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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 11/16/2023
NAME OF PROVIDER OR SUPPLIER: AVANTARA LAKE NORDEN		STREET ADDRESS, CITY, STATE, ZIP CODE: 803 PARK STREET, LAKE NORDEN, SD 57248	

(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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/14/23 through 11/16/23. Avantara Lake Norden was found not in compliance with the following requirements: F658 and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 11/14/23 through 11/16/23. The area surveyed was resident neglect. Avantara Lake Norden was found in compliance.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure a Foley catheter change was completed per a physician's order for one of one sampled resident (93). Findings included: 1. Observation and interview on 11/14/23 at 9:05 a.m. with resident 93 revealed: *He was in his room sitting in a recliner watching television. *There was a catheter drainage bag hanging below his waist attached to the recliner and covered with a blue bag. *The urine in the catheter bag was concentrated	F 658	1. Resident 93 catheter was changed November 16, 2023. Urologist was made aware of late change. No adverse effects. Audit of other residents with catheters was completed with no findings of missed changes. Following review of policy and Procedures with the Medical Director all licensed nurses will be educated by the Director of Nursing on the policy "Following Physician Orders" by December 15, 2023. 2. All residents with a foley catheter have the potential to be impacted because of missed catheter changes.Policy education/re-education about roles and responsibilities for the above identified will be provided by December 15. 2023 by the Director of Nursing or designee. 3. Root cause analysis completed by Director of Nursing and Administrator on December 5, 2023 identified the nurse did not complete the order and no one followed up on the missed order as per our processes. When the Director of Nursing is absent the Assistant Director of Nursing or Clinical Care Coordinator will review Point Click Care for any missed orders. 4. Director of Nursing or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. After 4 weeks of monitoring expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Director of Nursing or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	12/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Grimm	Administrator	12/8/2023

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

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F 658	Continued From page 1	F 658		

and dark yellow.
*There was sediment in the urine and the catheter tubing.
*He stated he was seen by a urologist.
*The staff were good about emptying the urine from the drainage bag and completed catheter care every morning and evening.
*He could not recall if the nursing staff had changed his Foley catheter since he arrived at the facility a couple of months ago.

Review of resident 93's electronic medical record (EMR) revealed:
*He was admitted on 9/8/23.
*He had a Brief Interview for Mental Status (BIMS) score of 14 indicating he was cognitively intact.
*His diagnoses included urine retention.
*Physician orders included the following:
-"Change catheter monthly and PRN [as needed] every night shift starting on the 1st and ending on the 1st of every month." initiated on 10/5/23 to start on 11/1/23.
-"Foley catheter 16 French with 10 cc balloon. change if becomes dysfunctional or if sterility is compromised." Initiated on 9/9/23.
-"Change Foley catheter per facility protocol or MD order" Initiated on 09/09/2023.
-"Monitor urine/catheter output every shift" Initiated on 09/09/2023.
-"Follows urology, [name of urologist], change catheter monthly" Initiated on 09/21/2023.
*A review of his care plan revealed:
-He had an alteration in bladder functioning related to urinary retention with a Foley catheter.
-On 9/29/23 they attempted to discontinue the catheter, but he was unable to void (urinate), and the catheter was reinserted.
*A review of his November 2023 treatment record

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F 658	Continued From page 2	F 658		

revealed:
-"Change catheter monthly and PRN every night shift starting on the 1st and
ending on the 1st of every month" with a start date of 11/1/2023 had been listed to have been completed on 11/1/23 but it was not initialed or documented that it had or had not been completed.

Interview on 11/16/23 at 10:53 a.m. with the director of nursing (DON) B regarding a missed Foley catheter change for resident 93 revealed:
*They had removed his Foley catheter on 9/29/23 per the physician's order and had to replace it because he could not void.
*Urology ordered catheter changes monthly for resident 93 on 10/5/23.
*His Foley catheter change was scheduled on the 1st of November, and had not been documented as completed.
*She was not sure why his Foley catheter change was not completed on the 1st of November as scheduled or within 48 hours after, she had been gone.
*Perhaps he refused as they were in a COVID outbreak at that time.
*Her day nurse from November 1st reported she had not changed the catheter, and the night nurse was home sleeping and could not be reached.
*She had the day nurse change his Foley catheter on 11/16/23 and sent an order/notification to urology that it had been changed late.
*Nurses were alerted to tasks due through the dashboard in the PointClickCare EMR system.
*If the treatment was not completed it continued to show up for 48 hours as not done until the task was completed and then would fall off the

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dashboard alerts.
*If the treatment was not done within 48 hours, they fell off the dashboard alerts.
*She or the assistant director of nursing (ADON) checked missed tasks daily.
*She expected that if a treatment was due and it was not completed when scheduled it would have been documented as to the reason why it was not completed, the physician was notified with new orders, and for the scheduled task to have been completed at another time.

Interview on 11/16/23 at 11:25 a.m. with registered nurse (RN) D regarding the missed Foley catheter change for resident 93 revealed:
*Treatments or tasks scheduled during shifts were located on the resident's treatment administration record and were highlighted on the dashboard in the EMR.
*If the scheduled treatment or task was not signed off, it did not go away and hung out on the dashboard in the EMR.
*If a nurse had not completed a scheduled treatment, it would have been documented as to why in the EMR, they would have notified the physician by a facsimile (fax), notified the DON or ADON, rescheduled or had the ADON reschedule the treatment in the EMR and reported it to the next shift.
*If the above process was not completed then it would have stayed on the treatment record until it was completed.
*There was a way to set up treatment orders in the system to have the system continue to notify on the dashboard until the treatment was signed off.
*Typically, urology ordered Foley catheter changes every 30 days.

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F 658	Continued From page 4 Interview on 11/16/23 at 12:40 p.m. with the assistant director of nursing (ADON) C regarding a missed Foley catheter change revealed: *Foley Catheters scheduled to be changed were all set up on the resident's treatment administration record in the EMR per the physician's order. *Most physician's ordered routine Foley catheter changes and the urologists wanted the Foley catheters changed monthly. *Foley catheters scheduled to have been changed alerted the nurses by popping up on the treatment record dashboard in the EMR. *If the Foley catheter change was not completed for some reason on the scheduled date the nurses should have passed it on through the shift change report with the next shift. *She would have expected the missed Foley catheter change to have been reported to the physician and rescheduled in the treatment administration record. *They typically had not had any issues with missed treatments. *His Foley catheter change was missed due to the COVID outbreak all the staff were busy. *She had planned to look at the system and find a way for treatments to not fall off the EMR dashboard alert until completed.	F 658		
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.	F 880	1. Three drawer plastic storage bin with towels and washcloth was removed November 16, 2023. Commode liners will be used in the shower for removal of and transport of bowel movement(s) during showering. Cleaning instructions for the foot soak basin has been posted. Individualized resident hygiene products were removed from shower room and discarded. Individualized resident hygiene products will be labeled and stored in an indivdualized storage area.	12/28/23

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F 880	Continued From page 5 §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: (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	F 880	After reveiwing the policy and procedures with the Medical Director, all facilty staff who provide or are responsible for the above cares and services will be educated/re-educated by December 15, 2023 by Director of Nursing and/or Infection Control Nurse. 2. All residents receiving showering care have the potential to be impacted because of the conditions of this area. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by December 15, 2023 by Director of Nursing and/or Designee. 3. Root Cause Analysis was completed on December 5, 2023 with the findings of cleaning method for all items in the shower room was not specific to our facility. Quality Improvement Advisor for the South Dakota Quality Improvement Organization was contacted December 5, 2023 and Team Meeting was held December 8, 2023 to discuss plan of correction, revising the cleaning instructions, re-education to staff.	

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F 880	Continued From page 6 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: Based on observation, interview, and policy review the provider failed to ensure necessary infection control practices in one of two shower rooms that included: *Maintenance of a plastic three drawer towel and washcloth storage bin. *An appropriate and sanitary process for the removal of and transport of bowel movement(s) occurring during showering. *Appropriate care and maintenance of a multi-resident use foot soak basin. *Appropriately individualized resident identified personal hygiene products. Findings include: 1. Observation and interview on 11/15/23 at 2:35 p.m. with certified nursing assistant (CNA) E regarding cleaning the shower room revealed: *The shower room was in the south hallway and	F 880	4. Director of Nursing or designee will conduct auditing and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensures effective implementation and on-going sustainment. *Staff compliance in the above identified area. *The area identified in the Root Cause Analysis of specfic training of cleaning method for all items in the shower room. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Director of Nursing or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 7 was used by all residents except for those residents who resided in the memory care unit. *The shower room was a 6 x 6 feet room with no toilet, sink, or hand sanitizer dispenser. *From the doorway at the back right wall was a shower head, with a commode-style shower chair and a floor drain under it. *Approximately 1.5 feet to the left of the shower chair was a three-drawer plastic storage bin with towels and washcloths stored in it. -The storage bin was observed as black at one time but now was covered in a white hard water build-up from the shower water. -The storage bin had approximately one-fourth to one-half inch of white hard water build-up inside the handles and along the left bottom edge from the shower water. *On the floor in front of the storage bin was an empty white ice cream bucket. *On the left wall above the storage bin was a wood cabinet and when opened it contained a box of gloves and more than a dozen assorted bottles and tubes of personal hygiene products consisting of baby powders, barrier cream, lotions, body washes, deodorants, shampoos, and conditioners. -None of the above containers were labeled with the resident's names. *Stored on top of the wood cabinet approximately one-half inch below the ceiling was a pink plastic basin and sitting inside of that basin was a gray bucket. *Hanging off the top edge of the cabinet were three disinfectant spray bottles. *On the wall between the shower and the plastic storage bin was a laminated instruction sheet for cleaning the shower that included a three-minute disinfectant contact time. -The instruction sheet had no instructions for	F 880		

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F 880	Continued From page 8 cleaning the storage bin, pink basin or buckets. *She was able to refer to the shower cleaning instructions on the wall and demonstrate appropriate shower cleaning. *When asked about cleaning the storage bin next to the shower she reported she had not cleaned it when she cleaned the shower and confirmed the shower cleaning instructions on the wall did not include cleaning it. *She stated the ice cream bucket on the floor was used by CNAs to put under the commode chair if a resident had a bowel movement during their shower and she used it to put her wet washcloths in to take to the soiled laundry. *She stated the bucket used for residents having a bowel movement during their showers was taken to either the bathroom outside the shower room or the soiled utility room around the corner and down the hall to discard the feces. *When asked how the bucket was transported, she denied having bags or a lid for the bucket. *She stated she cleaned the bucket with the same disinfectant spray they used for the shower. *She denied receiving any training on how to remove the feces in the bucket from the shower room or how to clean that bucket. *When asked about the pink basin on top of the cabinet she stated they used it to soak residents' feet before trimming their toenails. *She reported that the pink basin was cleaned with the same spray bottle of disinfectant used to clean the shower and denied receiving any training on how the basin was to have been cleaned between each resident. *When asked about the personal hygiene products inside the cabinet she reported they belonged to multiple residents and were used during their showers and despite that there was no resident's names on those products she stated	F 880		

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she sort of knew what belonged to the residents.

Observation and interview on 11/15/23 at 3:00 p.m. with the director of nursing (DON) B in the shower room revealed:
*All CNAs were responsible for giving their assigned residents showers during their scheduled shifts.
*The instructions for shower cleaning were on the wall and they were to also clean the outside of the storage bin when they cleaned the shower between residents.
*The white build-up on the storage bin was from the hard water and they replaced the storage bin several times.
-She agreed the build-up in the drawer handles was a concern for the shower water leaking into the drawers and contaminating the clean towels and wash clothes.
*She stated the plastic bin on top of the cabinet was for soaking resident's feet before clipping their toenails and the gray bucket sitting inside of it was to have been placed under the commode chair if a resident was having a bowel movement while taking a shower so the feces would not go down the water drain and clog it.
*She stated the pink basin was cleaned with the same disinfectant spray they used to clean the shower and denied that there were instructions posted in the room or a policy instructing on how to clean the basin used for multiple residents.
*She stated a biohazard bag could have been placed in the gray bucket before a resident had a bowel movement and then tied to transport it to the soiled utility room for disposal.
*She agreed there were no biohazard bags or lids for the bucket stored in the shower room.
*She agreed hand hygiene would have been difficult to maintain in the shower room as there

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F 880	Continued From page 10 was no handwashing sink and no hand sanitizer in that room. *She agreed the personal products located in the cabinet should have residents' names on them and posed a concern for cross-contamination. *She was not aware of how staff were using the white ice cream bucket located on the floor next to the storage bin with clean towels and washcloths. Interview on 11/16/23 at 12:40 p.m. with assistant director of nursing (ADON) C regarding infection control and the shower room revealed: *She was the infection preventionist. *She had a Centers for Disease Control (CDC) infection preventionist training certificate with a completion date of 1/31/2022. *CNAs received training on showering residents during their CNA course. *She had not trained or monitored staff for infection prevention in the shower room. *She had not made rounds or performed any spot checks in the shower room. *Housekeepers have a routine cleaning schedule for deep cleaning, and it included the shower room. *If the housekeepers had seen something that was not cleaned in the shower room, they would have let the appropriate person know. *The storage bin next to the shower was to have been cleaned when the shower was cleaned. *She agreed the shower cleaning instructions posted in the shower did not include spraying disinfectant and wiping down the storage bin. *She agreed the drawers of the storage bin were not leakproof and agreed that shower water leaking into the drawers and onto the clean towels and washcloths was an infection control concern.	F 880		

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F 880	Continued From page 11 *She stated the buckets in the shower room were used if residents had a bowel movement while they were in the shower. *There was no process in place for transporting that bucket from the shower room to the utility room. *She stated staff could use a bag and then take it to the soiled utility room down the hall with the hopper and throw the bag away. *She had not placed bags in the shower room or developed a process for staff to follow. *She agreed leaving the shower room with a bucket of feces that was not covered with a bag or lid did not follow the infection control process. *The pink basin on top of the cupboard was for soaking residents' feet before clipping toenails. *Basins could be a one-time use or could have been used for more than one resident if the staff would disinfect it with the same spray, they used to clean the shower. *She does not train staff on cleaning basins after use or between multiple residents use. *She expected that the dozen or more personal hygiene products stored in the cabinet were to have been labeled with the resident's name. *She agreed that since they were not labeled, there was the potential that the personal hygiene products had been used on multiple residents and that was an infection control concern. A review of the provider's 1/24/23 Infection Prevention Program policy revealed: *"The goals of the infection prevention and control program are to: -A. Decrease the risk of infection to residents and personnel. -B. Prevent, to the extent possible, the onset and spread of infection. -C. Monitor for occurrence of infection and control	F 880		

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
	435059	A. BUILDING ___ B. WING ___	C 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET LAKE NORDEN, SD 57248

(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 outbreaks and cross-contamination. -D. Monitor for the occurrence of infection and implement appropriate control measures. -E. Identify and correct problems related to infection prevention practices. -F. Maintain compliance with state and federal regulations and standards of practice relating to infection prevention and control." *"The facility-wide comprehensive infection prevention and control program addresses detection, prevention, and control of infections among residents and personnel. It is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases for all."	F 880		

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

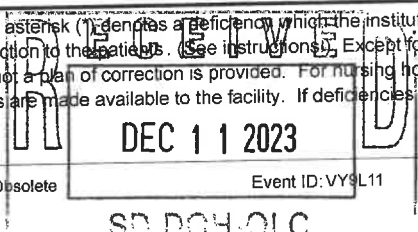
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435059	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET LAKE NORDEN, SD 57248

(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 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 11/14/23 through 11/16/23. Avantara Lake Norden was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 12/05/2023

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
	435059	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**11/14/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	**803 PARK STREET** **LAKE NORDEN, SD 57248**

(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 11/14/23. Avantara Lake Norden 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 K916 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 916 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, testing, record review and interview, the facility failed to provide a functional essential electric system alarm annunciator for the onsite generator (generator annunciator at the nurse station). Findings include: 1. Observation and testing on 11/14/23 at 11:28 a.m. revealed the generator annunciator mounted	K 916	1. Butler Machinery Company arrived onsite on November 22, 2023 to re-connect the line to the annunciator. 2. This deficiency has the potential to affect 100% of the occupants of the building. Contracted company Butler Machinery was informed of deficit practice on November 14, 2023. 3. Butler Machinery Company was informed on November 14, 2023 of the error of not re-hooking up the annuncator after the monthly service call. Facility Maintenace Director was educated by the Administrator on December 6, 2023 of the need to audit the above identified area. 4. Maintenance Director or designee will conduct auditing and monitoring of the above identified items 2-3 times weekly. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Contractor in compliance in the above identified area. 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 Maintenance Director or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	12/28/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Grimm	Administrator	12/06/2023

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

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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
	435059	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET LAKE NORDEN, SD 57248

(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 916	Continued From page 1 at the nurse station did not light or alarm when the light/alarm test button was pressed. Further testing by the maintenance director at that same time revealed the annunciator failed to show trouble with the generator being offline (not in auto). Further testing involved running the generator without carrying a load. Neither scenario showed any indication on the annunciator at the nurse station. Record review that same day revealed the generator servicing company had been there the day prior and noted no issues. Interview with the maintenance director at that same time confirmed those findings. He stated he was unsure why the annunciator would not show the generator's offline or ruining statuses. This deficiency has the potential to affect 100% of the occupants of the building. Ref. NFPA 99, Health Care Facilities Code (2012) 6.4.1.1.17	K 916		

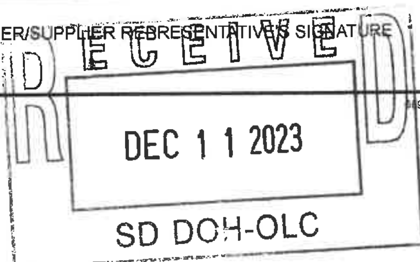
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10639	A. BUILDING: ______ B. WING ______	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248

(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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/14/23 through 11/16/23. Avantara Lake Norden was found not in compliance with the following requirement(s): S195.	S 000		
S 195	44:73:03:02 General Fire Safety Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation and interview, the provider failed to maintain exit corridors continually free of obstruction to full use at one randomly observed location (service wing exit corridor). Findings include: 1. Observation on 11/14/23 at 10:38 a.m. revealed two resident beds being stored in the service wing exit corridor restricting this width by one half. Those beds would have impeded the free and fully use of that exit corridor. Further observation later that same day revealed the beds had been moved to a different location not in an exit corridor. Interview with the maintenance director at the	S 195	1. Two resident beds were removed from the service wing on November 14, 2023. Staff will be educated by December 15, 2023 of the need of facility shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. 2. This deficiency has the potential to affect 100% of the occupants of the service wing smoke compartment and the one directly adjacent to it. 3. All staff will be educated/re-educated by the Administrator by December 15, 2023 on the need to keep hallways clear. 4. Administrator or designee will conduct auditings and monitoring of above identified items 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above idientied area. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at minimum for 2 months. Monitoring results will be reported by Administrator or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	12/28/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Grimm	Administrator	12/08/2023



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
	10639	A. BUILDING: ______ B. WING ______	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK ST POST OFFICE BOX 139 LAKE NORDEN, SD 57248

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S 195	Continued From page 1 time of the observation confirmed that finding. He stated those beds had issues that needed to be fixed and he needed an area where he could work on them. This deficiency has the potential to affect 100% of the occupants of the service wing smoke compartment and the one directly adjacent to it.	S 195		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 11/14/23 through 11/16/23. Avantara Lake Norden was found in compliance.	S 000		