admit, she would inform social services.	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 578	Continued From page 9 *Stated she was not allowed to document in the resident's electronic medical record. *Social services had been in charge of contacting the legal representatives to complete the advanced directives and documenting these attempts in the electronic medical record. *The admitting nurse entered the orders sent from the transferring facility into the computer. -This had included the advanced directives sent from the transferring facility. *She had been waiting on the resident's representatives to come and sign the advanced directive paperwork. *Agreed the advanced directives had not been completed when the above residents had been admitted. Interview on 8/17/21 at 9:25 a.m. with clinical services coordinator C revealed: *She had been in charge of putting resident's admit orders into the computer, including the advanced directives. *She entered the advanced directives that had come from the discharging facility. *Social services confirmed electronic advanced directives were correct according to the admit paperwork. *She had depended on social services to tell her if the advanced directives had changed once a resident had been admitted. Interview on 8/17/21 at 9:16 a.m. with social services designee F revealed: *She had been responsible for confirming advanced directives. *She was not aware resident 7's advanced directive was not signed by the legal representative. -Informed this surveyor the legal representative	F 578	1. An advanced directive has been completed for resident 7 on September 7, 2021 and resident 252 on August 17, 2021. 2. All residentws are at risk of being affected by not having and advanced directive completed. An audit of all residents' medical records will be conducted to ensure an advance directive has been comple3ed with the resident and/or the resident's represenative no later than October 4, 2021. 3. The Director of Nursing (DON) will educate the Social Service Designee (SSD), Admission's Coordinator and the Clinical Care Coordinator (CCC) on the Advanced Directives policy to ensure an advanced directive is completed with the resident and/or the resident's representative upon admission. The cited deficency will be reviewed as well. Education will occur no later than September 16, 2021 4. The DON or designee will audit all new admissions each week to ensure an advanced directive has been completed with the resident and/or resident representative upon admission. Audits will be done weekly for 4 weeks and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with th eIDt and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 578	Continued From page 10 was scheduled to be in the facility that day and she would have them sign the advanced directive. *She did not know why resident 252 had not signed her advanced directives when admitted. -Stated resident 252 can still make those kinds of decisions. *Agreed there is room to improve the admission process with advanced directives. Interview on 8/17/21 at 9:18 a.m. with administrator A revealed: *She recognized there was an admission process improvement that needed to occur, especially signing the advanced directive form at admission. Review of the September 2019 Advanced Directives Policy revealed: *It was the policy of the facility for each resident to choose their advanced directives upon admission and may be changed by the resident at any time during their stay. *Discussion of advanced directive options would be reviewed with the resident or resident representative during quarterly and significant change assessments, and with care planning. *Staff will request documentation to determine if the resident has a POA [power of attorney] for health care in place.	F 578		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582	1. Resident 23 and resident 50Advanced Beneficiary Notice (ABN) have been issued and appropriately signed. Resident 50's ABN has been corrected with the accurate date. 2. All residents on a Medicare stay are at risk for not having ABN's issued timely or accurately. A retrospective review of all residents who still reside in the facility after a Medicare stay dating back to January 2021 was conducted to ensure ABN's were issued and are accurate.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 582	Continued From page 11 nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due	F 582	3.The Social Services Director, Administrator, Director of Nursing will be educated on ABN requirements, including timely delivery, required signatures adn date accuracy, by the Vice President of Clincial Reimbursement and Assessment no later than Sepetmber 16, 2021. 4. The Adminisrator or designee will audit all residents who have come to the end of their Medicare stay to ensure the ABN was issued timely and the form is complete wiht signatures and accurate dates. The audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by th Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings. 5. Please see Legacy Health Care Beneficiary Notice Initiative	Typo for Form

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 582	Continued From page 12 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on record review and interview, the provider failed to ensure Medicare notifications had been completed or accurately completed for two of three sampled residents (23 and 50) who had remained in the facility following their discharge from skilled services. Findings include: 1. Review of the Beneficiary Notice-Residents Discharged Within the Last Six Months form revealed: *Resident 23's last day of covered Medicare part A services was 6/25/21. -He had covered days remaining and continued to reside in the facility. *There was no record of a signed Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) or a Notice of Medicare Non-Coverage (NOMNC) as required. -Those standardized notices allow Medicare beneficiaries to make informed decisions about whether to receive certain Medicare services and accept financial responsibility for those services if Medicare does not pay. 2. Resident 50's last day of covered Medicare part A services was 7/30/21. -She had covered days remaining and continued to reside in the facility. *Her SNF ABN had incorrectly identified 2/18/21 as the last day of her covered Medicare part A	F 582		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 582	Continued From page 13 services. *Her representative had not selected one of the three options listed on that form to indicate whether or not she had wanted those skilled services to continue or not. *The NOMNC was signed. Interview on 8/17/21 at 8:45 a.m. and 11:30 a.m. with social services designee F regarding Medicare notifications revealed she: *Was responsible for ensuring completion of ABN and NOMNC forms. *Confirmed there was no record resident 23's representative had completed and signed his forms. *Confirmed she had not reviewed resident 50's ABN for accuracy and completeness after her representative had signed that form. *Was not comfortable educating representatives and residents on those forms and needed additional training. -Planned to talk with her social work consultant about this when she visited in the next week. Review of the Advance Beneficiary Notice of Noncoverage Policies and Procedures printed by administrator A on 8/17/21 from the http://pattinternalmedicine.com website that the facility followed as their policy revealed: *That website was a personalized adult primary and preventative medicine practice overseen by a board certified internist. *Information related to the Medicare forms referred to above from that website applied to the Patt Internal Medicine practice only.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584	1. The dining room floor was cleaned after breakfast meal at the tim eof survey on August 16, 2021. Resident 18,23,27, and 47's toilet was cleaned during surevey on August 17,2021 at the time of identification. Residents' 20,30,34, and 37's	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 584	Continued From page 14 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable	F 584	toilet was cleaned during survey on August 17, 2021 at the time of identification. 2. All residents are at risk to have an environment which is not homelike. The facility will complete an audit of the dining room and all resident room toilet to ensure a homelike environment is maintained. 3. The Administrator will educate all staff, to include CNA J and Housekeeping Supervisor H, on the Homelike Environment police to ensure that the facility is kept clean allowing for a homelike environment. The cited deficiency will be reviewed as well. The education will occur no later than September 16, 2021 and those not in attendance of the education session due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. Administrator or designee will audit the dining room following 5 meals weekly to ensure it is kept clean following the meal. The Administrator or designee will audit 5 toilets to ensure they are kept clean. Audits will be weekly for four weeks and theen monthly for two months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting to identify trends or additional education needs and will include continuatio or discontinuation of audits based on the findings. Type text here	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 584	Continued From page 15 sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to ensure: *One of one resident dining room floor had been cleaned between two of two observed meal services. *Two of four observed soiled resident bathroom toilets shared by eight residents had been promptly cleaned. Findings include: 1. Observation and interview with administrator A on 8/16/21 at 8:00 a.m. in the dining room revealed: *Residents were being seated or had just begun eating their morning meals. -Remnants of food laid under and around all seventeen dining room tables. *Administrator A confirmed that food debris was from the previous meal service the day before. -She expected kitchen staff had cleaned the floor after each meal service. Interview on 8/17/21 at 9:21 a.m. with dietary manager G regarding dining room cleaning revealed: *It was his staff's responsibility to ensure the dining room floor was cleaned after each meal service. *Was unsure why the floor had not been cleaned after the 8/15/21 evening meal or before breakfast on 8/16/21. *Had not expected residents to have been seated for a meal in a dirty dining room. 2. Observation on 8/16/21 at 9:00 a.m. of east	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 584	Continued From page 16 hall resident bathrooms revealed: *Residents 18, 23, 27, and 48 shared one bathroom toilet. -There was bowel movement throughout the inside of that toilet bowl, the top of the toilet base in the open area between the toilet seat, and on the front of the toilet base. *Residents 20, 30, 34, and 37 shared a second bathroom toilet. -There was bowel movement throughout the inside of that toilet bowl and the back of the rim of the toilet seat. Observation on that same date at 3:08 p.m. revealed those two identified bathroom toilets remained dirty. Interview on 8/16/21 at 3:10 p.m. and 4:30 p.m. with certified nurse aide (CNA) J regarding resident room cleaning revealed: *Caregivers made resident beds and took out their garbage as needed. *Housekeeping staff was responsible for all other cleanings. *When she assisted resident 27 to use the toilet that day she noticed it was unclean. *Stated housekeeping staff were responsible for toilet cleaning. -Had not notified them the toilet was dirty. -Had not thought to clean the toilet herself before having resident 27 use it. Interview on 8/16/21 at 3:20 p.m. with housekeeping supervisor H regarding resident toilet cleaning revealed: *Housekeeping staff was responsible for daily cleaning of the inside of the toilet bowl. -That was included on the Housekeeping Daily Checklist For Rooms form.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 584	Continued From page 17 *Direct care staff had been responsible for cleaning all other parts of the toilet. *She was unaware the two identified toilet bowls had been uncleaned by housekeeping staff that day. -She was unable to complete her daily quality check of resident room cleaning that would have identified those unclean toilets because she had been working in the laundry. Interview on 8/16/21 at 4:55 p.m. with administrator A regarding toilet cleaning revealed she: *Confirmed housekeeping supervisor H's understanding of toilet cleaning responsibilities. *Would not have expected direct care staff to allow a resident to use a visibly dirty toilet. -Expected dirty toilets had been cleaned by direct care staff immediately upon noticing. Review of the provider's October 2019 Homelike Environment policy revealed: *"2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Cleanliness and order;".	F 584		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644	1. Resident 6 had a Level II Pre-Admission Screening and Resident Review (PASRR) completed on August 19, 2021. 2.All residents are at risk for not having a PASRR in a timely manner. An audit of all resident's medical records will be conducted to ensure an appropriate PASRR has been completed at the appropriate time. 3. The Administrator or designee will educate SSD on the guidelines and requirements for the completion of PASRRs to ensure the appropriate timing of a PASRR with Level II exception for a stay of less than 100 days. The cited deficiency will be reviewed as well. The education will occur no later than September 16, 2021.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 644	Continued From page 18 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on record review and interview, the provider failed to coordinate the appropriate timing of a Pre-Admission Screening and Resident Review (PASRR) for one of one sampled resident (6) with a Level II exception for a stay of less than one hundred days. Findings include: 1. A review of resident 6's medical record revealed: *She had been admitted on 3/2/21. *The level 1 PASRR Determination Report completed on 3/1/21 revealed an exception for a stay after hospitalization for less than 100 days. Interview on 8/16/21 at 3:03 p.m. with the social services designee F regarding resident 6's PASRR revealed: *Resident 6 should have had another PASSR completed before her one-hundredth day. *She had been aware that resident 6's PASSR was for less than one hundred days but had forgotten to send in another PASRR. *She did have the contact information for Long	F 644	4. The Administrator or designee will audit 5 residents' medical records to ensure the appropriate timing for the completion of a PASRR. Audits will be done weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 644	Continued From page 19 Term Services and Supports and knew how to complete the PASRR request. Interview on 8/16/21 at 3:43 p.m. with administrator A revealed she stated another PASSR should have been completed prior to resident 6's one hundredth day. Interview on 8/17/21 at 11:48 a.m. with clinical consultant/registered nurse T revealed the provider did not have a policy regarding PASSRs.	F 644		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661	1. No immdeiate corrective action could be for the failure to ensure there was documentation for an accurate counting of medications sent with resident 52, as he discharged 5/17/21. 2. All residents are at risk for not having documantation for an accuate accounting of medications when they discharge from the facility. 3. The DON will educate all licensed nurses on the Discharge to Home with Medications policy to ensure there is documentation for an accurate accounting of medications sent with resident upon discharge. The cited deficiency will be rivewed as well. The education will occur no later than September 16, 2021. 4. The DON or designee will audit all residents that discharge to ensure thr is documentation for an accurate accounting of medications that were sent with resident upon discharge. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting wiht the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	10/04/21

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 661	Continued From page 20 the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Surveyor: 40053 Based on closed record review, interview, and policy review, the provider failed to ensure there was documentation for an accurate accounting of disposal of or medications sent with him for one of one sampled discharged residents (52). Findings include: 1. Review of resident 52's closed record revealed: *He was admitted on 4/7/21. *He was discharged on 5/17/21. *There was no documentation of the accounting of his medications. Interview on 8/17/21 at 2:30 p.m. with the director of nursing (DON) B regarding resident 52 revealed: *She had been able to find a progress note for 5/17/21 at 10:36 a.m. by registered nurse (RN) P. related to his discharge summary. *It stated he was discharged home with his medications. *The progress note did not state which medications those were. *DON B stated RN P should have documented which medications he had been given when he was discharged from the facility. Review of the 11/2016 Discharge to Home with Medications Policy revealed: *"5.3 Discharge to home with Medications (DischargeRX)" *"Procedures"	F 661		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 661	Continued From page 21 -"2. Two days prior to discharge, the "Release of discharge to home medications form" is faxed to the pharmacy..." -"3. At discharge:" -"h. File in patient medical record: 1) Completed form. 2) Copy of prescriber's order to discharge resident with medication."	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking,	F 676	1. Resident 6 received a bath on August 16, 2021 during survey. Resident 33 received a bath on August 17, 2021. 2. All residents are at risk for not being bathed per their bath schedule. An audit of all resident's bathing schedules will be completed to ensure they are being bathed per their bathing schedule. An audit of the bath list will be audit weekly. 3.The DON will eudcate all nursing staff on the Bathing policy to ensure baths are being prvided to residents per their bathing schedule. The cited deficiency will be reviewed as well. Education will occur no later than September 16, 2021 and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 residents to ensure they are being bathed per their bathing schedule. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting wiht the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 676	Continued From page 22 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, and policy review the provider failed to ensure two of three sampled residents (6 and 33) had received baths according to their bath schedules. Findings include: 1. Observation and interview on 8/15/21 at 4:59 p.m. with resident 6 regarding her bathing revealed: *Her hair appeared to be greasy and not clean. *She stated she had not had a bath in two weeks. *She stated the staff were busy helping other residents and did not have time to give her a bath. Review of resident 6's medical record revealed her last documented bath had been on 8/4/21. Review of provider's west bath schedule from 8/9/21 through 8/15/21 revealed she was scheduled for a bath on 8/9/21 in the evening and on 8/14/21 on the day shift. 2. Review of resident 33's medical record revealed her last documented bath had been on 8/3/21.	F 676		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 676	Continued From page 23 Review of provider's west bath schedule from 8/9/21 through 8/15/21 revealed she was scheduled for a bath on 8/10/21 in the evening and on 8/13/21 on the day shift. 3. Interview on 08/16/21 at 10:35 a.m. with certified nursing assistant (CNA) N regarding documentation of bathing revealed baths were documented on the bath schedule and in the residents electronic health record. Interview on 8/16/21 at 3:09 p.m. with the director of nursing B about bathing revealed: *Agreed resident 6 had not had a bath since 8/4/21 and resident 33 had not had a bath since 8/3/21. *She had assigned each CNA certain baths to be completed during their shift. -If the CNA did not complete the bath she would talk with them one on one to see why the bath had not been completed. *She had tried to look at the bath schedule daily to ensure baths were getting done. *If a bath had not been complete when it was scheduled it should have been added to the following days bath schedule. 4. Review of the provider's September 2019 Bathing policy revealed: "The resident had the right to choose timing and frequency of bathing activity."	F 676		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812	1. The following corrections were made at the time of discovery: All food items not labeled with open date were discarded; A temperature log was started for the breakroom refrigerator, and all refrigerators and freezers were checked to ensur appropriate temperatures were documented; The tongs were removed from the cookie storage and cookies were discarded; Food items that are prepped prior to serving were covered; All freezers were checked and defrosted to ensure there was not ice build-up. The cold drinks that were not the proper temperature were	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 24 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: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Proper hand hygiene and glove use techniques for one of one dietary manager (G) and one of one cook (I). *Proper use and storage of a wet cloth used in the food preparation area of the kitchen by one of one cook (I). *Milk and juice had been maintained at a safe temperature during one of one observed meal service. *All food had been stored in a sanitary condition and labeled. *Safe handling and storage of food brought into the facility for residents. *All refrigerator and freezer temperatures through out the facility had been monitored to ensure foods had been maintained at a safe temperature for food storage. Findings include: 1. Observation on 8/15/21 at 2:00 p.m. during the	F 812	not served. No immediate correction could be made for the missed hand hygiene or improper storage of wet sanitizing rag. The offending staff were educat3ed at the time of survey. 2. All residentws are at risk. All refrigerators/freezers in all alreas of the facility were checked to ensure a temperature log is in place and temperatures are being recorded daily and all refrigerators checked to ensure food is properly labeled. All food prepped before serving is covered and drinks are served at an appropriate temperature. At the time of survey all kitchen staff were verbally educated on hand hygiene and glove use. 3.All dietary staff will receive education from Devin Brown, Regional Dietary Specialist, on the following: hand gygiene/glove use, food and drink temperatures, covering of food and drink items prepped prior to food service, refrigerator and freezer cleaning and temperature checks, storage of untensils, labeling and dating of stored foo items, proper use and storage of sanitizing dish rags. Additionally, all staff will be educated on the food storage and labeling requirements for food that is brought in for residents. Education will occur no later than September 16, 2021 and thos not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The Administrator or designee will observe five meal ervices each week at various mealtimes to ensure the following: Prepped items are covered prior to serving; drinkis are at the proper serving temperature, dish rags are stored appropriately, serving untensils are not stored in opened food bins/ containers and hand hygiene and glove use are occuring per policy. Additional auditing will include: checking all refrigerators/freezersw twice each week to ensure temps are recorded daily, they are clean and free of ice build-up and any food stored is labeled/ dated. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 25 initial tour of the provider's kitchen revealed a: *Metal cart with one whole pie in a pan and three pieces of pie on plates not covered. *Measuring cup containing a white powder sitting on top of a bucket of thickener for liquids not covered or labeled. Observation on 8/15/21 at 6:00 p.m. of a clear plastic container on top of the white refrigerator in the kitchen revealed: *A clear plastic container with a red lid that was not sealed. -There had been 3 or 4 four cookies and a tongs in the container. Interview on 8/15/21 at 6:30 p.m. with dietary manager G revealed: *It was not common practice to store the tongs in a container with food. *Agreed the tongs were possibly contaminated. *The tongs were supposed to be kept on the snack cart. Observation on 8/16/21 at 4:26 p.m. in the kitchen revealed: *Brownies and dinner rolls on a metal cart not covered. *Measuring cup containing a white powder sitting on top of a bucket of thickener for liquids not covered or labeled. Interview on 8/16/21 at 4:30 p.m. with dietary manager G revealed: *All foods should be covered and not left out open to air. *The white powder in the measuring cup was thickener for liquids. -He had agreed it should be covered or left in the container until used.	F 812		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 26 Review of the provider's October 2019 Food Storage policy revealed all food items should have been stored in covered containers with a label and date. 2. Observation and interview on 8/15/21 at 5:21 p.m. through 6:15 p.m. with cook I preparing the food serving line and serving the resident's food for supper revealed: *A sheet pan on top of the three-compartment sink with a small amount of water and food particles in it. -A wet cloth was sitting on the sheet pan. *She had picked up and rinsed the wet cloth with tap water and used it to wipe down the countertop by the microwave, the food processor, the front of the microwave, and food preparation table in front of the stove. -Then she returned the wet cloth to the sheet pan on the sink. *Cook I walked out of the kitchen with a styrofoam cup into the dining room to the ice/water machine, filled the cup with ice water, returned to the kitchen, pulled down her mask, and drank from the cup. *She did not wash her hands and she put on a pair of gloves and took the temperature of the food items on the serving line in the steam table with a thermometer. *With those same gloves on she had: -Touched her mask two times to push it back up over her nose. -Went to the oven to put in some items to warm. -Dished food onto several plates. -Touched the beets she had put on a plate to move them to the side four different times. -Touched the surface of the clean plates she was putting food on.	F 812	Identification of Others: f22ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes: 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 27 *She removed the gloves, went across the kitchen to get papers from a counter by the microwave; put on new gloves, and went back to the food serving line. -Had not washed her hands. -Opened and closed a drawer of kitchen utensils on the kitchen preparation table. *She removed her gloves, walked back to her styrofoam cup, pulled down her mask, and drank from the cup. *She put on new gloves without washing her hands and returned to the food serving line. -Touched the ground meat she had dished onto a plate. -Adjusted her mask. -Walked back to the counter and took a drink of water from the styrofoam cup. *Changed her gloves, did not wash her hands, and returned to the food serving line. *With those same gloved hands she had put a pork chop on a plate and held onto the pork chop while she had used a knife to cut it up. Observation of dietary manager G during the above observation revealed: *He had entered the kitchen and did not perform hand hygiene. *He had removed food items from the oven, took their temperatures, and set them into the food serving line. Interview on 8/15/21 at 6:15 p.m. with cook I regarding the above observations revealed she did not know she should have: *Washed her hands before and after glove use. *Washed her hands each time she entered the kitchen. *Removed her gloves, washed her hands, and put on new gloves when she had touched her	F 812	Identification of Others: f 2 ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes: 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 28 mask. *Did not feel she had received the appropriate education upon being hired for the position. Interview on 8/16/21 at 4:30 p.m. with dietary manager G revealed: *All kitchen staff should have washed their hands each time they entered the kitchen. *All kitchen staff should wash their hands before and after glove use. *Cook I should have changed her gloves and washed her hands each time she touched her mask. *He does not wash his hands as often as he should or when he came into the kitchen. *He knew the wet cloth should have been kept in a bucket with sanitizer or in the kitchen sink. -He had said he was going to look for a policy to see if it was ok for the staff to leave the wet cloth in soapy water. -He had not provided this policy to the survey team prior to the end of the survey. Review of the provider's October 2019 Hand Hygiene policy revealed: *"5. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:" -"b. c. Before and after eating or handling food." *"8. The use of gloves does not replace handwashing/hand hygiene." Review of the provider's October 2019 Food: Preparation policy revealed: "The Dining Services Director insures [ensures] all staff practice proper handwashing technique and practice proper glove use."	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 29 3. Observation and interview on 8/16/21 at 8:25 a.m. with cook Q and culinary specialist R revealed: *Milk and juices were poured into glasses prior to the meal service and stored on trays in the refrigerator. *During the meal service the trays of juice and milk were set out on a cart near the serving window to be put on the trays to be served to the residents. *The breakfast meal service had just ended and culinary specialist R was asked by this surveyor to check the temperature of a glass of cranberry juice and a glass of milk on those trays. -The milk was 53.7 degrees Fahrenheit. -The cranberry juice was 56.1 degrees Fahrenheit. *They had both agreed juice and milk was to be stored and maintained at a temperature of 41 degrees Fahrenheit or lower. *Cook Q stated they would need to change the serving line to ensure the liquids stayed at a proper temperature. *The remaining milk and juice that had been on the trays were disposed of and not served. Interview on 8/16/21 at 4:30 p.m. with dietary manager G regarding the temperature of the juice and milk during the meal service revealed: *He had not been aware the milk and juices had not stayed cold enough during the meal services. *Milk had used to come in single serving cartons that had been stored on ice during the meal service. *Now the milk did not come in a single serving carton and had to be poured in a glass. *He did not know how they could ensure the milk and juice were going to be kept at appropriate temperatures during the meal service.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 30 Review of the provider's October 2019 Food: Preparation policy revealed: "The Dining Services Director/Cook(s) is responsible for food preparation techniques which minimize the amount of time, that food items are exposed to temperatures greater than 41 [degrees Fahrenheit] and or less than 135 [degrees Fahrenheit], or per state regulation." 4. Observation on 8/17/21 at 8:30 a.m. of the refrigerator/freezer in the staff break room revealed: *In the refrigerator: -A styrofoam food container with resident 31's name on it but no date. -A glass bowl with a plastic lid with resident 26's name on it but no date. -There was no thermometer to monitor the temperature. *In the freezer: -A paper cup with resident 49's name on it but no date. -There was no thermometer to monitor the temperature. Interview on 8/17/21 at 9:01 a.m. with dietary manager G about the refrigerator/freezer in the staff break room revealed: *Food brought in for the residents from outside the facility was to be stored in the refrigerator/freezer. *Staff were to label the items with resident's name and date it was put into the refrigerator/freezer. *He stated it was housekeeping's responsibility to monitor the temperatures and ensure they were kept clean.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 31 Interview on 8/17/21 at 10:27 a.m. housekeeping supervisor H about the refrigerator/freezer in the staff break room revealed she had: *Stated that they do not monitor the temperatures of the refrigerator/freezer. *Been told by her supervisor that her department was only required to clean the outside of the refrigerator/freezer. Interview on 8/17/21 at 10:49 a.m. with the director of nursing B about the refrigerator/freezer in the staff break room revealed she: *Was not aware no one had been monitoring the temperatures or ensuring they had been kept clean. *Thought it was housekeeping's responsibility. *Housekeeping had not told her they would only be cleaning the outside. Review of the provider's October 2019 Food: Safe Handing for Foods from Visitors policy revealed: *"It is the center policy to assist residents in properly storing and safely consuming foods brought into the center for residents by visitors." *"When food items are stored for later consumption the responsible staff member will: -Insure [ensure] that foods are in a sealed container to prevent cross contamination [cross-contamination]. -Label food with the resident name and the current date." *"Refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and: -Equipped with thermometers." -Monitor temperatures daily. -Any food items stored for 7 days or more should be discarded. -Cleaned weekly.	F 812	Identification of Others: 2 ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes:fhfh 3333	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 32 5. Observations on 8/17/21 at 8:40 a.m. of the two freezers in the social area revealed: *The deep freezer with the top opening lid: -Contained meat products. -All meat products appeared to be frozen solid. -Did not have a thermometer to monitor the temperature. *The upright freezer: -Contained vegetables, ice cream, whipped cream, and pizza. -All products appeared to be frozen. -Thermometer read 10 degrees Fahrenheit. -There had been a large amount of thick frost covering the items on the roof, the first shelf, and the second shelf. -There had been thick ice along the left side of the door jam, about half-inch thick. Observation and interview on 8/17/21 at 9:10 a.m. of the two freezers in the social area with dietary manager G and maintenance director S revealed: *They had not been aware the upright freezer had frost and ice build-up. *Maintenance director S stated the freezer must have been left open at some point allowing it to start defrosting. *Dietary Manager G stated he rarely looked in these freezers and the temperature of these freezers were not monitored. Observation on 8/17/21 at 10:39 a.m. of maintenance director revealed he had put a thermometer in the deep freeze with the top opening lid. Review of the provider's July 2021 refrigerator and freezer temperature logs for the units in the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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 33 kitchen revealed: *One of one freezer temperature had not been monitored on 7/14/21 or 7/31/21. *Two of three refrigerator temperatures had not been monitored on 7/14/21, 7/21/21, or 7/31/21. *The provider had been asked for the last thirty days of temperature logs but only had provided the logs for July of 2021. *No logs had been provided for the break room refrigerator or the two freezers in the social area. Review of the provider's October 2019 Food Storage: Cold policy revealed: *"2. The Dining Services Director/Cook(s) ensures that all perishable foods will be maintained at [a]temperature of 41 degrees F [Fahrenheit] or below except during necessary periods of preparation and service. *3. The Dining Services Director/Cook(s) monitors that all frozen foods will be stored at temperature to maintain frozen state, [the] target temperature is 10 degrees F or below. *4. The Dining Services Director/Cook(s) insures [ensures] that an accurate thermometer will be kept in each refrigerator and freezer. A written record of daily temperatures is recorded."	F 812	Type text here	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	Corrective Action: 1.Time cannot be turned back to a time prior to the identification of lack of: * appropriate hand hygeine and glolve use and procedural technique during provision of resident cares * appropriate hand hygiene when completing task of obtaining resident vitals with resuable medical equipment * appropriate maintenance and sanitation of multi-resient resuable medical euqipment The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review, revise, create as necesary potocies and procedures about: * appropriate hand hygiene and gloce use and procedural tehcnique during provision of resident cares * appropriate hand gygiene when completing task of obtaining resident vitals with reusable medical equipment * appropriate maintenance and sanitation of multi-resident reusable edical equipment * necessary Infection control and prevention plan that incluedes effective compliance All staff who provide above care and services to residents will be educated/re-educated by September 16, 2021by DON or Infection Control Nurse.	09/016/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 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; §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	F 880	Identification of Others: 2 ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes: 3. Root casue analysis conducted answered the 5 Whys: ensuree staff are thoroughly educated between pericares and proper glove use with handwashing. Administrator, DON, infection control nurse, medical director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received eucation /training with demonstrateed competency. Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 09/14/2021 asking input on RCA. Monitoring: 4. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Observations of staff performing task(s) do need to be documented. Verbally talking through a process is a way of teaching but also need actual ovserved performance for demonstrated competency. Monitoringof determined approaches to ensure effective ifection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan tht includes compliance in teh above identified areas. * Any other areas identified through the 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 of 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person, or whomever else is determined necessary, to the QAPI committee and continued until the facility demonstrates sustained complinace then as determined by the committee and medical director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to ensure infection control practices were maintained for: *Hand hygiene by one of one licensed practical nurse (LPN) (D) during a dressing change for one of one sampled resident (39). *Hand hygiene and glove use by two of two certified nurse aides (CNAs) (N and O) during personal care for one of one observed resident (5). *Hand hygiene by one of one CNA (J) taking vital signs for five of five (14, 24, 29, 38, and 45). *Cleaning of reusable medical equipment by one of one CNA (J). Findings include: 1. Observation on 8/16/21 at 10:00 a.m. with infection control nurse/licensed practical nurse (LPN) D performing a dressing change for one of one sampled resident 39 revealed she had:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 *Set up her dressing supplies on a clean barrier. *Washed her hands and put on a pair of gloves. *Removed the dressing, removed her gloves, washed her hands, and put on a new pair of gloves. *Cleaned the wound, removed her gloves, washed her hands, and put on a new pair of gloves. *Packed the wound with 4 x 4 gauze pads soaked with Dakin's solution. *Removed her gloves and, without washing her hands, she put on a new pair of gloves. *Finished dressing the wound with an abdominal pad and tape. Interview on 8/16/21 at 10:13 a.m. with infection control nurse/LPN D regarding the above observation revealed she should have washed her hands each time she had changed her gloves. Review of the provider's October 2019 Hand Hygiene policy revealed hand hygiene should be completed after removing personal protective equipment such as gloves. Surveyor: 42558 2. Observation and interview on 8/16/21 at 9:41 a.m. with CNA's N and O of resident 5's morning care revealed they: *Applied gloves and both provided groin, anal and buttock cleansing to resident 5. *Without removing the same gloves or washing their hands, they: -Applied a clean absorbent underpad, a clean gown, applied deodorant to his underarms, shaved and washed his face, repositioned his body, adjusted his pillow, and applied a new top sheet and bedspread.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 *CNA N stated this was the usual way they provided cares to the residents. -When asked if there was anything they should have done different, both CNA's identified they did not cleanse their hands and apply clean gloves following the resident's cleansing of his groin and buttocks. *Both agreed this should have been done before any further care to resident 5. Interview on 8/17/21 at 1:33 p.m. with DON B regarding the above observation revealed: *She had agreed this had not been an acceptable practice for hand hygiene and glove use. *Stated hand washing and glove use audits had been occurring weekly. -This had been monitored thru QAPI PIPS(quality assurance performance improvement plans). --The CNAs would verbally talk thru the hand hygiene process with the auditor. *Agreed this was an area that may need further auditing and re-training. Interview on 8/17/21 at 2:15 p.m. with administrator A revealed she agreed the above observation had not been an acceptable infection control practice. Review of the providers October 2019 Hand Hygiene policy revealed: *Hand hygiene and glove use should be performed before moving from a contaminated body site to a clean body site during resident care. Surveyor: 40788 3. Observation and interview with CNA J on 8/15/21 between 3:10 p.m. and 3:20 p.m. during resident cares revealed: *Without performing hand hygiene she entered	F 880	Identification of Others: f 2 ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes: 3ŦB3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 resident 29's room with a mobile cart that held vital signs equipment. -Exited that room without performing hand hygiene or cleaning the vitals equipment. *She immediately entered residents 38 and 45s' room. -Exited that room without performing hand hygiene or cleaning the vitals equipment. *She immediately entered residents 14 and 24s' room. -Exited that room without performing hand hygiene or cleaning the vitals equipment. *Confirmed she had not performed hand hygiene entering or exiting those rooms or between resident care but knew she should have. *She had taken resident temperatures, blood pressure and pulse oximeter readings in those rooms. -She was expected to use the packaged alcohol pads on that vitals cart to clean the vitals equipment between resident use but had not used them. Interview on 8/17/21 at 9:11 a.m. with director of nursing B regarding hand hygiene and resident equipment cleaning revealed she: *Expected caregivers to perform hand hygiene entering and exiting resident rooms and between resident care. *Re-usable resident equipment such as temperature probes, blood pressure cuffs, and pulse oximeters were expected to be cleaned preferably with a bleach wipe or alcohol pad between resident use. Review of the provider's October 2019 Hand Hygiene policy revealed hand hygiene was expected: *"6.a. Before and after direct contact with	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 residents. -b. When entering and leaving a resident care area/room..." Review of the provider's November 2019 Cleaning and Disinfection policy revealed: "I. A. Supplies and equipment will be cleaned immediately after use."	F 880	Identification of Others: f 2 ALL residents have the potential to be affected if staff do not adhere to: * appropriate hand hygiene and glove use as well as procedure technique when providing cares * Appropriate maintenance and sanitization of multi-use and indicivual resident care items ALL staff completing the care and/or assigned tasks have potential to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by September 16, 2021 by DON or Infection Control Nurse. System Changes: 3. Root caue analysis conducted answwered the 5 Whys: Ensure staff are thoroughly educated between pericares and proper glove use with hand washing. Administrator, DON, Infection Control Nurse, Medical Director and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency . Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 9/14/21 asking input on RCA. Monitoring: 4. Administrator, DON, Infection Control Nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Observations of staff perforing task(s) do need to be documented. Verbally talking through a process is a way of teaching but also need actual observed performance for demonstrated competency. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance in the above identif	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(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
E 000	Initial Comments Surveyor: 40788 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 8/15/21 through 8/17/21. Avantara Pierre was found in compliance.	E 000		

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

Sharon Martin | Administrator | 09/10/2021

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET PIERRE, SD 57501**

(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
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 8/16/21. Avantara Pierre was found not 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 upon correction of the deficiency identified at K211, K321, K324, K345, K355, K918, K920, and K923 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to provide egress doors as required at one randomly observed location (former acute care unit wing cross-corridor doors). Findings include: 1. Observation on 8/16/21 at 1:00 p.m. revealed the alternate swing cross-corridor doors leading	K 211	1. All residents are at risk. The secure locks are taken out of service in the former memory care unit wing. The doors will remain open without code activiation ot release. The doors are in accordance with NFPA 101, Chapter 7 and remain free of all obstructionsto full use in case of emergency. 2. Administrator will in -service maintenance supervisor to ensure facility follows the egress door release on all facility doors and will be completed by October 4, 2021. 3. The adminisrator or designee complete monthly adits x's 4 to ensure egress doors are in accordance with NFPA 101, Chapter 7. Results of audits will be reported by administrator or designeee to monthly QAPI meeting for further review and recommendation and/or continuance/discontinuance of audits. 4. October 4, 20201	10/04/21

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

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.

Sharon Martin | Administrator | 09/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 211	Continued From page 1 into the former acute care unit (ACU) were equipped with magnets and hardware at the top of the doors for locking the doors. Testing of the doors revealed the magnets were in service (had power) and did not function as delayed-egress type magnetic locks and would not release when tested. A code had to be entered into the keypad located at the right side of each of the alternate-swing cross-corridor doors to allow passage through the doors. The locked doors would not open in an emergency situation without entering the code into the keypad. Interview with the administrator at the time of the observation revealed the provider previously had an ACU but discontinued the unit during the COVID-19 pandemic. The secure locks had not been taken out of service when the ACU was discontinued. She added the doors were normally held open with magnetic hold-open devices. Failure to provide egress doors as required increases the risk of death or injury in emergency situations. The deficiency affected 100% of the smoke compartment occupants.	K 211		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting	K 321	1. All residents are at risk. The boiler room door has been repaired to self-close in accordance with the CFR: NFPA 101 enclosure code. 2. Administrator will in-service maintenance supervisor to ensure all floor and zone locations in hazardous areas will have doors that are self-closing or automatic-closing and permitted to have nonrated or field-applied protectve plates that do not exceed 48 inches from bottom of the floor by October 4, 2021. 3. The administrator or designee will complete monthly audits x 4 to ensur3e all facility fire rated doors are in accordance with the CRF:NFPA enclosure code. Results of audits will be reported by administrator to monthly Quality Assurance meeting for further review and recommendatins and/or continuance/discontinuane of the audits. 4. October 4, 2021.	10/04/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 321	Continued From page 2 partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (boiler room) as required. Findings include: 1. Observation on 8/16/21 at 11:30 a.m. revealed the ninety-minute fire-rated door for the boiler room swung out into the corridor and would wedge open at the floor level before the door was opened a full ninety degrees. Interview with the maintenance director at the time of the observation confirmed that finding. He revealed the flooring in the corridor had been replaced within the past twelve months. He added the corridor flooring was higher than the bottom of the	K 321		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 321	Continued From page 3 boiler room door. He was aware the door could not open fully before becoming wedged into the floor. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 18087	K 324	1. All residents are at risk. The kitchen hood fire suppression inspection in accordance with NFPA 96 will be set for every six months starting from the 09/09/2021 new inspection date. The second inspection will be set within the next six months to remain in compliance with the code. The facility had the kitchen range hood fire-suppression system (hydrostatic testing) for the tank on 09/07/2021 in compliance with CFR:NFPA 101 and will occur no less than 12 years after the last inspection. 2. The administrator will in-service the maintenance director by October 4, 2021, to ensure the kitchen hood fire suppression inspection will occur every six and the kitchen hood fire-supression system (hydrostatic testing) occurs no less than 12 years in compliance with CFR:NFPA 101 by October 4, 2021. 3. The administrator or designee will complete monthly auditx x 4 to ensure teh kitchen hood inspection occurs every six months and hydrostatic testing occur no less than every 12 years. Results of audits will be reported by administrator to monthly Quality Assurance meeting for further review and recommendations and/o continuance/discontinuance of the audits. 4. October 4, 2021.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 324	Continued From page 4 A. Based on document review and interview, the provider failed to conduct the required every six-months inspection of the cooking facility's fire suppression system for the range hood. The records regarding the kitchen hood fire suppression system indicated an inspection had last been done 12/20/20. Findings include: 1. Document review on 8/16/21 at 12:30 p.m. of the kitchen hood fire suppression system records indicated the inspections had been performed on 12/20/20. The kitchen hood fire-suppression system must be inspected not less than every six months. There was no further documentation indicating other required inspections had taken place. A six month inspection would have been due in June 2021. B. Based on document review and interview, the provider failed to perform required maintenance for the kitchen range hood fire-suppression system (hydrostatic testing). Findings include: The records regarding the kitchen hood fire suppression system indicated a twelve-year hydrostatic test was needed for the tank for that system. Findings include: 1. Document review on 8/16/20 at 12:35 p.m. of the kitchen hood fire suppression system records indicated the tank for the system had last had a hydrostatic test in April 2008. Hydrostatic tests are required every twelve years. The tank was overdue to be tested no later than April 2020. Interview with the maintenance director at the time of the document review revealed he called the vendor during the survey and discovered the vendor was scheduled for annual inspections	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 324	Continued From page 5 only. He was unaware the cylinder hydrostatic date was beyond acceptable time frames. This deficiency affected two of the kitchen hood fire suppression system requirements.	K 324		
K 345 SS=C	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to maintain one of one fire alarm system as required (smoke detector sensitivity readings). Findings include: 1. Record review on 8/16/21 at 12:00 p.m. revealed the annual fire alarm inspection report dated September 2020 and March 2021 did not list sensitivities for the ionization-type smoke detectors. Numerical sensitivity testing must be performed by a qualified entity for smoke detectors. Ref: 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11 2. Interview with the operations manager at the time of the record review revealed the following:	K 345	1. All residents are at risk. The facility will complete yearly testing on ionization-type smoke detectors in compliance with the NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signal code. All records will be systematicaly recorded monthly. 2.Administrator will in-service maintenance supervisor to ensure facility will conduct yearly numerical testing by a qualified entity for smoke detectors in compliance with NFPA 72 by October 4, 2021. 3. The administrator or designee will audit the fire alarm yearly smoke detector testing 1 x per month to ensure the fire inspection has been completed. Results of the audits will be reported by administrator or designee and discussed at monthly Quality Assurance meeting for further review and/or continuance/discontinuance of the audits. 4. October 4, 2021	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 345	Continued From page 6 *He stated the contractor who provided the testing only confirmed a pass or fail condition. *He stated the contractor would need to add sensitivity testing and documentation to their annual report requirments. The deficiency affected 100% of the building occupants.	K 345		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."	K 923	1. All residents are at risk. The facility removed the combustible materials from the oxygen storage room in compliance with the NFPA 99 requirements 2. Administrator will in-service maintenance supervisor to ensure all oxygen storage compartments will not have combustibles stored less than five feet from the oxygen cylinders in complinace wiht NFPA 99 by October 4, 2021. 3. The administrator or designee will complete monthly audits x 4 to ensure combustible materials are not less than five fet from the oxygen cylinders in storage areas. Results of the audits will be reported by Administrator or designee and discussed at monthly Quality Assurance meeting for further review and/or continuance/ discontinuance of the audits. 4. October 4, 2021.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET** **PIERRE, SD 57501**

(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
K 923	Continued From page 7 Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the facility failed to protect medical gas storage as required. Combustible items were stored on racks within five feet of the oxygen cylinders in the 200 wing oxygen storage room. Findings include: 1. Observation on 8/16/21 at 11:20 a.m. revealed combustible materials were found to be stored adjacent to and within five feet of oxygen cylinders in the 200 wing oxygen storage room. The combustible materials inclued cardboard boxes, plastic tubing, and other supplies in plastic bags that were kept on three shelves above the bank of cylinders on the floor. There were 42 oxygen e cylinders kept in the storage room which measured approximately 4.5 feet wide by 6.5 feet long. The minimum five feet of separation between combustibles and oxygen storage was not maintained as required in this area. The deficiency affected one of four smoke compartments.	K 923		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435047	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **8/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET PIERRE, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to correctly document monthly fire extinguisher inspections on the extinguisher tag (month and day). Findings include: 1. Observation on 8/16/21 at 11:45 a.m. revealed a fire extinguisher located adjacent to the nurses station in the corridor. Inspection of the monthly documentation on the back of the tag revealed numerical notations corresponding to the consecutive months of inspection along with the year designation and initialed by the maintenance director. Monthly inspections shall be logged using the month and day of the inspection as well as the initials of the person performing the monthly check. 2. Interview with the maintenance director at the time of the observation confirmed that finding. He was unaware of the requirement to log the day of the month on the tag. He stated all the inspected fire extinguishers in the building were similarly documented. The deficiency affected one of numerous requirements for installing and maintaining fire extinguishers.
K 918	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	435047	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	**8/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET PIERRE, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 918	Continued From Page 1 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 A. Based on record review and interview, the provider failed to document generator battery conductivity monthly (May, June, July, and August of 2021). Findings include: 1. Record review on 8/16/21 at 12:15 p.m. revealed the maintenance record for the generator listed battery specific gravity tests and battery conductivity readings. Specific gravity tests are no longer accepted due to the use of maintenance-free batteries allowed with the 2012 Life Safety Code. The battery conductivity was not logged into all of the reviewed forms (May, June, July, and August of 2021). Battery conductivity must be confirmed and logged each month along with the generator load testing. 2. Interview with the maintenance director at the time of the document review confirmed that condition. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants. B. Based on record review and interview, the provider failed to document generator percentage of nameplate load runs correctly. Findings include: 1. Record review on 8/16/21 at 12:30 p.m. revealed the the May, June, and July generator log sheets indicated a value of 30% for those monthly load tests. The generator was a 230 kW diesel generator. The minimum percentage of nameplate load run must meet or exceed 30% of the name plate value of the diesel generator's rating to avoid required annual load bank testing. There was no indication of the formula or information used to obtain the 30% notation. 2. Interview with the maintenance director at the time of the record review revealed he had been told to use the 30% figure by the generator maintenance vendor. He added the provider had been performing annual load banks as well. The deficiency affected two of numerous generator maintenance requirements.
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435047	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **8/16/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	**950 EAST PARK STREET PIERRE, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 920	Continued From Page 2

cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.
10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5
This REQUIREMENT is not met as evidenced by:
Surveyor: 18087
Based on observation and interview, the provider failed to correctly use electrical powerstrips at one randomly observed location (resident room 200). Findings include:

1. Observation on 8/16/21 at 11:00 a.m. revealed resident room 200 had a power strip in use for the television equipment (entertainment center) on the west wall. In addition to the television equipment, a floor fan was also plugged into the powerstrip. A power strip must only be used at computer, monitors and printer or at entertainment center locations. The power strip was also not mounted but was hanging freely from the attached power cords.

2. Interview with the administrator on 8/16/21 revealed she was not aware the power strip usage was not in compliance.

This deficiency has the ability to affect 100% of the smoke compartment occupants.

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
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/15/21 through 8/17/21. Avantara Pierre was found not in compliance with the following requirements: S206, S210, S236, S296, and S301.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	1. The facility has established a formal orientation and an ongoing education program for all personnel. Employees G,I, and L, wil recieve the formal orientation to include: 1) Fire prevention and response; 2) Emergency procedures and preparedness; 3) Infection control and prevention; 4) Accident prevention and safety procedures; 5) Proper use of restraints; 6) Resident rights; 7) Confidentiality of resident information; 8) Incidents and diseases subject to mandatory reorting and the facility's reportng mechanisms. 9) Care of residents with unique needs; 10) Dining assistance, nutritional risks, and hydration needs of residents. 11) Abuse, neglect misappropriation of resident property and funds, and mistreatment no later than September 16, 2021. 2. All residents are at risk for receiving improper care related to the lack of formal orientation programand an ongoing education program for all personnel. An audit of all employee files will be conducted to ensure that all associates have received the aboce formal orientation no later than October 4, 2021. 3. The Administrator will educate teh Human Resources Director M on the Administrative Rule of South Dakota requirement for having a formal orientation program and an ongoing annual education program for all personnel to include: 1) Fire prevention and response; 2) Emergency procedures and preparedness; 3) Infection control and prevention ; 4) Accident prevention and safety procedures; 5) Proper use of restraints; 6) Resident rights; 7) Confidentiality of resident information ; 8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms. 9) Care of resdent swith unique needs; 10) Dining assistance, nutritional risks, and hydration needs of residents; 11) Abuse, neglect misappropriation of resident property and funds, and mistreatment. Educatio will occur no later than September 26,2021. 4. The Administrator or designee will audit all new employee filesto ensure they have received the ongoing annual education requirements. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reported by the Administrator or designee and discussed at monthly Quality Assurance and Process Improvement (QAPI) meting for further review and reccomendations and /or continuation/discontinuation of audits. 5. October 4, 2021	10/04/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Martin

TITLE: Administrator

(X6) DATE: 09/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40053 Based on interview and personnel file review, the provider failed to ensure orientation education had been offered to three of five sampled employees (G, I, and L) for education related to: *Fire prevention/response *Emergency procedures/preparednes. *Infection control and prevention. *Accident prevention/safety procedures. *Proper use of restraints. *Resident rights. *Confidentiality of resident information. *Incidents/disease reporting. *Care of residents with unique needs. *Dining assistance. *Nutritional risks. *Hydration. *Abuse, neglect. *Misappropriation, mistreatment. *Facility identified needs. Findings include: 1. Review of the personnel files for employees G, I, and L revealed: *Employee G had been employed since 4/1/21 . *Employee I had been employed since 5/12/21. *Employee L had been employed since 7/14/21. Interview on 8/17/21 at 2:00 p.m. with human resources director M revealed he had been unable to find any of the above education for employees G, I, and L. Interview on 8/17/21 at 1:35 p.m. with administrator A revealed:	S 206		

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
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 206	Continued From page 2 *It was her responsibility to ensure required training had been completed for all employees. *She had been unaware employees' G, I, and L had not received required training upon hire. *An orientation/annual training policy had been requested from administrator A and had not been received by 8/17/21 at 4:30 p.m. prior to the survey exit.	S 206		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40053 Based on record review and interview, the provider failed to ensure: *Two of three sampled employees (G and J)	S 210	1. Employees G,J, I and L will have health evaluation completed, then reviewed and signed by a licensed health professional to determine these employees are free of communicable diseases no later tahn September 16, 2021. 2. All residents are at risk for a communicable disease related to the failure to ensure a health evaluaation of all employees has been completed and reviewed by a licensed health professional to determine they are free of communicable diseases An audit of all employees will be conducted to ensure that a health evaluation has been completed, then reviewed and signed by a licensed health professional to determine all employees are freee of communicable diseases no later than October 4, 2021. 3. The Administrator will educte the Human Resources Director M and Infection Control Nurse D on the Administrative Rul of South Dakota requiring that all employee health evaluations are completed, then reviewed and signed by a licensed health professional upon hire to determine the employee is free from communicable diseases no later than September 16,2021. 4. The Administrator or designee will audit all new employee files to ensure a health evaluation has been completed, then reviewed and siged by a licensed health professional upon hire to determine the employee is free from communicable disease. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reported by the Administrator or designee and discussed at monthly QAPI meeting for further review and reccomendations and/or continuation/discontinuation of audits. 5. October 4, 2021	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 210	Continued From page 3 health evaluation had been reviewed and signed by a licensed health professional. *Two of two sampled employees (I and L) had a health evaluation completed within fourteen days of being hired. Findings include: 1. Review of the following employees' personnel records revealed the following hired dates: *Employee G 4/1/21. *Employee J 4/17/21. *There was no documentation their health evaluation had been reviewed and signed by a licensed health professional to determine the employees were free of communicable diseases. 2. Review of the following employees' personnel records revealed the following hired dates: *Employee I 5/12/21. *Employee L 7/14/21. *The above employee files had no employee health evaluation. Interview on 8/17/21 at 2:00 p.m. with human resources director M revealed he and infection control nurse D were responsible for timely and accurate completion of employee health evaluations. Interview on 8/17/21 at 2:15 p.m. with administrator A revealed her expectation was that employee health evaluations would have been completed, reviewed, and signed by a licensed health professional within 14 days of the employees hire date.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare	S 236	1. Employees G, I, and J have completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screening completed. Employee G first step was started September 9, 2021 and the second step is scheduled for September 12, 2021. Employee I received the first step on August 30,2021 and the second step is scheduled for September 10, 2021. Employee J had a chest x-ray on August 17, 2021. 2. All residents are at risk related to the failure to ensure that all employees have completed the two-step method for the TB skin test or TB screenings within 14 days of being hired to	10/04/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 236	Continued From page 4 workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40053 Based on record review and interview the provider failed to ensure three of five sampled employees (G, I, and J) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Review of the following employees' personnel records revealed: *Employee G had been hired on 4/1/21.	S 236	prevent the nosocomial transmission of TB. An audit of all employee health files will be conducted to ensure a TB skin test or TB screeing has been completed by no later than October 4, 2021. 3. The Administrator will educate the Human Resources Director M and Infection Control Nurse D on the facility's Tuberculosisi Prevention and Control - South Dakota policy to ensure that employees receive the two-step TB skin test or TB screening is completed within 14 days of hire to prevent the nosocomial transmission of TB no later than September 16, 2021. 4. The Administrator or designee wil audit all new hires to ensure a two-step method for the TB skin test or TB screening has been completed within 14 days of hire to prevent the nosocomial transmissino of TB. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of audits will be reported by the Administrator or designee and discusse at monthly QAPI meeting for further review and reccomendations and/or continuation/discontinuation of audits. 5. Octo ber 4, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 236	Continued From page 5 *Employee I had been hired on 5/12/21. *Employee J had been hired on 4/17/21. *There was no documentation in the above employees' personnel files a two-step TB skin test or screening had been completed within fourteen days of being hired. Interview on 8/17/21 at 2:00 p.m. with human resources director M revealed he and infection control nurse D were responsible for timely and accurate completion of employees TB screening and documentation. Interview on 8/17/21 at 2:15 p.m. with administrator A revealed: *Her expectation had been all employees two-step TB skin test would have been completed within 14 days of hire. *A policy was requested and she stated their policy was to have followed South Dakota nursing facility guidelines.	S 236		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed	S 296	1. Both Dietary Manager G and dietary cook enrolled in the ServSafe Food Protection Program on September 1, 2021 for the October 6, 2021 program. 2. All residents are at risk related to the failure to have the Dietary Manager and a cook be ServSafe Food Protection certified. 3. The Administrator will educate Dietary Manager G on the Aministrative Rules of South Dakota requirement that the Dietary Manager and at least one cook must successfully complete and possess a current certificate from a ServSafe Food Protection Program Education will be no later than September 16, 2021. 4. The Administrator or designee will audit Dietary Manager G's and one cook's progress on the ServSafe Food Protection Program. Audits will be done weekly for 4 weeks, then monthly for 2 months. Results of audits will be reported by the Administrator or designee and discussed at monthly QAPI meeting for further review and recommendatioons and/or continuation/discontinuation of audits. 5. October 4, 2021	10/04/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 296	Continued From page 6 equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41895 Based on interview and job description review, the provider failed to ensure the dietary manager and one cook possessed a current ServSafe Food Protection Program certificate. Findings include: 1. Interview on 8/16/21 at 4:30 p.m. with dietary manager G revealed he: *Had not completed a ServSafe Food Program. *There was not a cook who had completed the ServSafe Food Program. *Had talked about it with his supervisor but no one had looked to see when a class was available or registered him for the class. Interview on 8/17/61 at 3:00 p.m. with administrator A revealed: *A third party company was hired by the provider to run the dietary program.	S 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 296	Continued From page 7 *The dietary manager was employed by the third party. *She had been unaware dietary manager G did not have a current ServSafe Food Protection Program certificate. *She did not know a cook was also required to have the ServSafe Food Protection Program certificate. Review of dietary manager G's job description revealed he was required to have a food sanitation certification.	S 296		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41895 Based on interview and record review, the provider failed to ensure all of the required dietary training's (food safety, handwashing, food handling/prep, food-borne illness, serving and distribution, leftovers, time/temp controls, nutrition/hydration, and sanitation) were completed by all dietary staff. Findings include: 1. Interview on 8/15/21 at 6:30 p.m. with dietary manager G revealed: *He had the list of required training's for all dietary	S 301	1. All dietary staff will receive insrvice training on food safety, handwashing, serving/distribution, leftovers, time/temp controls, nutrition/hydration, food handling, food-borne illness, and sanitation no later than September 16, 2021. 2. All residents are at risk related to the failure to provide ongoing inservice training on food safety, handwasing, serving/distrubution, leftovers, time/temp controls, nutrition/ hydration, food handling ,food-borne illness, and sanitation. 3. The Administrator will educate Dietary Manager G and Human Resources Director M on the Administrative Rules of South Dakota requirement that the Dietary Manager or Dietician shall provide ongoing inservice training to new employees upon hire and annually on food safety, handwashing, serving/distribution, leftovers, time/temp controls, nutrition/hydration, food handling, food-borne illness, and sanitation no later than September 16, 2021. 4. The Administrator or designee wil audit all newly hired dietay employees to ensure they have reeived inservice training on food safety,handwashing serving/distribution, leftovers, time/temp controls, nutrition/hydrtion, food handling, food-borne illness, and sanitation upon hire. The Administrator or designee will audit all other dietary employees to ensure ongoing inservice training on food safety, handwashing, serving/distribution, leftovers, time/temp controls, nutrition/ hydration, food handling, food-borne illness, and sanitation is being completed annually. Audits will be weekly for 4 weeks, then monthly for 2 months. Results of audits will be reported by the Administrator or designee and discussed at monthly QAPI meeting for further review and recommendations and/or continuation/discontinuation of audits. 5. October 4, 2021.	10/04/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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 301	Continued From page 8 staff. *His supervisor had not provided him with the tools to provide the education to his staff. Continued interview on 8/17/21 at 8:56 a.m. with dietary manager G revealed: *All new hires were given a "Dietary Orientation Annual Inservice Information" document. *He did not have documentation all five of five dietary employees had received that document upon hire or annually. *He had thought the human resources (HR) director may have documented some education. Interview on 8/17/21 at 9:00 a.m. with HR director M revealed he did not have any documentation of education provided to the dietary department staff. Review of the "Dietary Orientation Annual Inservice Information" document revealed: *It did cover six of the required dietary training's (food safety, handwashing, serving/distribution, leftovers, time/temp controls, and nutrition/hydration). *It did not cover food handling, food-borne illness, or sanitation. Interview on 8/17/21 at 10:37 a.m. with administrator A revealed: *The dietary staff was employed by a third party. *The provider was responsible to ensure all the staff had the appropriate training. *They did not have a policy regarding required dietary training.	S 301		
S 000	Compliance/Noncompliance Statement Surveyor: 40788	S 000		

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
	10663	A. BUILDING: _____ B. WING _____	08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

(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	Continued From page 9 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/15/21 through 8/17/21. Avantara Pierre was found in compliance.	S 000		