STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435058	A. BUILDING _____ B. WING _____	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CLARK CITY	201 8TH AVENUE NW CLARK, SD 57225

(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 9/9/24 through 9/12/24. Avantara Clark City was found not in compliance with the following requirement: F689.	F 000	F689- Free of Accident Hazards/Supervision/ Devices 1. The Administrator, DON, and interdisciplinary team in collaboration with the medical director reviewed the procedures about ensuring resident use equipment that including the beds are on a preventative maintenance and safety review schedule. All preventative maintenance tasks were reviewed.	10/6/24
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and record review, the provider failed to ensure a bed frame was maintained and free of hazardous sharp areas for one of one sampled resident (1) who acquired a skin tear to her right lower outer ankle. Findings include: 1. Interview on 9/09/24 at 3:51 p.m. with resident 1 revealed: *She was lying in her bed and stated she had a cut on her right leg that was caused from the metal on her bed when they were putting her to bed after using the bathroom. *She stated she had no other skin concerns. 2. Record review of resident 1's skin alteration evaluations revealed: *On 8/18/24 resident 1 received a skin tear to her	F 689	The Administrator educated all staff on ensuring any equipment breakages or safety concerns are reported to the Administrator immediately, including any resident or staff injuries that involve any equipment and a work order placed in TELS Staff were also educated that any equipment involved in an injury must be taken out of service until it is inspected/repaired by maintenance personnel. Education will take place no later than 10/6/24. 2. Maintenance assistance provided with access to TELS communication to ensure necessary repairs or maintenance is done timely if maintenance director is out of facility. 3. Housekeeping manager updated daily duties sheets for the housekeepers to include area for reporting repairs and maintenance found during daily cleaning Housekeeping manager or charge nurse will put work order in TELS. Manager to inspect deep cleans and equipment in resident rooms for hazards weekly. 4. Steps on how to create a work order in TELS placed at nurse's station for CNAs and nurses to refer to. 5.IDT to complete room round audits weekly 6. All audits and TELS work orders will be reviewed monthly at QAPI and quarterly at safety committee meetings. TELS work orders are reviewed daily at stand up meeting as well. continued-	

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

Rachel Morehouse | Administrator | 10/1/24

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.

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F 689	Continued From page 1 right outer ankle while CNA I transferred her into bed. -The skin tear measured 6.0 L X 3.0 W x 0.5 centimeters (cm) deep. -Resident 1 declined go to the emergency room (ER) for an evaluation. *The residents wound was cleaned, Steri strips and a gauze pad were applied, and then her leg was wrapped in a gauze bandage. -The family was notified and agreed that she would not go to the ER for evaluation of the right leg wound. *On 9/11/24 the wound measured 6 cm X 2.2 cm X 0.1 cm. 3. Observation and interview on 9/10/24 at 9:26 a.m. with resident 1 revealed: *She stated nothing had been done to her bed to prevent her from being cut again. *The bed frame was exposed under her mattress and had seven metal square bars. -Three of those bars, from the middle of the bed to the head of the bed, had plastic protective caps on the ends of them. -Four those bars, from the middle of the bed to the toot of the bed, did not have protective caps. 4. Observation and interview on 9/10/24 at 9:52 a.m. with certified nursing assistant (CNA) G revealed: *She stated, "I am almost positive she cut her leg on those bars." *She pointed to the bars on the bed frame. 5. Observation on 9/10/24 at 2:58 p.m. with resident 1 while she was asleep in her bed revealed sheepskin cover was under the mattress and over the edge of the bed covering the bed frame.	F 689	All residents and staff have potential to be affected if staff do not adhere to the identified issues. Policy education/reeducation about roles and responsibilities for the above identified assigned service tasks will be provided by DON/administrator to all staff including RN E by 10/6/24.	

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F 689	Continued From page 2 6. Interview on 9/10/24 at 3:24 p.m. with registered nurse (RN) C and administrator A revealed: *They both confirmed a sheepskin cover had been placed over resident 1's bed frame. *Administrator A stated she had informed maintenance staff H of the resident's bed frame that past weekend when she was the manager on duty, but he had not been notified previously. *She agreed nothing had been done about the bed frame until today (9/10/24). 7. Interview on 9/10/24 at 3:45 p.m. with RN E revealed: *Resident 1 acquired a skin tear to her right leg during a transfer on 8/18/24 and was "bleeding pretty good." *Resident 1 and her family did not want her to go the ER for evaluation because the bleeding had stopped. *She would monitor the resident's leg for redness and cellulitis because she worked the next day. -The wound was not red. *She had evaluated the resident's bed and wheelchair but did not see anything dangerous that would have caused the skin tear, so she did not report it to others. *She agreed that resident 1 had acquired a skin tear to her right leg that measured 8.0 X 3.0 x 0.5 cm when staff had transferred her from the wheelchair to her bed. 8. Observation on 9/11/24 at 9:18 a.m. of resident 1's bed revealed. *Her bed was made with the blankets tucked under the mattress. *There was no sheepskin on the bed to cover the bed frame.	F 689		

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F 689	Continued From page 3 *There were end caps on all the square bars. 9. Interview and observation on 9/11/24 at 10:06 a.m. with administrator A revealed: *She said TELS (a building management software system) communication was how staff communicated with maintenance staff if something needed his attention. *She stated nothing had been put in TELS for maintenance staff about resident 1's bed. *She clarified she had taken a picture of the bed with her phone and had sent it to maintenance staff when she was the manager on duty and showed the message to the surveyor. 10. Observation and interview on 9/11/24 at 1:00 p.m. with resident 1 revealed: *She was in the hall in her wheelchair and was heading to her room. She stated, "My bed was fixed, I wish it had been done before I cut my leg on it." *She asked the surveyor to return to her room with her. *The sheepskin was back on the bed, and it was held in place with Velcro. *She said she should have gone to the ER for an evaluation but, "it was in the middle of the night, and I didn't want to go." 11. Observation on 9/11/24 at 2:26 p.m. of resident 1's wound care with licensed practical nurse (LPN) F and CNA D revealed: *CNA D removed the dressing to resident 1's lower outer right leg. *LPN F said Resident 1 had a "skin tear" on her right lower leg. *LPN F cleansed the wound with saline wound cleaner, applied medihoney (a topical medication) with a cotton -tipped applicator, and applied a	F 689		

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F 689	Continued From page 4 Mepilex bandage. -The wound bed was wet with pink outer edges. *LPN F did not measure the wound's size and said that measurements were done weekly on Mondays. 12. Interview on 9/11/24 at 2:46 p.m. with director of nursing (DON) B revealed: *She expected staff would have reported an equipment problem to maintenance staff and or her after a resident acquired a skin tear or injury. *She stated the bed should have been investigated because of the skin tear. *She agreed that equipment problems would have been reported to maintenance staff through TELS communication. *She confirmed the CNA I that had assisted resident 1 with her the transfer when she received the skin tear 8/18/24 was a traveler and no longer worked there.	F 689		

South Dakota Department of Health

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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 9/9/24 through 9/12/24. Avantara Clark City was found in compliance.	S 000		

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Rachel Morehouse, LNHA | Administrator | 10/1/24