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
	435039	A. BUILDING _____ B. WING _____	C 08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(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 complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/19/24 through 8/21/24. Areas surveyed included nursing services, dietary services, accidents, quality of care and treatment, resident abuse and neglect. Avantara Norton was found not in compliance with the following requirements: F686, F760, and F804.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, observation, interview, and policy review, the provider failed to implement pressure ulcer prevention interventions to prevent the development of pressure ulcers for one of one sampled resident (3). Findings include:	F 686	1. Resident 3 no longer resides in the facility. All residents will have a Braden scale completed to identify those residents at high risk for pressure injuries or skin breakdown. Residents determined to be at risk will have their care plan reviewed and revised to ensure pressure injury prevention interventions are in place. Facility will review all Braden scales completed weekly for changes in risk and ensure care plans are revised and daily report sheets are accurate. DON or designated RN will collaborate with LPN wound nurse on those with pressure injuries at least weekly. 2. The DON or designee will educate all nursing staff on the Skin and Pressure Injury Prevention Program policy by 09/20/2024. Any staff unable to attend education will receive education prior to their next shift worked. On 9/11/2024, the Administrator, DON and Medical Director reviewed and revised the Skin and Pressure Injury	09/20/24

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

Ashley Nickel | LNHA | 09/13/2024

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 686	Continued From page 1 1. Record review of the SD DOH complaint revealed: *Resident 3 was coded that she did not have skin issues. -She had a pressure ulcer that had worsened. -She had no wound interventions in place to ensure her wound healed. -She did not have documentation in her electronic medical record of her refusing repositioning. -She did no have documentation of her being educated to why repositioning would be beneficial to her wound healing. 2. Observation on 8/19/24 at 4:45 p.m. revealed resident 3 was sleeping in bed on her back, with her call light within reach. 3. Observation on 8/20/24 at 4:45 p.m. revealed resident 3 was again sleeping in bed on her back with her call light within reach. 4. Observation and interview on 8/20/24 at 8:53 a.m. with resident 3 with certified medication aide (CMA) P and certified nursing assistant (CNA) Q revealed: *They were repositioning her in bed because she had shifted down her mattress. *CMA P stated resident 3 does have pain because her legs are stiff. *Resident 3 asked CMA P why they were moving her and told her it was because she said she was uncomfortable when she got her medications. *She had bilateral heel boots on, and refused to have a pillow placed between her legs and said "Maybe later." *Resident said when she was at home her husband had taken care of her wounds but could no longer care for her. *She had a carton of Boost supplement, drank a	F 686	Prevention Program policy and discussed how resident(s) will have thorough and accurately documented skin and/or wound assessments, including units of measure when documenting measurement detail, when residents are identified as at risk for developing pressure injury and what the facility protocol for identified risk is and how to implement interventions and when care plans are updated. Discussed LPN role and RN collaboration and revised policy with the addition of: "LPNs may serve as the wound nurse and can complete the weekly Skin Alteration Evaluation UDA in PCC or the assessment in the Wound Rounds platform. If the assessment is completed by a LPN, there should be collaboration with a RN (may be the DON or other designated RN) to ensure wound status, treatments and interventions are reviewed. This may be accomplished through the facility's "at risk" meeting or other documented means to show LPN to RN collaboration is occurring at least weekly". 3. The DON or designee will audit Braden scales weekly for changes in scores and ensure appropriate interventions and care plan reviews and/or revisions are made. Audits will be completed weekly for 3 months. The DON or designee will audit 5 random residents weekly x 3 months to ensure repositioning and pressure	

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F 686	Continued From page 2 few sips and said that was enough. 5. Interview on 8/20/24 at 11:53 a.m. with resident 3's family revealed: *Resident 3 accepted repositioning if she was comfortable and without pain. *He stated resident 3 had three pressure ulcers and the one on her sacrum (tailbone) was down to the bone and was the size of a half dollar. She had been cared for at home for 7 years and the wounds had healed, but would open easily with any movement. -The family used foam surgical tape and rolled towels for repositioning. -Pillows were kept under her feet to prevent heel wounds. -She would refuse to move from her recliner, which was brought from home, to bed because it was uncomfortable. - They could have stood her up and adjusted the cushion for repositioning. *Family stated she laid in a "crappy diaper" for half an hour, and they were short on help. *She had been placed on hospice care last week and they were readjusting her oxycodone (pain medication) so she doesn't sleep as much. *Call light staff response had taken an hour at times, and she would call her family and they would call the facility and ask someone to go help her. *They had talked to social service director N and she would file grievances. *She didn't get the heel boots until after the right heel wound had already started. Before that, she had been wearing regular nursing home slippers. 6. Interview on 8/20/24 at 9:14 am. with Registered Nurse (RN) D regarding resident 3 revealed:	F 686	injury interventions are. Audits will be presented by the DON and reviewed in QAPI monthly to determine if additional audits must be completed or revised.	

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F 686	Continued From page 3 *She had a history of wounds at home and had come back but were getting better. *The heel wound was newer, and she had an order for heel protector boots. *Resident 3 had refused to wear the boots, and her refusals were documented. - She would wear them now because of the heel wound. *RN D said the wounds could have been prevented if she would have worn the Prevlon heel boots. *She would refuse repositioning because she couldn't see the TV while lying on her side. *She had refused physical therapy. 7. Interview 8/21/24 at 9:08 with CNA R regarding resident 3 revealed: *She would get repositioned every 2 hours but would refuse at times. *When she complained of pain it would have been reported and the nurse would get pain medication for her. 8. Record review of call lights response from 6/1/24 to 8/20/24 for resident 3 revealed on multiple occasions it had been on for 20-38 minutes. 9. Review of resident 3's care plan dated 3/13/24 revealed: *The skin ulcer prevention interventions did not include repositioning *She had heel protectors ordered but didn't care to wear them as she preferred socks. *Prevalon boots were not included in her care plan but were ordered on 8/2/24. 10. Review of resident 3's skin/wound note on 6/27/24 at 4:44 p.m. revealed "Reviewed	F 686		

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F 686	Continued From page 4 resident's sacrum/bilateral buttocks. When resident first admitted to facility resident resident had a stage 3 pressure, it healed and resident developed a rash. Rash has healed and resident's sacrum/bilateral buttocks has re-opened. Due to previously having a stage 3, it is classified as a stage 3 with re-opening. Current measurement: 13x13.0.01 cm. writer applied triad and border foam to area. Faxed provider update and for new orders. Updated family." 11. Review of resident 3's skin/wound care orders revealed: *On 5/28/24 "Following facility standing wound orders. Cleanse with normal saline, pat dry, cover with collagen gel, apply bordered foam." *On 5/31/24 "Reviewed resident's sacrum/buttocks. Current measurement: 10 x 8.5 cm. Applied current orders: Cleanse with normal saline, pat dry cover with collagen gel, apply bordered foam. Applied barrier cram to erythema." *On 6/20/24 "Clean wound, apply medihoney and cover with bordered foam dressing daily until resolved." *On 6/28/24 "PCP-ok to apply collagen particles mixed with triad daily and as needed with incontinence episodes to sacrum/bilateral buttocks ok to discontinue medihoney/borderfoam." *On 7/19/24 "Updated orders: 1. Sacrum: cleans with wound cleanser, apply skin prep, apply collagen particles, and cover with hydrocolloid. 2. Bilateral buttocks: apply triad mixed with collagen particles." *On 8/19/24 "Ok for avera hopice to eval and treat." *On 8/19/24 "Received fax from hospice . New orders: right heel-cover with optifoam dressing	F 686		

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F 686	Continued From page 5	F 686		

every other day. Coccyx-apply therahoney, then calcium alginate and cover with optifoam dressing every day."

12. Review of resident 3's wound assessments details report for her sacrum/buttocks and right heel revealed:
*The reports were signed and completed by a licensed practical nurse (LPN).
-There was no collaboration between a registered nurse (RN) and he LPN for skin assessments.
*The wound was on the bilateral buttocks/sacrum.
*The wound was facility-acquired 7/4/24
*The status, type, classification, clinical stage and measurement size in centimeters in Length (L) x width (W) x depth (D) of that wound was documented as follows:
-On 6/6/24 active, rash, erythema (redness) and measured 10.00 x 8.50 x 0.01.
-On 6/13/24 active, rash, erythema and measured, 9.00 x 6.50 x 0.01.
-On 6/20/24 active, rash, erythema and measured, 9.00 x 7.00 x 0.01.
-On 6/27/24 healed, rash, erythema and measured, 0.00 x 0.00 x 0.00.
-On 7/4/24 active, pressure ulceration, stage 3, and measured 13.00 x 11.00 x 0.01.
-On 7/11/24 active, pressure ulceration stage 3 and measured 13.50 x 12.0 x 0.01.
-On 7/18/24 active, pressure ulceration, stage 3 and measured 15.00 x 12.50 x 0.01.
-On 7/25/24 active, pressure ulceration, stage 3 and measured 12.50 x 12 x 0.01.
-On 8/8/24 active, pressure ulceration, stage 3 and measured 13.00 x 12.50 x 0.10.
-On 8/1/24 active, pressure ulceration, stage 3 and measured 12.50 x 12.0 x 0.01.
-On 8/12/24 active, pressure ulceration, stage 3

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F 686	Continued From page 6 and measured 3.20 x 4.50 x unknown. -On 8/19/24 active, pressure ulceration, stage 3 and measured 3.40 x 4.00 x 1.10. *On 8/1/24 active, pressure blister, deep tissue pressure injury and measured 2.0 x 3.50 x unknown. -On 8/8/24 active, pressure blister, deep tissue pressure injury and measured 2.0 x 3.50 x unknown. -On 8/12/24 active, pressure blister, deep tissue pressure injury and measured 2.70 x 2.20 x unknown. -On 8/19/24 active, pressure blister, deep tissue pressure injury and measured 4.10 x 2.90 x unknown. Summary Resident 3's Sacrum and buttocks wounds were healed 6/27/24 and a facility acquired pressure injury that measured 13.00 x 11.00 x 0.01 on 7/4/24 as a stage 3 and had worsened and measured 3.40 x 4.00 x 1.10. Her right heel wound was a facility acquired deep tissue pressure injury that measured 2.0 x 3.50 on 8/1/24 and had worsened to 4.10 x 2.90. 13. Record review of the providers skin and pressure injury prevention program policy dated March 23, 23 revealed: *To provide care and services to prevent pressure injury development to promote the healing pressure injuries/wounds that are present. 14. Grievances were reviewed, but none were found from resident 3.	F 686		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760	1. No immediate correction can be made for Resident 2's missed immunosuppressant medication	09/20/24

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F 760	Continued From page 7 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: A. Based on South Dakota Department of Health (SD DOH) complaint online report, observation, interview, and policy review, the provider failed to administer medications ordered by the physician for 2 of 2 sampled residents (1 and 2). Findings include: 1. Review of SD DOH 8/14/24 complaint revealed: *Resident 2 had a lung transplant and had not been getting her immunosuppressant medication. *The medication had not been ordered timely and received at the facility. 2.Interview on 8/20/24 at 10:17 a.m. with registered nurse (RN) unit manager O regarding missed doses of resident 2's medication Everolimus (an immunosuppressant medication for her lung transplant) revealed: *He was aware that she had not received a dose on 8/18/24. *Her 2.5 mg tablet supply of Everolimus did not come in. * He notified director of nursing (DON) B and he had emailed the pharmacy and expected it to be delivered "today 8/20/24." *He agreed the doctor should have been notified. 3. Interview on 8/20/24 at 12:38 p.m. with resident 2 revealed: *She had a lung transplant on March 20, 2023. *She stated her medications were sometimes difficult to get while living a home she would order them in plenty of time to prevent running out.	F 760	The medication has been received from pharmacy and is being given as ordered. No immediate correction can be made for Resident 1's missed Lorazepam doses. Education provided to nurses on following the physician's order for this as needed medication. No immediate correction can be made for Resident 5's missed insulin doses. LPN S is no longer employed at facility for further education. All Residents are at risk for failure to order medications appropriately or administer medication per physician's order. New orders and review of any missed medication doses is being reviewed at the morning clinical meeting. 2. Immunosuppressant medication will be reviewed for changes during morning clinical meeting, to ensure dose changes are correct and accurate, labs are scheduled as ordered, and supply has been received by pharmacy. Medication Administration Records will be reviewed during morning clinical meeting for previous 24-72 hours to ensure there is no missed documentation of medication administration. The DON or designee will educate all nurses and medication aides on Medication Error Policy, Following Physician Order Policy,	

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F 760	Continued From page 8 *She had no problems with her medications being available since living at the nursing home. *She was not aware that she had ever missed any doses while at the nursing home. 4. Interview on 8/21/24 at 10:09 a.m. with DON B and observation of the Everolimus medication package on the medication cart revealed: *There were two boxes of 1 milligram (mg) tablets (tabs) of Everolimus labeled with instructions to give 3 tabs (3 mg) two times daily. *The box contained individual foil - backed bubble packages that indicated each bubble contained a 1 mg tablet. *He stated there were no 2.5 mg or .5 mg tabs available on the cart because the order was for was 3 mg dose which had changed from the 2.5 mg dose. 5. Interview on 8/21/24 at 12:40 p.m. with DON B and nurse consultant C regarding resident 2's Everolimus medication order revealed: *The order had changed from 2.5 mg to 3.0 mg. *There was possibly a transcription error in the electronic medical record (EMR) and they would start an investigation. *The pharmacy would fax the current order. *The lab would come in and obtain a specimen to get the resident's current trough (lowest concentration of medication in a person's system) level of that medication in her system. 6. Review of resident 1's EMR revealed: *She had an order for Lorazepam injection solution 2 MG/ML, inject 0.5 ml intramuscularly every 6 hours as needed for violent muscle twitching, muscle jerking greater that 5 minutes related to conversion disorder with seizures or convulsions dated 4/11/24.	F 760	Medication Administration-General Guidelines, and Medication Ordering and Receiving from Pharmacy by 09/20/2024. Any staff unable to attend education will receive education prior to their next shift worked. On 9/11/2024 Administrator, DON, Pharmacy Consultant and Medical Director reviewed the Medication Error Policy, Following Physician Order Policy, Medication Administration-General Guidelines, and Medication Ordering and Receiving from Pharmacy. Reviewed current staffing and ensured current delivery model meets needs of resident. 3. The DON or designee will audit 5 random MARs weekly for missed medication and supporting documentation x 3 months. Audits will be presented by the DON and reviewed in QAPI monthly to determine if additional audits must be completed or revised.	

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F 760	Continued From page 9 *On 7/14 the nurse progress noted she had a second episode that lasted 6 minutes with more "thrashing" but there was no documentation that the medication was administered. *On 7/28/24 the nurse noted she had "convulsions" during the episode but there was no documentation that the medication was given. 7. Interview on 8/21/24 at 11:39 a.m. with DON B regarding resident 1's medication revealed: *He confirmed she had an order for "Lorazepam injection solution 2 MG/ML, inject 0.5 ml intramuscularly every 6 hours as needed for violent muscle twitching, muscle jerking greater that 5 minutes related to conversion disorder with seizures or convulsions" dated 4/11/24. *He stated the nurses would assess her during an episode and decide if she should get that medication at that time. *He stated if the nurses charted the term convulsion or thrashing that he would have expected the medication to be given. 8. Review of resident 2's medication administration record (MAR) notes regarding Everolimus revealed: *On 8/13/24 "partial administration, no 0.5 mg tabs." *On 8/7/24 "medication was not given." *On 8/8/24 "There was a duplicate order." *On 8/9/24 "a partial dose of 2 mg had been given, and the pharmacy was called to order the 0.5 mg tabs." *On 7/29/24 a new order was put in, and the new order was received for Everolimus. Take 6 (3 mg) PO BID." *On 8/14/24 "the medication was on order." *On 8/18/24 "The medication was not given due to there was no 0.5 mg tabs available."	F 760		

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F 760	Continued From page 10 9. Review of resident 2's medication administration orders and administration documentation for July and August 2024 revealed: *A 5/29/24 order to start Everolimus Immunosuppressant give 3 mg by mouth one time a day every Wednesday for lung transplant that discontinued on 7/2/24. *A 7/10/24 order to start Everolimus Immunosuppressant give 3 mg by mouth one time a day every Wednesday and no discontinue date. -There was no documentation as given on 7/3/24 and there was no reason documented as why it was not given. *A 5/28/24 order to start Everolimus Immunosuppressant give 2.5 mg by mouth at bedtime every Mon, Tue, Wed, Thurs, Fri, Sat, Sun related to lung transplant that discontinued 7/2/24. -There was no documentation that dose was given on 7/2/24 *A 7/3/24 order to start Everolimus Immunosuppressant give 2.5 mg by mouth at bedtime every Mon, Tue, Wed, Thu, Fri, Sat, Sun related to lung transplant status. -Medication was documented as not given and to see progress note -There was no documentation that a dose was given and indicated to see nurse note which was not viewed. *In August the orders were as follows: *A 7/3/24 to start Everolimus Immunosuppressant give 2.5 mg by mouth at bedtime every Mon, Tue, Wed, Thu, Fri, Sat, Sun related to lung transplant status there was no discontinue date. -There was no documentation that a dose was given on August 7 and August 18 and indicated to	F 760		

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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 760	Continued From page 11 see nurse note which noted 8/7/24 medication not given and no reason of why and on 8/18/24 noted not given due to no .05 mg dose. *A 7/4/24 order to start Everolimus Immunosuppressant give 3 mg by mouth one time a day every Mon, Tue, Thu, Fri, Sat, Sun related to lung transplant and there was no discontinue date. -This was not reviewed after the 19th. *A 7/10/24 order to Everolimus Immunosuppressant give 3 mg by mouth one time a day every Wed for lung transplant status there was no discontinue date. -This record was not reviewed after the 19th. *A 7/20/24 order to start Everolimus Immunosuppressant give 3 mg by mouth every morning and at bedtime related to lung transplant status and there was no discontinue date. -Documented as see nurse note for 8/7/24 which noted medication not given and on 8/14/24 noted medication on order. 10. Review of a physician's order faxed to the facility from the pharmacy on 8/21/24 at 3:57 p.m. revealed: *Resident 2 had an order to increase her Everolimus dose to 3 mg twice daily as of 7/29/24. *A 12 -hour trough was to be obtained one week after dose changes. 101. The provider's undated medication administration general guidelines revealed: *The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. *Procedure, "A. 4. FIVE RIGHTS-Right resident, right drug, right dose, right route and right time, are applied for each medication being	F 760		

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	435039	A. BUILDING _____ B. WING _____	C 08/21/2024

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F 760	Continued From page 12 administered ..." *"B. Administration 6. Medications are administered without unnecessary interruptions." *"D. Documentation (including electronic) 6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time (e.g., the resident is not in the facility at scheduled dose time, or a started dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is [initialed and circled]. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedures for use of the eMAR system. An explanatory note is entered on the reverse side of the record. If [XX consecutive doses] of a vital medication are withheld, refused, or not available the physician notified. Nursing documents the notification and physician response. " B. Based on the South Dakota Department of Health (SD DOH) complaint online report, observation, interview, record review, and policy review, the provider failed to ensure that one of one sampled resident (5) received medications as prescribed by a physician. Findings include: 1. Review of SD DOH complaint online report on 8/19/24 at 10:00 a.m. revealed: *An anonymous complainant reported that resident 5 had not received his ordered insulin. *The anonymous source reported a nurse assigned to another unit was asked to administer medications to resident 5 at 1:00 a.m. by his licensed practical nurse (LPN) S. *The anonymous source reported that nurse was not comfortable giving resident 5's insulin past the prescribed time and not being able to adequately monitor him from their assigned wing.	F 760		

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F 760	Continued From page 13 *The anonymous source reported that on another shift that same nurse had been asked to administer resident 5's medications. 2. Observation and interview on 8/19/24 at 3:10 p.m. with resident 5 revealed: *Resident 5 had lived at the facility for two years. *He described staff and said, "there's good people, and there are not so good people." *Resident 5 stated there were times when he did not get his medications, including his insulin. *Resident 5 stated he was told, "a high sugar is better than a low sugar." *He stated he had blood sugars higher than 250 [milligrams per deciliter (mg/dl)] and there were nurses who would not give him his insulin. *He said there was a nurse that he did not like, and that he did not let her in his room. 3. Review of resident 5's medication (med) administration record (MAR) revealed: *Ordered bedtime blood glucose checks were not obtained on 7/5, 7/10, 7/12, 7/23, 7/24, 7/30, 7/31, 8/4, and 8/6. *Ordered bedtime long-acting insulin was not administered on those dates or on 8/11 and 8/12. *Ordered 8:00 p.m. Latanoprost eye drops were not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Propranolol (blood pressure med) capsule was not administered on 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Topiramate (seizure/headache med) tablet was not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Brimonidine Tartrate eye drops were not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6.	F 760		

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F 760	Continued From page 14 *Ordered 8:00 p.m. Carboxymethylcellulose Sodium eye drops were not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, 8/6, and 8/13. *Ordered 8:00 p.m. Dorzolamide HCL eye drops were not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, 8/6, and 8/13. *Ordered 8:00 p.m. Methenamine Hippurate (antiseptic med) tablet was not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Polyethylene Glycol (laxative)powder was not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Saline Nasal Solution was not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *Ordered 8:00 p.m. Vitamin C tablet was not administered on 7/5, 7/10, 7/12, 7/24, 7/30, 7/31, and 8/6. *LPN S was the charge nurse on those night shifts and was assigned to the wing resident 5 resided on. 4. Review of resident 5's progress notes revealed: *Progress notes in resident 5's chart written by agency registered nurse (RN) L indicated that on the night of 7/26, she was pulled from her unit to give medications on LPN S's unit because LPN S was not allowed in resident 5's room. -Agency RN L agreed to administer resident 5's medications. -Agency RN L obtained resident 5's blood glucose and it was 357mg/dl. -After collecting insulin syringe for administration, LPN S said, "resident 5's BS (blood glucose) is known to fall quickly and if patient's BS crashed it would be on me." -Agency RN L then called the on-call RN and was advised to recheck blood glucose and then	F 760		

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F 760	Continued From page 15 administer if she was comfortable administering the insulin. -Agency RN L did not administer the insulin out of caution. She faxed the resident's primary care physician and left a note for the director of nursing describing the incident. 5. Interview on 8/20/24 at 8:45 a.m. with agency RN V revealed: *She stated resident 5 was different than most diabetics. -She said he would skip a lot of meals and his blood glucose would drop fast if he were not eating. -She said she would make sure he has been eating before she would give him his insulin. *When asked if there was a reason that the resident did not receive his insulin on the dates previously listed, she said she would have to talk to the nurse who was working that shift. *She said there was a nurse resident 5 would not allow to provide cares for him. She did not want to provide a name. 6. Interview on 8/20/24 at 9:25 a.m. with LPN E revealed: *When asked if she had ever worked with LPN S, she said that she had only met her during the change of shift because she worked the day shift. *She also said she would describe LPN S as "abrasive, but not rude." *When asked if there was a nurse that resident 5 would not allow in his room, she said yes, but that nurse no longer works here, and identified her as LPN S. 7. Follow up interview on 8/20/24 at 12:30 p.m. with resident 5 revealed: *He was asked if he was able to feel when his	F 760		

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F 760	Continued From page 16 blood glucose went low, he said sometimes. *Resident said "I'm a brittle diabetic." He stated that his blood glucose would go up and down frequently. *He stated that he could sometimes tell when his blood glucose gets low because he would get hungry or feel tired. But he could not always tell when his blood glucose was getting low. *He said that he wanted to get a Dexcom device that would give him constant blood glucose monitoring. 8. Interview on 8/20/24 at 2:20 p.m. with director of nursing (DON) B regarding resident 5 revealed: *He can be a difficult resident. *He felt LPN S and resident 5 had never been able to get along but was not aware of a specific reason why. *He stated resident 5's blood glucose was known to range widely from high to low, and resident 5 would go unresponsive if his blood glucose got too low. *Resident 5's evening blood glucose on 8/11/24 was 301mg/dl and on 8/12/24 it was 366mg/dl, ordered insulin was not administered. -LPN S was the charge nurse both of those nights and was assigned to resident 5's wing. -Resident 5's ordered insulin was not given those evenings. *DON B stated it was not acceptable that insulin was not given unless there was a reason, it should have been documented. *When asked if he agreed with the progress note from 7/26, he stated even if agency nurse L administered the insulin, resident 5 would still have been the responsibility of LPN S. *LPN S had resigned on 8/14/24, and DON B stated he was not able to speak to LPN S about the insulin.	F 760		

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F 760	Continued From page 17 9. Review of a grievance filed by resident 5 revealed: *On 7/25/24, a grievance report was filed by resident 5 and collected by social service designee F. *In the grievance form, it stated, "Resident stated he did not get his medication and insulin last night." *Resolution of grievance stated, "Nurse verbalized medication was given. Notified provider. Resident verbalizes it was not given. EMAR doesn't show meds given 7/24/24. Education provided to nurse." 10. Interview on 8/21/24 at 10:25 a.m. with DON B and regional nurse consultant (RNC) C revealed: *Reviewed July dates in which evening medications were not administered to resident 5 (July 5, 10, 12, 23, 24, 30, and 31). *It was DON B's expectation that resident 5's medications should have been administered, and if they were not administered, it should have been document in resident's chart and the provider should have been notified. *When asked if management received any type of notification when medication administrations were missed, DON B stated he would only receive a notification if a medication was documented as not given, but not if the medication was just not given and not documented. *It was DON B's expectation that even if resident 5's medication administration needed to be delegated to another nurse, that resident 5 should have received his mediations. 11. Review of the provider's Medication	F 760		

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F 760	Continued From page 18 Administration-General Guidelines revealed: *Section B. Administration stated, "2. Medications are administered in accordance with written orders of the prescriber." *Section D. Documentation stated, "1. The individual who administers the medication dose records the administration on the resident's MAR/eMAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensure necessary doses were administered and documented. In no case should the individual who administered the medication report off-duty without first recording the administration of any medications.	F 760		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) complaint online report, observation, interview, resident council meeting minutes review, and policy review the provider failed to ensure room trays were served at a satisfactory temperature for two of three sampled residents (4 and 6). Findings include: 1. Review of the 8/2/24 DOH complaint online	F 804	1. No immediate correction could be made for improper food temperatures for residents 4 and 6. Residents are receiving room trays at a proper temperature. All residents who receive room trays are at risk for food being served at improper temperature. Meals will be delivered utilizing facility dishware, hot plates, plate bases and covers to ensure food temperatures meet facility policy. Food temperatures will be taken per facility policy. 2. The Administrator or designee will provide education with all dietary staff on food temperature policy, including taking temperatures after reheating the food, by 09/20/2024. Any staff unable to attend education will receive education prior to their next shift worked.	09/20/24

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F 804	Continued From page 19 report revealed: *Alternate menu items were: -Warmed up. -Wrapped in plastic. -Set on the counter until served. *The food had sat on the counter for an hour before being served. *Hamburgers, chicken strips, and fried eggs were examples of foods left on the counter. 2. Observation and interview on 8/19/24 at 4:30 p.m. with resident 4 in his room regarding food temperatures revealed: *He was sitting up in his bed. *He preferred to eat in his room. *Breakfast was the only meal he ate. *His menu consisted of two fried eggs and a hamburger patty. *His breakfast had been delivered to his room cold several times. *He had discussed his issue with the food temperature with the dietary manager. Observation and interview with cook U on 8/20/24 from 7:50 a.m. through 8:38 a.m. in the east dining room kitchenette revealed: *At 7:50 a.m. there were three Styrofoam plates with two fried eggs on each plate on the back kitchenette counter. *Another Styrofoam plate had a cheeseburger on it. *All the plates were covered in plastic wrap. *Cook U was serving breakfast from the steam table to the residents in the dining area. *At 8:22 a.m. cook U reheated two of the plates of fried eggs in the microwave for 45 seconds. *He put two eggs each on two new plates and covered them with an insulated cover. *The eggs were put on a cart and were delivered	F 804	3. The Administrator or designee will complete 3 test tray audits per week to ensure food is at the proper serving temperature. Test tray will be delivered during meal service to Administrator or Designee as a resident tray would be delivered. Audits will be presented by the Administrator and reviewed in QAPI monthly to determine if additional audits must be completed.	

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F 804	Continued From page 20 to resident rooms. *Cook U did not check the temperature of the eggs. *At 8:32 a.m. cook U reheated the last plate of two eggs and the plate with the cheeseburger for 45 seconds each. *He was asked by this surveyor to get a current temperature of the eggs and cheeseburger. *The eggs had a temperature of 122 degrees (Fahrenheit). *The cheeseburger had a temperature of 132 degrees. *Cook U stated the eggs and cheeseburger had not gotten hot enough. *He put the eggs in the microwave for another 45 seconds and took the temperature again. *The eggs were then at 183 degrees. *He put the cheeseburger in the microwave for another 45 seconds and took the temperature. *The cheeseburger was then at 182 degrees. *He covered the eggs and cheeseburger with an insulated cover and an unidentified certified nursing assistant took the room tray to resident 4. *Cook U stated the preferred temperature for reheated eggs was a minimum of 145 degrees and the cheeseburger should have been at least 165 degrees. *He confirmed he had not temped the first two plates of fried eggs before they were sent to resident rooms. *He agreed the reheated items had to be microwaved for more than 45 seconds to reach appropriate temperatures. Observation and interview on 8/20/24 at 8:44 a.m. with resident 4 in his room regarding his breakfast revealed: *He was sitting upright in his bed with his breakfast on an over-bed table in front of him.	F 804		

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F 804	Continued From page 21	F 804		

*One of the fried eggs and the cheeseburger were on the over-bed table.
*He confirmed that his breakfast was hot when it came to his room today.

Interview on 8/20/24 at 10:20 a.m. with dietary manager T regarding food temperatures revealed:
*She was aware room tray food temperatures had been an issue.
*They had tried different methods to ensure food was kept warm.
*Dietary staff were educated on proper food temperatures during general orientation and annually.
*It was a trial and error process.
*She had done some food audits to monitor the room tray food temperatures.
*She expected the dietary staff to reheat food items to the appropriate temperatures.

3. Observation and interview on 8/20/24 at 1:45 p.m. with resident 6 in his room regarding his breakfast room tray revealed:
*He was sitting in his wheelchair.
*He eats most of his meals in his room.
*He stated the food could be hotter when it was delivered.
*His eggs were cold that morning.
*He thought the food was cold because the room trays were served after other residents were served in the dining room.

4. Review of the May, June, July, and August resident council meeting minutes regarding food temperatures revealed:
*Food temperature issues were documented in the May and June meeting minutes.
*There was no follow up documentation for food

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F 804	Continued From page 22 temperatures in the July meeting minutes. *The August meeting minutes indicated food was at acceptable temperatures for the last couple of days. 5. Interview on 8/21/24 at 12:20 p.m. with social services designee F regarding food temperatures revealed: *Food issues were a topic at almost all resident council meetings. *The dietary department had implemented several changes to try to address food temperatures. *The dietary manager would address concerns that were brought up at resident council with the residents. *The administrator had done several audits on food temperatures and food services. Interview on 8/21/24 at 1:10 p.m. with administrator A regarding food temperatures revealed: *She knew food temperatures were an issue. *Dietary manager T had educated staff on proper food temperatures. *She had conducted audits and tested sample food trays personally. *Her expectation was dietary staff would follow the food service policies. 6. Review of the provider's revised 3/19/2020 Food Temperatures policy revealed: *"Food should be served at proper temperature to insure food safety and palatability." *"9. Reheating food for hot holding either in the oven or microwave must reach 165 (degrees) F and hold for 15 seconds. Reheating should be done within a 2-hour period. Reference Food Code Temperatures (DOC 401)."	F 804		

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