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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. BUILDING _____ B. WING _____	C 06/16/2023

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

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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 6/15/23 through 6/16/23. Areas surveyed included resident neglect and physical environment. Avantara Pierre was found not in compliance with the following requirements: F684 and F776.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) physician orders were followed for medical imaging and the physician's involvement with decision making regarding medical imaging. Findings include: 1. Observation and interview on 6/15/23 at 1:15 p.m. with resident 1 in her room revealed: *She was sitting up in her wheelchair with her cellular phone in her lap. *She had invited the surveyor in to the room to visit. *The cellular phone was on speaker phone and she had been talking with her boyfriend. *She had indicated her boyfriend could stay on	F 684	1. All previously cancelled medical imaging and follow-up appointments for resident 1 were rescheduled on 6/1/23 and 6/2/23. All provider ordered medical imaging has been completed as of 6/23/23. Admissions director D was educated upon discovery on 6/16/23 that ordered medical imaging and appointments require a physician's order for cancellation. 2. All residents are at risk for the failure to follow physician orders for medical imaging upon the resident's return from provider visits. Medical records for all current residents residing in the facility will be reviewed for the past 3 months to ensure all scheduled medical imaging has been completed or a physician's order has been obtained for any cancelled medical imaging by July 31. 3. Administrator or designee will educate the interdisciplinary team (IDT), to include admissions director D, and all licensed nurses on the Following Physician Orders policy to ensure physician orders are followed for medical imaging and the physician's involvement with decision making regarding ordered medical imaging. The Director of Nursing (DON) or designee will educate all licensed nurses on the protocol for obtaining the proper paperwork when a resident returns from a medical appointment, as well as timely scheduling of ordered medical imaging.	7/31/23

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

Chase Watson | Interim Administrator | 06/27/2023

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 684	Continued From page 1 the phone and listen during the interview. *She stated her neck was hurting today but she had just taken a pain medication. *She was unable to kick her feet out in front of her. *She had a difficult time moving the cellular phone from her lap to the bedside table next to her. *She had a problem with her neck and thought it was making her weak and unable to move. *She had required staff assistance with most of her activities of daily living. *She had seen a specialist in Sioux Falls about her neck pain a couple of months ago. -He had: --Told her she would possibly need surgery in the future. --Ordered some medical imaging to be completed. --Referred her to another physician in Minnesota. *She had some of the medical imaging done last week and had more coming up in the next couple of weeks. *Her boyfriend had expressed concerns the medical imaging had not been done sooner. *The appointment that had been scheduled with the physician in Minnesota had to be rescheduled because the medical imaging had not been done. Review of resident 1's medical record revealed: *She had been admitted on 3/16/23. *Her diagnoses included: left humerus fracture, congestive heart failure, chronic kidney disease, chronic obstructive pulmonary disease, diabetes, chronic pain syndrome, repeated falls, lumbar rediculopathy (narrowing of the space where the nerve roots exit the spine), difficulty walking, and reduced mobility. *Her 6/12/23 brief interview for mental status	F 684	The education will occur no later than 7/17/23 and those not in attendance of the education session due to vacation, illness, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 residents' medical records to ensure proper paperwork has been received and/or obtained from the medical center when the resident returns from a medical appointment, the physician orders were followed for medical imaging and to ensure there is physician's involvement with decision making regarding medical imaging. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 684	Continued From page 2 score was 15, indicating her cognition was intact. *There had been no documentation in the medical record there had been orders written for medical imaging when she saw the orthopedic physician. Review of resident 1's interdisciplinary progress notes revealed: *She had seen an physician in Sioux Falls on 4/25/23. *Upon return from the appointment in Sioux Falls she did not have any paperwork with her from the appointment. *The night nurse documented the day nurse would be notified and would contact the physicians office in Sioux Falls for information from the appointment. *On 5/1/23 there was a note that had indicated resident had been scheduled to have: *Two Magnetic Resonance Imaging's (MRIs) completed on 5/24/23 at the local hospital. *A dual x-ray absorptiometry (DEXA) scan completed on 5/24/23 at the local clinic. *A MRI and a computerized tomography (CT) scan on 5/26/23. *On 5/31/23: -At 8:45 a.m. a certified nurse practitioner (CNP) had been contacted regarding "resident change in ability to walk and use of extremities upper and lower had diminished in her ability and coordination." The CNP: --Reviewed the orders the orthopedic physician had made for the medical imaging. --Suggested the provider call the orthopedic physician in Sioux Falls, update him on resident's condition, and see if the medical imaging needed to be done sooner. -At 10:56 a.m. a message was left for the orthopedic physician in Sioux Falls regarding	F 684		

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F 684	Continued From page 3	F 684		

residents change in condition. The note also indicated the medical imaging was scheduled at the local hospital to be done post discharge from the facility on "June 7th or 8th as an out patient."
*On 6/1/23 at 5:00 p.m. a note indicated:
-A CT scan was scheduled for 6/9/23.
-MRIs were scheduled for 6/21/23 and 6/23/23.
-A message had been left to schedule the DEXA scan.
-The appointment with the spine specialist in Minnesota that had been scheduled for 6/5/23 would need to be rescheduled after all the medical imaging was completed.
*On 6/2/23: The appointment with the spine specialist had been scheduled for 6/28/23.
*There had been no documentation of why the medical imaging had not been done when scheduled in May 2023.
*There had been no documentation the orthopedic physician had been consulted about waiting to complete the medical imaging until resident 1 was discharged.

Interview on 6/15/23 at 4:46 p.m. with director of nursing (DON) B revealed:
*She had been unaware of the orthopedic physician in Sioux Falls had ordered medical imaging until she had contacted the CNP on 5/31/23.
*On 5/31/23 the CNP had faxed her the note from the specialist in Sioux Falls that had contained the orders for the medical imaging.
*She then scheduled the medical imaging as it was ordered.

Review of resident 1's 4/25/23 orthopedics visit note provided by DON B on 6/15/23 at 4:20 p.m. revealed:
*She was being referred to Twin Cities Spine.

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F 684	Continued From page 4 *Orders for Dexa scan of hip, pelvis, spine, and MRIs of cervical spine, thoracic spine, and lumbar spine. Interview on 6/16/23 at 10:30 a.m. with admissions director D regarding resident 1's medical imaging appointments revealed: *She had been aware resident 1 had appointments scheduled in May 2023 for medical imaging that had been ordered from the orthopedic physician in Sioux Falls. *They had been discussed at a morning meeting between the staff about whether the medical imaging was necessary or if it could wait until resident 1 had been discharged. *It had been decided the medical imaging could wait and DON B had told a nurse to cancel resident 1's appointments. *She had not known if the physician was contacted regarding the medical imaging being canceled. Interview on 6/16/23 at 11:30 a.m. with physical therapist E regarding resident 1 revealed: *She had been aware the medical imaging appointments scheduled in May 2023 had been canceled and rescheduled for when resident should have been discharged. *When resident 1 showed a decline in physical condition the medical imaging had been rescheduled. *She was not aware if resident 1's physician had been involved in decision making regarding the medical imaging appointments being canceled in May 2023. Interview on 6/16/23 at 11:40 a.m. with interim administrator A, DON B, and regional nurse consultant C regarding resident 1 revealed:	F 684		

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F 684	Continued From page 5 *DON B was aware resident 1 had medical imaging appointments scheduled in May 2023. *She had not instructed a nurse to cancel resident 1's appointments. *They had started an internal investigation to determine why resident 1's appointments were canceled. *They had interviewed the nurse who had canceled the medical imaging appointments and she indicated admissions director D had told her to cancel them. *Agreed the orthopedic physician should have been consulted about the timing of the medical imaging appointments. Interview on 6/16/23 at 12:21 p.m. with licensed practical nurse (LPN) F regarding following physician orders and how medical imaging appointments for residents were scheduled revealed: *If a resident returned from a medical appointment without the proper paperwork the nurse would contact the medical office and request the proper paperwork be faxed to the facility. *When new orders for medical imaging were received for a resident, the nurse would call and schedule those appointments for the resident. Interview on 6/16/23 at 12:49 p.m. with DON B regarding process for resident medical appointments revealed: *When a resident returned from a medical appointment without the proper paperwork, she expected the nurse to call the medical office and request the paperwork be faxed to the facility. *When a resident returned with new medical imaging orders from a medical appointment she expected the nurse to schedule appointments	F 684		

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F 684	Continued From page 6 and follow through with those orders. *The provider did not have a policy regarding process for scheduling medical imaging. Review of the provider's May 2021 Following Physician Orders policy revealed: *It had not addressed following up if paperwork had not been received when a resident returned from a medical appointment without the proper paperwork. *It had not addressed medical imaging orders.	F 684		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure one of one sampled resident (1) had physician orders followed timely for medical imaging. Finding include:	F 776	1. All previously cancelled medical imaging and follow-up appointments for resident 1 were rescheduled on 6/1/23 and 6/2/23. All provider ordered medical imaging has been completed as of 6/23/23. Admissions director D was educated upon discovery on 6/16/23 that ordered medical imaging and appointments require a physician's order for cancellation. 2. All residents are at risk for the failure to follow physician orders for medical imaging upon the resident's return from provider visits. Medical records for all current residents residing in the facility will be reviewed for the past 3 months to ensure all scheduled medical imaging has been completed or a physician's order has been obtained for any cancelled medical imaging by July 31. 3. Administrator or designee will educate the IDT, to include admissions director D, and all licensed nurses on the Following Physician Orders policy to ensure physician orders are followed for medical imaging and the physician's involvement with decision making regarding ordered medical imaging.	7/31/23

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F 776	Continued From page 7 1. Interview on 6/15/23 at 1:15 p.m. with resident 1 revealed: *She had seen an orthopedic physician in Sioux Falls a couple of months ago. *The orthopedic physician had orders some medical imaging tests to be completed. *She had a couple of the medical imaging tests done the prior week and had more coming up in the near future. *She did not know why it had taken so long to get the medical imaging done. Review of resident 1's medical record revealed: *She had seen an orthopedic physician in Sioux Falls on 4/25/23 with orders for medical imaging to be completed. *A nurses note indicated medical imaging appointments had been scheduled in May 2023. *No documention those medical imaging appointments had been canceled. *No documentation of consultation with the residents medical physician or the orthopedic physician regarding timing of the medical imaging appointments. Refer to F684. Review of resident 1's 4/25/23 orthopedics visit note provided by DON B on 6/15/23 at 4:20 p.m. revealed orders for medical imaging to be completed. Interview on 6/16/23 at 11:40 a.m. with interim administrator A, DON B, and regional nurse consultant C regarding resident 1 revealed: *DON B was aware resident 1 had medical imaging appointments scheduled in May 2023. *They had started an internal investigation to see why resident 1's appointments were canceled.	F 776	The DON or designee will educate all licensed nurses on the protocol for obtaining the proper paperwork when a resident returns from a medical appointment, as well as timely scheduling of ordered medical imaging. The education will occur no later than 7/17/23 and those not in attendance of the education session due to vacation, illness, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 residents' medical records to ensure proper paperwork has been received and/or obtained from the medical center when a resident returns from a medical appointment, the physician orders were followed for medical imaging and to ensure there is physician's involvement with decision making regarding medical imaging. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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