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	435048	A. BUILDING _____ B. WING _____	C 07/31/2024

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/29/24 through 7/31/24. Avantara Groton was found not in compliance with the following requirements: F657, F759 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/29/24 through 7/31/24. Area surveyed included a facility initiated discharge of a resident. Avantara Groton was found in compliance.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657	Resident 11, 15, and 32 care plans were updated during the survey to reflect the need for Enhanced Barrier Precautions (EBP). Policy was reviewed with no revisions needed. Annual review of IPCP was completed. All residents on EBP have the potential to be affected and were reviewed to ensure if EBP were indicated, care plans were updated as appropriate and EBP signs were in place.	08.27.24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda -LNHA	Administrator	08.19.24

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F 657	Continued From page 1 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, interview, observation, and policy review, the provider failed to ensure resident care plans were revised to reflect the current enhanced barrier precautions (EBP) need for three of eight sampled residents (11, 15, and 32) who required EBP. Findings include: 1. Review of resident 11's Skin Alteration Evaluation completed on 7/22/24 revealed resident 11 had a pressure ulcer (damaged skin and tissue caused by sustained pressure) to her left calf. Review of resident 11's care plan revealed: *"[Resident 11] has an actual impairment to skin integrity due to left calf hematoma and pressure ulcer." *It had not been revised to indicate the need for EBP. Interview on 7/31/24 at 2:58 p.m. with director of nursing (DON) B: revealed: *Resident 11 was re-admitted to the facility on 7/26/24 with a wound vacuum (a device that removes pressure and fluid from a wound) to her left lower leg. *She expected that all residents with a wound would be on EBP. *She would have updated a care plan "at the resident care conferences or whenever	F 657	2 The DON or designee will educate nursing staff on care plan policy and the need to ensure all care plans are up to date reflecting the resident's current care needs. All staff will be educated on Enhanced Barrier Precautions (EBP). Education will include reporting changes in care needs or preferences to the nurse. Care plans will be updated as changes occur. Education will occur no later than August 27, 2024. Those not in attendance at the education session, due to illness, vacation, or casual work status, will be educated prior to their first shift worked. 3. DON/Designee will conduct audits on care plans to ensure revisions are made and care plans reflect the resident's current care needs. The DON/designee will audit random care plans weekly for 4 weeks, bi-weekly for 2 months and monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT team and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F 657	Continued From page 2 something changed". *She confirmed that resident 11's care plan had not been updated to reflect EBP. Review of the provider's August 23, 2023 Advanced Care Planning policy revealed it was a process "used to identify and update the residence preferences regarding care and treatment ..." 2. Observation on 7/29/24 at 4:19 p.m. of residents 15 and 32's doors revealed they had Enhanced Barrier Precautions (EBP) signs hung on their doors with drawered bins of PPE available outside of those resident's rooms. Review of resident 32's care plan revealed: *The resident had an indwelling foley catheter. *Her care plan did not indicate the need for Enhanced Barrier Precautions (EBP). Review of resident 15's care plan revealed: *The resident had an open wound to his coccyx region. *His care plan did not indicate the need for EBP. Interview on 7/31/24 at 2:27 p.m. with registered nurse (RN) unit manager C revealed: *She believed EBP would have been indicated in the resident's care plans. *She and DON B were responsible for updating resident's care plans. Interview on 7/31/24 at 3:00 p.m. with DON B revealed: *Residents 15 and 32 should have EBP included in their care plans. *Verified EBP had not been revised on their care plans.	F 657		

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F 657	Continued From page 3 Review of the provider's September 2019 Care Plan policy revealed: *"Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan. The care plan is broken down into separate focus areas: Psycho-Social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Function, Hygiene ADL's/Skin, Safety/Vulnerability, Mobility/Fall Prevention, Medications and Special Attention for Other Physical Conditions." *"Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur."	F 657		
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, manufacturers' instructions review, and policy review the provider failed to ensure two of two randomly observed residents' (21 and 26) insulin had been administered according to the instructions for use by one of one registered nurse (RN) F. Those observations created a medication error rate of 9.68%. Findings include: 1.Observation on 7/30/24 at 7:59 a.m. with RN F	F 759	1. Residents 21 and 26 insulin orders were reviewed and priming insulin pen needle was added to providers order to ensure residents are receiving correct insulin dosage. All residents on insulin are at risk for deficient practice. Orders were updated to include priming insulin pen to ensure the resident is receiving the correct insulin dosage.	08.27.24

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F 759	Continued From page 4 during resident 21's Aspart and Degludec insulin administration revealed: *She had not primed the Aspart insulin pen needle prior to setting the dose of insulin. *She had not primed the Degludec insulin pen needle prior to setting the dose of insulin. *She administered the insulin to resident 21. 2.Observation on 7/30/24 at 10:57 a.m. with RN F during resident 26's Lispro insulin administration revealed: *She had not primed the Lispro insulin pen needle prior to setting the dose of of insulin. *She administered the insulin to resident 26. Review of the 2020 Insulin Lispro Injection KwikPen manufacturer's instructions for Use obtained from the Lispro Injection KwikPen box on 7/30/24 revealed: *"Prime before each injection." *"If you do not prime before each injection, you may get too much or too little insulin." *"Instructions to prime insulin pen:" -"The dose knob should be set to two units." -"While holding the pen with the needle pointing up, tap the cartridge to move the bubbles to the top." -"Push the dose knob until "0" is seen in the dose window." -"Insulin should be seen at the tip of the needle." -"If insulin is not there, then repeat priming steps." Review of the provider's revised January 2018 Specific Medication Administration Procedure policy revealed: *For pen devices, "dial dose as instructed by pen manufacturer." *There was no mention of specific use for insulin pen devices.	F 759	2. DON will in-service nurse performing deficient practice on manufacturer's instruction and how to properly prepare and administer insulin pens, Residents 21 and 26 are currently receiving their medication per physician's orders. 3. Don/Desginee will in-service all nurses on how to properly prepare and administer insulin pens according to manufacturer's instruction. DON/Designee or consulting pharmacy will train nurses with a teach-back approach to verify understanding of how to properly prepare insulin pens. Education will occur no later than August 27, 2024. Those not in attendance, at the education session, due to illness, vacation, or casual work status, will be educated prior to their first shift worked. 4.Audits will be conducted weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed, by the DON or designee, at the monthly QAPI meeting with the IDT team and Medical Director for analysis and recommendation for continuation, discontinuation, or revision of audits based on findings.	

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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 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:	F 880	1. Resident 15 room deep-cleaned completely. Resident 11 had Enhanced Barrier Precautions (EBP) sign posted. Resident 27 catheter care/peri care was completed during the survey. Care plans were reviewed and updated as appropriate. All residents with wounds, indwelling medical devices (central line/peripheral inserted central lines, urinary catheter, feeding tube, tracheostomy, ventilator) are at risk for deficient practice. 2. The Administrator, DON, and interdisciplinary team, in collaboration with the medical director, reviewed the policies and procedures about appropriate hand hygiene and glove use for the assigned task as well as procedural technique during catheter care and dressing change. All staff will be educated no later than August 27th on the following:Staff notification and instruction/ signage when resident(s) is in enhanced barrier precautions, Hand Hygiene Policy (which includes glove use), and housekeeping for those on EBP; The Nurses and CNAs will be educated on Catheter care and peri care procedure; and Nurses will be educated on the dressing change procedure. Those not in attendance at the education session due to illness, vacation or casual work status will be educated prior to their first shift worked. 3. DON/Designee will complete audits for 4 weeks, bi-weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months. Results of the audits will be discussed by DON or designee at the monthly QAPI meeting with the IDT team and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on findings.	08.27.24

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F 880	Continued From page 6 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, and policy review, the provider failed to ensure one of one registered nurse (RN) unit manager C had performed glove changes during a dressing change for one of one sampled resident (15). Findings include: 1. 0bservation on 7/30/24 at 9:16 a.m. of RN unit manager C performing a dressing change with resident 15 revealed: *She applied PPE (personal protective	F 880		

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F 880	Continued From page 7 equipment). *She wheeled a tray into the room and laid a barrier down for the dressing supplies. *She placed the dressing supply container on a pillow in the resident's wheelchair. *She lowered the blinds in the resident's room. *With those same gloved hands she: -Adjusted the tray. -Lowered resident 15's shorts and brief. -Retrieved her walkie from her pocket and used it. -Assisted resident 15 to the bathroom with his shorts and brief half way down. -Pulled his walker from out in front of him. -Retrieved a garbage bag. -Removed the resident's soiled shorts and brief. -Retrieved her walkie and used it again. -Removed the resident's socks. -Used a peri wipe to clean feces from his legs. -She removed those gloves and performed hand hygiene. *She applied a new pair of gloves and retrieved a clean brief and a pair of the resident's shorts. *With those same gloved hands she assisted him with a new pair of gripper socks and provided peri care. *She removed her gloves and performed hand hygiene and put on a new pair of gloves. *With those gloved hands she: -Used wound cleanser and cleaned the wound with gauze. -Opened the collagen packet, and applied ointment to the resident's wound bed. -Removed her gloves, performed hand hygiene and applied a new pair of gloves. *She poured collagen onto her gloved hand and applied it to the wound. *She asked for assistance to retrieve a sharpie marker from her pocket and used it to date the	F 880		

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F 880	Continued From page 8 dressing. *She applied skin prep around the wound, applied the dressing to resident 15's coccyx, and removed his soiled shorts. *She removed those gloves and performed hand hygiene. *She applied a new pair of gloves and with those gloved hands she: -Assisted with dressing the resident with a new pair of shorts. -Cleaned the feces off of the floor and removed the garbage from her tray. -Continued to clean the feces off of the floor. -Removed the garbage bags and dirty laundry bag. -Replaced the garbage bags in the two garbage bins. -Opened the resident's blinds. *She removed her gown and gloves and performed hand hygiene. *She retrieved the resident's dressing supplies from the tray and placed them in the garbage, and removed her gloves. *She performed hand hygiene and applyied a new pair of gloves. *Used sani-wipes to clean her dressing tray. *She then removed those gloves and without washing her hands she, replaced the dressing supply container back into the medication cart without sanitizing it. Interview on 7/31/24 at 2:41 p.m. with RN unit manager C regarding the above dressing change revealed: *She agreed that she had missed some opportunities when she should have changed her gloves or washed her hands. *She agreed her pocket was not a clean area for her marker to have been placed and then used.	F 880		

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F 880	Continued From page 9	F 880		

*She agreed she had performed unclean tasks and then opened the resident's blinds with soiled gloves or washed hands.
*She agreed she had not sanitized the resident's dressing box before she returned it to the medication cart.

Interview on 7/31/24 at 3:30 p.m. with director of nursing (DON) B and regional nurse consultant H regarding the observed dressing change revealed:
*They agreed that RN unit manager C should have changed her gloves when going from a dirty task to a clean task.
*They agreed that RN unit manager C should have sanitized resident 15's dressing container prior to putting it back in the medication cart.

Review of the provider's February 2024 Hand Hygiene Policy revealed:
*"Before moving from a contaminated body site to a clean body site during resident care, (e.g., after cleaning perineal area and prior to proceeding to another area of body or dressing resident. Gloves should be removed, hand hygiene performed and new pair of gloves applied)."

B. Based on observation, interview, and policy review the provider failed to ensure:
*One of nine sampled residents (11) had been placed on enhanced barrier precautions (EBP).
Findings include:

1.Observation and interview on 7/29/24 at 4:24 p.m. with resident 11 revealed:
*She had returned from the hospital "a few days ago" after a surgical procedure for a wound on her left leg.
*There was a wound vacuum (a device that

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F 880	Continued From page 10 removes pressure and fluid from a wound) on the arm of her recliner and attached to her left lower leg., *There had not been any signage on the door that indicated she was on EBP. Observation on 7/30/24 at 11:45 a.m. with resident 11 revealed: *The director of rehabilitation (DOR) G was standing in resident 11's bathroom doorway when the surveyor entered the room. -She was not wearing a gown or gloves. -She stated she was assisting the resident with toileting and asked the surveyor to come back in a few minutes. Interview on 7/30/24 at 1:25 p.m. with resident 11 revealed "staff does not wear a gown" when providing any of her care, however, they wore "gloves for personal private area care". Observation and interview on 7/31/24 at 8:44 a.m. with DOR G revealed: *She was in resident 11's room. -Resident 11's room had a sign on the door that indicated EBP were to be followed and a cart outside that room contained gowns and gloves. *She stated, "Gowns and gloves are needed if we are doing ADL [activities of daily living] tasks; like if she needs toileting." *She confirmed that she had worked on toileting with resident 11 on 7/30/24 and that the sign indicating EBP and the cart with gowns and gloves had not been there at that time. *She did not know when EBP had started for resident 11. Interview on 7/31/24 at 2:58 p.m. with director of nursing (DON) B: revealed:	F 880		

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F 880	Continued From page 11 *Resident 11 was re-admitted to the facility on 7/26/24 with a wound vacuum device to her left lower leg. *She expected that all residents with a wound would be on EBP. Review of the provider's June 21, 2024 Enhanced Barrier Precautions policy revealed "Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices." C. Based on observation, interview, and policy review, the provider failed to ensure appropriate glove use, hand hygiene, and catheter care technique had been performed during one of one sampled resident's (27) foley catheter care by one of one certified nursing assistant (CNA) D. Findings include: 1.Observation and interview on 7/31/24 at 1:52 p.m. with resident 27 during his foley catheter care revealed CNA D: *Did not perform hand hygiene before she put on personal protective equipment (PPE) for resident 27 who was on enhanced barrier precautions (EBP). *She did not change gloves or wash her hands after she emptied the foley catheter and began his catheter care. *She cleaned the resident's groin area first and ended at the catheter insertion site with that same towel. *She placed the unclean, wet towel on a dry towel, which she then used to dry the resident. *She did not change her gloves or wash her hands before, during, or after she provided catheter cares for the resident. *When asked about hand hygiene and changing gloves during resident cares, CNA D stated if she already had been wearing gloves, she would have	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 performed all of cares for the resident and she would only have changed them if she was going to help another resident with their cares. Interview on 7/31/24 at 3:23 p.m. with registered nurse unit manager F revealed: *The CNA should have washed her hands before she applied PPE, after she emptied the foley catheter, and whenever she would have gone from soiled to clean items. *The CNA should have cleaned from the catheter insertion site and worked outward to not introduce bacteria to the opening. *She stated the groin should have been cleaned last. *She would have expected staff to have used clean wipes or towels after each time the area was wiped. Review of the provider's revised February 20, 2024, Hand Hygiene policy revealed: *Hand hygiene with alcohol-based hand rub must be done: -7) b. "When entering and leaving a Resident care area/room." - c. "Before donning and after removing gloves." - g. " ...after cleaning perineal area and prior to proceeding to another area of body or dressing resident. Gloves should be removed, hand hygiene performed, and new pair of gloves applied." - h. "After contact with residents' intact skin." - k. "After contact with body fluids ..."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING _____ B. WING _____	07/31/2024

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AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness requirements for Long Term Care Facilities, was conducted on 7/31/24. Avantara Groton was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Carda-LNHA
TITLE: Administrator
(X6) DATE: 08.19.24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 7/31/24. Avantara Groton was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K351 and K355 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by:	K 351	1. All residents are at risk. The ceiling noted in the deficiency has been repaired and is in compliance with NFPA 13, standard for installation of Sprinkler Systems. 2. Administrator will in-service Maintenance Director to ensure the facility follows the NFPA 13 Standard for Installation of Sprinkler Systems by August 27, 2024. 3. The Administrator or designee will complete monthly audits for 4 months to ensure ceilings comply with NFPA 13 Standard for Installation of Sprinkler Systems. Results of audits will be reported by administrator or designee in monthly QAPI meeting for further review and recommendation and/ or continuance/discontinuance of audits.	08.27.24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda LNHA	Administrator	08.19.24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 351	Continued From page 1 Based on observation and interview the provider failed to maintain the fire sprinkler system reaction time as designed in one randomly observed location (Maintenance shop) Findings include: 1. Observation on 7/31/24 at 2:27 p.m. revealed approximately one-quarter of the ceiling in the maintenance shop was missing. That missing portion of the ceiling was greater than one-foot square and would allow smoke and hot gasses to bypass the sprinkler head and slow the response of the building's fire suppression system. Interview with the maintenance director at that same time revealed that condition had existed since he had started roughly two years ago. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 351		
K 355 SS=E	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: Based on observation and interview, the provider failed to perform monthly checks of fire extinguishers in accordance with NFPA 10. Monthly checks had not been performed on four randomly observed extinguishers (Salon, employee lounge, transfer switch room, and electrical room "#1"). Findings include:	K 355	1. All residents are at risk. The fire extinguishers noted in the deficiency (salon, employee lounge, transfer switch room, and electrical room "#1") have been checked in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 2. Administrator will in-service Maintenance Director to ensure the facility follows the NFPA 10 Standard for Portable Fire Extinguishers by August 27, 2024.	08.27.24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2024**

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

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K 355	Continued From page 2 1. Observation on 7/31/224 at 2:06 p.m. revealed the fire extinguisher in the salon did not have monthly maintenance checks written on the fire extinguisher tag for the months of May and June of 2024. Interview with the maintenance director at the time of the observation confirmed that finding. He indicated the annual inspection of the extinguishers in the building had occurred in March 2024. He stated he had missed that extinguisher when he performed the monthly inspection of fire extinguishers in May and June of 2024. The deficiency had the potential to affect the entire smoke compartment. 2. Observation on 7/31/224 at 2:16 p.m. revealed the fire extinguisher in the employee lounge did not have a monthly maintenance check written on the fire extinguisher tag for the month of June of 2024. Interview with the maintenance services director at the time of the observation confirmed that finding. He stated he had missed that extinguisher as well when he performed the monthly inspection of fire extinguishers in June of 2024. The deficiency had the potential to affect the entire smoke compartment. 3. Observation on 7/31/224 at 2:28 p.m. revealed the fire extinguisher in the transfer switch room did not have monthly maintenance checks written on the fire extinguisher tag for the months of April, May, and June of 2024.	K 355	3. The Administrator or designee will complete monthly audits for 4 months to ensure extinguishers comply with NFPA 10, Standard for Portable Fire Extinguishers. Results of audits will be reported by the administrator or designee in monthly QAPI meeting for further review and recommendation and/ or continuance/discontinuance of audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/31/2024

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K 355	Continued From page 3 Interview with the maintenance services director at the time of the observation confirmed that finding. He stated he had missed that extinguisher when he performed the monthly inspections of fire extinguishers in those months of 2024. The deficiency had the potential to affect the entire smoke compartment. 4. Observation on 7/31/224 at 2:53 p.m. revealed the fire extinguisher in electrical room "#1" did not have monthly maintenance checks written on the fire extinguisher tag for the months of April, May, and June of 2024. Interview with the maintenance services director at the time of the observation confirmed that finding. He stated he had missed that extinguisher when he performed the monthly inspections of fire extinguishers in those months of 2024. The deficiency had the potential to affect the entire smoke compartment.	K 355		

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
	10626	A. BUILDING: _____ B. WING _____	07/31/2024

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

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/29/24 through 7/31/24. Avantara Groton was found in compliance	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/29/24 through 7/31/24. Avantara Groton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Carda-LNHA | TITLE: Administrator | (X6) DATE: 08.19.24