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 11/09/2023

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

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F 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/31/23 through 11/2/23 and from 11/6/23 through 11/9/23. Avantara Norton was found not in compliance with the following requirements: F561, F565, F623, F625, F656, F657, F658, F686, F689, F692, F725, F726, F756, F758, F802, F809, F835, F837, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/31/23 through 11/2/23 and 11/6/23 through 11/9/23. The areas surveyed were quality of care and treatment, cleanliness of the physical environment, and accident hazards with mechanical lifts. Avantara Norton was found not in compliance with the following requirements: F657, F689, and F726. On 10/31/23 at 7:03 p.m., immediate jeopardy was identified related to assessment for use of mechanical lifts and body slings at F689. On 11/1/23: *At 3:03 p.m. administrator A provided their plan for the removal. *At 3:50 p.m. the provider's removal plan was accepted by the survey team. On 11/2/23 at 12:30 p.m. the survey team determined the immediacy was removed. On 11/7/23 at 2:02 p.m., immediate jeopardy was identified related to elopement risk at F689. On 11/7/23: *At 4:11 p.m. administrator A provided their plan for the removal.	F 000		

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

Ashley Nickel | LNHA | 12/01/2023

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 000	Continued From page 1 *At 4:35 p.m. the provider's removal plan was accepted by the survey team. On 11/8/23 at 3:30 p.m. the survey team determined the immediacy was removed. The resident census was 95.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this deficiency are: 5 Whys 1. Missing residents that have visual deficits, language barriers, or unable to read menu. 2. Increase of room trays 3. Condiments not readily available for room tray service 4. Serving rooms trays out of center dining room versus out of each dining rooms. 5. Lack of follow up on Grievances and Resident council grievances. 1.The following corrections have been made to affected residents: Resident 12 is being read the menu and asked if he would like substitutions; Resident 72 discharged 11/8/23; Resident 253 has been discharged home on 11/17/23;	12/07/2023

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F 561	Continued From page 2 by: Based on interview, observation, resident grievance review, resident council minutes review, kitchen crew meeting minutes review, manager on duty checklist review, and policy review, the provider failed to support residents' choices for 22 of 53 sampled residents (5, 7, 11, 12, 19, 23, 28, 36, 38, 46, 53, 58, 62, 67, 71, 72, 73, 74, 81, 253, and two residents who had discharged prior to the survey) regarding menu options, condiments, beverages, and timely delivery of meal trays to residents who chose to eat in their rooms. Findings include: 1. Interview on 10/31/23 at 5:14 p.m. with resident 12 revealed: *He was unable to choose from the alternate menu. *The daily menu for lunch and dinner was listed in The Daily Chronicle, a newsletter the activities department supplied to the residents daily. *To order off the alternate menu, your choice for the lunch menu had to be given to the dietary personnel by 10:00 a.m. and by 3:00 p.m. for the dinner menu. *He was blind, so if no one read the menu to him, he was unable to choose an alternate. *The menus had previously been given out in advance. He was not sure how long ago that had been. Interview on 11/1/23 at 9:30 a.m. with activity coordinator C revealed: *The Daily Chronicle was passed out daily to all the residents. *There were copies by each nurses station. *The daily lunch and dinner menus were listed in the newsletter.	F 561	Resident 11 has been interviewed regarding his dietary preferences and is receiving condiments; Resident 5 is receiving her dietary choices and condiments; Resident 53 is being offered snacks; Resident 36 is deceased; Resident 74 is receiving meal trays. All residents are at risk for not being able to choose meal and receive condiments, receive meals timely and be offered snacks, and have their grievances not resolved timely or to their satisfaction. 2.The Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Resident choice and mitigating resident grievances. The grievance policy and dining room services policy was reviewed. All residents will be asked on menu preferences daily for the next day's menu. Condiments will be placed on tray carts for room trays. Room trays will be served out of each respective dining room. If resident is unavailable room tray will be held until resident is available. MOD schedule modified and implemented to cover into the evening hours to ensure HS snacks are passed. All residents who filed grievances in last 30 days will be interviewed to see if their grievance resolution was satisfactory. The DON will provide education on the following: resident rights and the resident's right to make choices; grievance policy and procedure; new process provided to nursing and dietary staff for asking meal	

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F 561	Continued From page 3 *Residents who were unable to read or were unable to understand had the menu read to them from the newsletter. *She did not keep a list of which residents required assistance to read the menu and chose an alternate if they wanted. 2. Observation and interview on 10/31/23 at 11:36 a.m. with resident 72 revealed: *She was eating soup in her room. *She said the soup had a "good temp, just could use some salt." *Licensed practical nurse (LPN)/unit manager M was in hallway outside of resident 72's room getting ready to serve a room tray to anther resident. When asked if resident 72 had requested or been offered salt, she replied that resident 72 "didn't [did not} ask [for salt] "because no one had been here" when her meal tray was delivered. Observation and interview on 10/31/23 at 11:38 a.m. with LPN/unit manager M revealed: *As she was putting on personal protective equipment to enter resident 253's room with his room tray, she confirmed there were no condiments or seasonings on his tray to go along with the meal. *She reported "many residents have some in their rooms." 3. Interview on 11/2/23 at 3:42 p.m. with resident 11 revealed he: *Had multiple complaints about the quality of the food delivered to his room including "over easy eggs have come to my room black," cheeseburgers were red in the middle, "they added water to the tomato soup instead of milk," and grilled cheese sandwiches were burnt.	F 561	preferences, condiments will be placed on tray carts for room trays, room trays to be served out each respective dining room, trays not delivered when resident is not available. Managers educated on new MOD expectations. Education will occur no later than December 7, 2023 and those staff not present for education sessions will be educated prior to their first shift worked 3.The Administrator or Designee will audit the following: Residents are receiving meals timely, residents are asked about menu choices, residents are receiving condiments, and resident is offered snacks. Audits will be 5 random residents each week x4 weeks and then monthly x 2 months. Additionally, the Administrator and/or Temporary Manager will audit all grievances submitted each week to ensure resolution is completed timely and the resident is satisfied with the resolution. This audit will be weekly x4 weeks and then monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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F 561	Continued From page 4 *Wrote down on the alternate menu request sheet the condiments he wanted with his meals, but they still had not come with the meals. *Had "told the aides [certified nursing assistants} about those concerns. *Never knew how to get ahold of anyone from the kitchen. *Talked with the dietary manager "just yesterday to quit sending out salads." 4. Review of Grievance and Satisfaction Forms for six months revealed the individual resident grievances related to meals and snacks as follows: *On 5/4/23, a resident who was discharged at the time of the survey reported she "waited an hour for her lunch tray which never came. She then asked for a PB&J [peanut butter and jelly sandwich] and asked for it again an hour later. At that time she was told she could have a snack because it was not a meal time." -There was no documentation in the investigation section. -The resolution section noted a PB&J sandwich was obtained for the resident and she was told "the DON [director of nursing] and administrator would follow up." *On 5/25/23, Resident 5 reported "Meals do not come complete. Regularly missing items that are not substituted." "Condiments are rarely sent on tray such as ketchup & [and] syrup. Also drinks are not being sent." "When alternative menu is filled out, alternatives are not sent." -The investigation section reiterated his grievances with more details but did not document any information that would have identified a root cause. -The resolution section noted a plan to meet with resident 5 "once a week to follow-up."	F 561		

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F 561	Continued From page 5 *On 6/21/23, a resident who was discharged at the time of the survey reported she "only had 6-7 [six to seven] hot meals since she has been here" and "does not get condiments & sometimes does not get desserts." -The investigation section noted, "Resident is on Heart Healthy diet. Educating resident on Diet" and "Serving out of east dining room. Educate/encourage resident to come out for meals." -The resolution section noted, "Informed resident issues would be addressed with each department. Resident educated." *On 6/21/23, resident 53 reported "snack pass cart is out...have asked about it and the [they] ignore him about it. happened 6/20 night. was on the phone ignoring him. third time this has happened." -There was no documentation in the investigation section. -The resolution section noted, "education and audits being completed to ensure snacks are being passed." *On 8/13/23, resident 36 who was discharged at the time of the survey, reported he was "angry that breakfast was over hour late, upset chicken was ground up like baby food." -The investigation section noted, "When upset resident focuses on dietary." -The resolution was noted as "educated staff on reading tickets appropriately." *On 8/18/23 at 9:20 a.m., resident 74 reported, "8 pm [p.m.] asked where supper was. Staff said they didn't [did not] know. 10 minutes later staff brought yogurt and said that was their supper. Currently [resident] does not have breakfast yet either." -The investigation section noted "reviewed cameras didn't get supper tray w/other room	F 561		

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F 561	Continued From page 6 trays. Did receive tray after identifying that supper was missed...Requested audit of tray tickets be completed to make sure all tickets are available for staff to prevent form occurring again." -The breakfast grievance was not addressed in the investigation section. -The resolution section noted, "Residents were given supper after identified they hadn't received." 5. Interview with on 11/6/23 at 10:10 a.m. during a resident group interview with sixteen residents (5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who attended resident council meetings revealed there was consensus on the following concerns: *You had to read "The Daily Chronicle" yourself to know what was being served for each meal. *If you wanted an alternate, you would have to turn in the request sheet by 10:00 a.m. for the noon meal or 3:00 p.m. for the evening meal. *Food options on the alternate request sheet were not always available. *They were tired of having to request the same alternate food options, but they had to because the food for planned meals were either undercooked or overcooked. *Room trays with meal items were not delivered timely to the resident rooms. *Some residents had gone without a breakfast or evening meal when they chose to eat in their rooms. *Staff did not take the time to offer condiments or help residents with setting up the meal trays when it was served in the residents' rooms. *Preferred beverages were not always served at the same time as the meal tray. *Snack carts were delivered to the nurses'stations, but snacks were not distributed. Residents would have to go to the cart to get a	F 561		

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F 561	Continued From page 7	F 561		

snack.

Review of the handwritten Resident Council Minutes for six months revealed concerns regarding meals and snacks had been reported on 6/14/23, 7/12/23, 9/13/23, and 10/11/23. (Refer to F 565.)

Review of minutes for Kitchen Crew Meetings [a meeting for residents to discuss concerns related to the dietary department] revealed concerns were reported as follows:
*On 8/29/23: temperature of food not right related to supper's slow delivery process, and condiments were missing on the trays.
*In September: still not getting condiments.
*In October: food not hot enough.

Interview on 11/7/23 at 9:37 a.m. with social service designee Q revealed:
*Resident council or individual resident concerns were reported during stand-up meetings and then passed off to the applicable department manager for investigation and correction.
*She confirmed the residents would be "a little frustrated that they don't know what changes have been made."

6. Observation and interview on 11/6/23 of the supper meal service between 6:00 p.m. and 6:30 p.m. revealed:
*Cook CC started dishing plates in the Center kitchen for the meal room trays at 6:00 p.m.
*Dietary Manager (DM) N said, "This is the normal time for room trays."
*At 6:05 p.m., one wheeled cart of room trays was taken out of the kitchen to the Center unit resident rooms.
*At 6:19 p.m., the first cart of room trays was

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F 561	Continued From page 8 taken of the kitchen out to the East unit resident rooms. *At 6:22 p.m., room trays were observed being served to resident rooms on the East unit. *At 6:28 p.m., another cart with room trays for resident rooms arrived on the East unit. DM N reported there was "one more [cart] to come" to the East unit. Interview on 11/8/23 at 9:01 a.m. with dietary manager N revealed: *When questioned about residents' concerns regarding timeliness of room meal tray delivery, she explained the operational process for serving three dining rooms and then room trays. -She confirmed the posted mealtimes were correct: breakfast started at 7:15 a.m., lunch started at 11:15 a.m., supper started at 5:15 p.m. -The dining rooms were served consistently in the order of Warren, Center, and then East. -The delivery of the room trays always followed after serving the dining rooms. -The order of room tray delivery was rotated so that one unit was not always the last one to receive room trays. *When residents voiced concerns, she educated them on the process and encouraged them to come to the dining room. *There was a manager on duty during each meal to ensure room trays were delivered to the rooms timely. *She did not know if the concerns about timeliness of meal delivery were related to the timing of the carts with room trays getting to the units or the room trays getting to the resident rooms. 7. Interview on 11/9/23 at 10:40 a.m. with administrator A and review of "Weekend MOD	F 561		

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F 561	Continued From page 9 [manager on duty] Checklist," MOD schedule, and November 2023 "On Call" nurse schedule revealed (refer to F 726): *The MOD was expected to have been in the building for three to four hours on the weekend, and should include being present for at least one meal. *The on-call nurse was scheduled to be the "evening manager" on weekdays in the building through the evening shift change and available every weekend. *The MOD checklist listed "general duties" to be addressed included: -Any customer complaints -Meals served timely (7:15 a.m., and 11:15 a.m., and 5:15 p.m.) -Snack pass (2:00 p.m., 8:00 p.m.) Review of the provider policy, "Dining Room Service," copyright 2018, Crandall Corporate Dietitians, revealed: *"Policy: Residents should be encouraged to receive dining room service whenever possible, be served with dignity and promptly assisted." *"Procedure:" -"1. Restaurant style service is encouraged." - "2. Resident trays or meals are distributed by nursing or dietary or other designated staff. Order of service should be rotated." -"7. Hotel style room service should be the goal for room trays. Room trays should be served in approximately 20 minutes or in a prompt manner in order to assure palatability."	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility.	F 565	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this	12/07/2023

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F 565	Continued From page 10 (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview, observation, review of resident council minutes, a resident council department response form, and policy review, the provider failed to promptly act upon grievances and provide a response for sixteen residents (5,	F 565	deficiency are: 5 Whys 1. Resident council format simplistic and did not address all areas that residents would like. 2. Grievances were not investigated thoroughly. 3. Lack of verification of resident satisfactory resolution. 4. Failure to see if resolution was sustained long-term 5. Resident perception of time varies. 1.The following corrections have been made: Residents 5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81 have all been interviewed to see if any of their previous grievances still persist and a plan to correct. A new resident council minutes format was developed to optimize resident council meeting times and cover more areas. Residents will be educated on the new format and grievance process on 11/29/2023. All residents will be asked on menu preferences daily for the next day's menu. Condiments will be placed on tray carts for room trays. Room trays will be served out of each respective dining room. If resident is unavailable room tray will be held until resident is available. MOD schedule modified and implemented to oversee evening hours to ensure HS snacks are offered and call lights are answered to efficiently to meet resident needs. Reviewed and revised Dining room services policy.	

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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 565	Continued From page 11 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who reported ongoing grievances regarding meal and snack service and response to call lights. Findings include: 1. Interview on 11/6/23 at 10:10 a.m. during a resident group interview with sixteen residents (5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who attended resident council meetings revealed there was consensus on the following concerns: *When asked if the nursing home acts promptly on grievances and provides a response to concerns that had been voiced by residents, the residents stated, -"If it suits the nursing home, sometimes there will be an explanation." -"A lot of times we just hear they are going to fix it. -They [staff] say, "We're working on it." -Staff "have bad attitudes," which was described as "employees talk about things that are not happening right," the "big bosses are never out of their offices when you [surveyors] are gone," and staff actions "will go back to the way they were doing it after you [surveyors] leave. *When asked if the residents received the help and care they needed without waiting a long time, the residents stated (Refer to F 725): -"Call light buttons are not being answered." -"It can be 3-4 [three to four] hours at night." -"The staff stick their hand through the doorway and turn off the call light and walk away." *When asked about receiving snacks at bedtime or when requested, the response was "No." (Refer to F 809.) *When asked if they felt the rights of the residents were respected and encouraged, the response	F 565	2. The Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Resident choice and mitigating resident grievances. The grievance policy, dining room services policy and resident council policy was reviewed and a new resident council format was developed. All staff will be educated by the DON or designee no later than December 7, 2023 on grievance policy and procedure, timely answering of call lights, bathing schedules, timely meal service and providing condiments. Those staff not present for education sessions will be educated prior to their first shift worked. 3. The Administrator and/or temporary manager will audit the following: Resident council minutes are completed, and any concerns are followed up on timely. This audit will be after each resident council meeting/monthly x 4 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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	435039	A. BUILDING _____ B. WING _____	C 11/09/2023

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was "No." Examples provided by the residents included:
-Not being able to choose and receive alternate food items, preferred beverages, timely snacks, and timely meal trays and snacks when choosing the eat in the resident's room (Refer to F 561, finding 5).
-Not getting a bath or shower when requested, and having to take a bath or shower when staff "offer to do it" or it would be "marked as a refusal."
-Not getting enough opportunities to do restorative exercises.
-Tired of being asked every shift if the resident had a bowel movement during the day when they [the staff] should know because they had to help the resident use the toilet.

Observation and interview on 11/6/23 between 6:00 p.m. and 6:30 p.m. revealed:
*Cook CC started dishing plates in the Center kitchen for the meal room trays at 6:00 p.m.
*Dietary manager (DM) N said, "This is the normal time for room trays."
*At 6:28 p.m., another cart with room trays for resident rooms arrived on East. DM N reported there was "one more [cart] to come" to East.

Review of the handwritten Resident Council Minutes for six months revealed concerns had been reported as follows:
*On 6/14/23:
-Call lights: "Staff will shut off light and not come. Sometimes not getting them [bathes]."
-Food: "Not getting what is listed. Undercooked sometimes. Not tasty. Cold.
-Nursing: "sometimes nurses dont [do not] help if CNA not around."
-Snacks: "Feels staff ignor [ignore] snacks - not

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F 565	Continued From page 13 getting." -Therapy: "would like one more restorative. Walking programs - sometimes not happening." *On 7/12/23: -Call lights: "Still shutting call light off and not answering, staff visiting at station instead of answering call lights." and -Food: "Fried chicken [served] undercooked. Feels like seeing more fish." -Nursing: "some [staff] good, some not so good - set at desk, grumpy." -Snacks: "Some [residents] state [they are] getting (East) [snacks], some [residents] state [they are] not getting." *On 8/9/23: -Call lights: Under "Resolved" column - "better, but still some'" -Food: "Chicken slimy, still feels like to [too] much fish." -Nursing: "would like to walk outside of therapy - restorative." -Snacks: Under "Resolved" column - "Yes" *On 9/13/23: -Activities: "like to go outside more before it turns too cold." -Call lights: "Same concerns - too long. Shutting light off and not returning" -Food: "New concerns: Condiments - do not get - East/T-wing" and "Center. Temp getting better, still not warm enough sometimes." -Nursing: "some say they [staff] are going to do something - didn't come back." *On 10/11/23: -Activities: "snacks [-] if activity coordinator C not here dont [do not] always get done." -Call lights: "Still issue [,] turn off and waiting long times over an hr [hour]. Residents are missing activities cause of it." -Food: "Run out of condiments. Still too much	F 565		

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F 565	Continued From page 14 fish. Pork chops overcooked. Veggies mushy." -Kitchen: "Late w/meals [with meals] - room trays, food overcooked, cold food sometimes, nurses aides not willing to warm up food." -Nursing: "Nurses & [and] aides [CNAs] still issues with saying come back and dont [do not]. "Snacks at night late. Issues with water pass during day." Review of a Resident Council Department Response Form regarding the concerns reported during the Resident Council meeting on 6/14/23 noted above revealed: *The "form was distributed to Department Head" on 6/19/23. *The department response included: -DM N will "be staying later on days to watch." -"Some menu items will be changing." -"We will start serving warren out of warren center out of center & east out of east." *The form was signed by DM N and Administrator (ADM) A on 6/20/23. *The date for "Departmental Response Presented to Resident Council" was blank. Interview on 11/7/23 at 9:37 a.m. with social service designee Q revealed: *Resident council or individual resident concerns were reported during stand-up meetings and then passed off to the applicable department manager for investigation and correction. *She had neglected to fill out Resident Council Department Response Form for the concerns from each of the Resident Council meetings except for the food concerns reported on 6/14/23. *Some of the resolutions that had been implemented were reported to the Resident Council and written on the Resident Council Minutes.	F 565		

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F 565	Continued From page 15 *She agreed that the handwritten Resident Council Minutes would be hard for residents to read and understand what was discussed during the meetings and what resolutions had been implemented. *She confirmed the residents would be "a little frustrated that they don't know what changes have been made." Interview on 11/8/23 at 9:01 a.m. with DM N revealed: *A couple of months ago they started using plate warmers to address concerns related to temperature palatability. *She had educated staff about proper cooking methods to ensure palatable results related to not being undercooked or overcooked. *When questioned about residents' concerns regarding timeliness of room meal tray delivery, she explained the operational process for serving three dining rooms and then the room trays. *She confirmed the posted meal times were correct: breakfast started at 7:15 a.m., lunch started at 11:15 a.m., supper started at 5:15 p.m. *The dining rooms were served consistently in the order of the Warren unit, the Center unit, and then the East unit. *The delivery of the room trays always followed after serving the dining rooms. *The order of room tray delivery was rotated so that one unit was not always the last one to receive room trays. *When residents voiced concerns, she educated them on the process and encouraged them to come to the dining room. *There was a manager on duty during each meal to ensure room trays were delivered to the residents' rooms timely. *She did not know if the concerns about	F 565		

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timeliness of meal delivery were related to the timing of the carts with room trays getting to the units or the room trays getting to the the residents' rooms.

Review of the provider policy, "Grievances," revised on 1/5/21 revealed:
*"POLICY: It is the policy of this facility to investigate all grievances."
*"PROCEDURE:"
-"The facility Administrator or Administrator Designee, referred to as the grievance official, has been designated to receive all grievances."
-"Any resident or representative or member of the resident's family or the resident council may present a grievance to the grievance official orally or in writing giving rise to the grievance."
-""The grievance official shall confer with persons involved in the incident and other relevant persons and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal representative, if any."
-"All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident concerns, a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance, and the date the written decision was issued."
*"PROCESS:"
-"Staff Member: Assist residents, family members or others who wish to voice a comment of grievances or satisfaction with locating the form

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and completing it."
-"Charge Nurse and Management Team Members: Attempt to gather as much information surrounding the grievance as you can, addressing anything you are able to...complete the areas on the form you can and submit it to the grievance official for further follow up."
-"Grievance Official:"
--"All Grievance and Satisfaction Forms will come to the stand-up meetings and are reviewed by the grievance official to determine what actions need to be taken and who will follow up on the Grievance."
--"The grievance official should actively participate in the investigation and resolution but may delegate portions of the tasks to the appropriate individuals."
*"RECOGNIZE: Recognizing a concern as a grievance early in the process is crucial to an effective and successful resolution."
*"Examine (investigate): Establish and investigate the Facts:"
-"The first objective is to determine who was involved, what happened and the circumstances surrounding the issues."
-"Next, determine the root cause of the issue based upon the information you have received. It is important to note that failure to accurately determine the room cause will inevitably affect satisfactory resolution of the grievance."
-"Based upon the facts determine if your investigation needs to be expanded to identify any other potential 'like' residents."
-"Decide what course of action will be taken to produce resolution to the grievance that will satisfy the customer. Discuss your findings and plan with the customer."
*"Action: The way in which the facility carries out the plan of action can have a significant impact

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F 565	Continued From page 18 on coming to a satisfactory conclusion for the customer. Clear communication between the customer and all involved facility staff is essential. Everyone needs to have a clear understanding of their role in resolving the grievance as well as what steps will be taken to minimize the chance of recurrence."	F 565		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;	F 623	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this deficiency are: 5 whys 1. Lack of education on process for notification 2. No process owner 3. Lack of accountability 4. Change over social services staff 5. No mechanism for oversight 1.Residents 6, 9, 24 – the ombudsman has been notified of their past discharge to hospital. Resident 91 is deceased. Social services Designee identified as process owner. Social Service Designee, Administrator and Ombudsman developed process to implement and maintain notification of resident transfer and discharge. All residents are at risk for not having the ombudsman notified of transfer or discharge. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any	12/07/2023

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F 623	Continued From page 19 (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and	F 623	consulting agencies utilized to review, revise, create as necessary policies and procedures that support Adequate notification to ombudsman of resident transfer. The Administrator has educated the Social Services Designee on the requirements for ombudsman notification. The facility implemented tracking log for transfers and discharges to hospital including date of notification of ombudsman. 3. The Administrator and/or Temporary manager will audit the following: All transfers and discharges will be reviewed each week to ensure they are logged for ombudsman notification. Audits will be weekly for 4 weeks and then monthly for 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 623	Continued From page 20 (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to notify the Ombudsman regarding transfers initiated by the provider for four of four sampled residents (6, 9, 24, and 91). Findings include: 1. Review of the electronic medical record (EMR) for resident 24 revealed a "Late Entry" "Incident Note" dated 10/23/23 at 4:45 p.m., created on 10/24/23 at 7:40 p.m. that documented: *The nurse was called to the room by two	F 623		

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F 623	Continued From page 21 certified nursing assistants (CNA) and observed the "resident laying on the ground with the hoyer [Hoyer] sling beneath her." *The nurse asked the CNAs about the transfer and they "stated the hoyer machine was tilting because the resident was leaning more to one side than the other on the hoyer sling." -No injuries were observed and no pain was reported at that time. Review of the facility investigation of the incident, completed on 10/27/23, revealed: *Resident 24 complained of pain in her left leg and head when she was laid down after dinner. *The provider was made aware of the symptoms as a result of the incident and sent orders to transfer her to the emergency room department. *Resident 24 was transferred on 10/23/23 at "approximately 10:00 p.m." and was admitted to the hospital with a fractured hip. Further review of the EMR revealed there was no notification to the Ombudsman that resident 24 had been sent and subsequently admitted to the hospital. 2. Review of resident 6's EMR revealed she: *Was hospitalized for shortness of breath on 7/19/23 and then readmitted to the facility on 7/27/23. *There was another hospitalization for shortness of breath and knee pain on 8/1/23 with a readmission to the facility on 8/4/23. 3. Review of resident 9's EMR revealed she: *Was hospitalized for low sodium on 10/18/23 and then readmitted to the facility on 10/19/23. 4. Review of resident 91's EMR revealed he: *Had been hospitalized on 8/8/23 and then	F 623		

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F 623	Continued From page 22 readmitted to the facility on 8/11/23. *Had fallen on 9/2/23 and was sent to the emergency room. -Sustained a right leg tibia and fibula fracture from the fall. *Had been readmitted to the facility on 9/8/23. 5. Interview on 11/8/23 at 10:30 a.m. with administrator A regarding notification to the Ombudsman when a resident had transferred to the hospital revealed: *She explained that they had discussed that after the last survey and social services would have been in charge of that task. *She was not aware if social services had been notifying the Ombudsman when a resident transferred to the hospital. 6. Interview on 11/8/23 at 11:09 a.m. with social services designee (SSD) Q regarding notifying the Ombudsman when a resident had been transferred to the hospital revealed: *She had not been notifying the Ombudsman if a resident had been transferred to the hospital. *She would have notified the Ombudsman if a resident had left the facility against medical advice or if the resident had been discharged from the facility. Review of the provider's February 2023 Discharge and Transfer of Residents/Bed Hold policy revealed: *It had not mentioned notification to the Ombudsman with transfers.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on	12/07/2023

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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 625	Continued From page 23 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to notify the resident or representative regarding the provider's bed-hold policy at the time of transfer for four of four sampled residents (6, 9, 24 and 91). Findings include: 1. Review of the electronic medical record (EMR) for resident 24 revealed a "Late Entry" "Incident Note" dated 10/23/23 at 4:45 p.m., created on	F 625	11/30/23. The "5 Whys " related to this deficiency are: 5 Whys 1. Lack of education on bed hold policy. 2. Lack of accountability 3. No mechanism for oversight 4. Agency staff utilization 5. Misunderstanding of responsibility 1. Residents 6, 9, and 24 have returned to the facility, therefore bed hold notice does not need to be issued for previous hospitalizations. Resident 91 is deceased. All residents who transfer or go on therapeutic leave are at risk for not receiving proper notice of bed hold policy. Residents who transfer or go on therapeutic leave are notified of bed hold. 2.Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support notification of bed hold. The DON or designee will provide education to all nurses, business office manager, and social services designee on Bed hold policy and procedure. The facility Implemented the Charge nurse to offer bed hold before/upon transfer out of facility. Charge nurse to document offer of bed hold in progress note. BOM or designee to follow up on next business to complete bed hold form with resident or designee. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked.	

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	435039	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 625	Continued From page 24 10/24/23 at 7:40 p.m. that documented: *The nurse was called to the room by two certified nursing assistants (CNA) and observed the "resident laying on the ground with the hoyer sling beneath her." *The nurse asked the CNAs about the transfer and they "stated the hoyer [Hoyer] machine was tilting because the resident was leaning more to one side than the other on the hoyer sling." -No injuries were observed and no pain was reported at that time. Review of the facility investigation of the incident, completed on 10/27/23, revealed: *Resident 24 complained of pain in her left leg and head when she was laid down after dinner. *The provider was made aware of the symptoms as a result of the incident and sent orders to transfer her to the emergency room department. *Resident 24 was transferred on 10/23/23 at "approximately 10:00 p.m." and was admitted to the hospital with a fractured hip. Further review of the EMR did not reveal notification to the resident's representative about the provider's bed-hold policy. Interview on 11/8/23 at 2:12 p.m. with licensed practical nurse/unit manager (LPN/UM) Y regarding the bed-hold notification process revealed: *We usually tell the business office manager (BOM) H when a resident was transferred to the hospital. *The bed-hold notice was "not in the transfer packet." *She did not know if it was listed on the checklist that staff would use when completing a transfer.	F 625	3. The Administrator or temporary manager will audit the following: All hospital transfers or therapeutic leaves will be reviewed each week to ensure they have been informed of the bed hold policy. Audits will be weekly for 4 weeks and then monthly for 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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F 625	Continued From page 25 Interview on 11/9/23 at 1:30 p.m. with director of nursing (DON) B and regional nurse consultant (RNC) HH revealed: *The nurse on duty at the time of the transfer "was supposed to talk with the resident or family about bed hold" but it was not documented. 2. Review of resident 6's EMR revealed she: *Was hospitalized for shortness of breath on 7/19/23 and then readmitted to the facility on 7/27/23. *There was another hospitalization for shortness of breath and knee pain on 8/1/23 with a readmission to the facility on 8/4/23. 3. Review of resident 9's EMR revealed she: *Was hospitalized for low sodium on 10/18/23 and then readmitted to the facility on 10/19/23. 4. Review of resident 91's EMR revealed he: *Had been hospitalized on 8/8/23 and then readmitted to the facility on 8/11/23. *Had fallen on 9/2/23 and was sent to the emergency room. -Sustained a right leg tibia and fibula fracture from the fall. *Had been readmitted to the facility on 9/8/23. 5. Interview on 11/6/23 at 11:30 a.m. with licensed practical nurse (LPN) D regarding bed hold notification upon a residents transfer to the hospital revealed: *She thought that social services had contacted the resident representative regarding the bed hold. -She had not reviewed the information with the resident or the resident's representative when a resident was transferred to the hospital.	F 625		

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F 625	Continued From page 26 Interview on 11/6/23 at 11:40 a.m. with social services designee (SSD) Q regarding bed hold notices reviewed upon transfer revealed: *She believed that BOM H would have provided the bed hold notice to the resident or the resident's representative when they are transferred to the hospital. Interview on 11/6/23 at 11:43 a.m. with BOM H regarding bed hold policy revealed: *She would have made a courtesy call to the family or the resident regarding the bed hold policy. *She believed that nursing services would have been in charge of the documentation of the bed holds when a resident left the building. Interview on 11/7/23 at 7:50 a.m. with LPN J regarding bed hold notification upon resident's transfers revealed: *She would have documented in a progress note that the bed hold policy had been discussed with the resident or the representative upon transfer. Interview on 11/7/23 10:18 a.m. with administrator A regarding the requested bed hold notices for residents 6,9 and 91 revealed: *They did not have any documentation that residents 6, 9 and 91 had been given the bed hold notices upon their transfer to the hospital. Interview on 11/8/23 at 8:08 a.m. with director of nursing (DON) B regarding bed hold notices given when the residents leave the facility revealed: *He knew that the business office manager would contact the family regarding the bed hold notice. *Agreed that nursing staff should have reviewed the bed hold policy with the resident and or	F 625		

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F 625	Continued From page 27 representative and documented it in the nursing progress notes. 6. Review of the provider's February 2023 Discharge and Transfer of Residents/Bed Hold Policy revealed: *"The Notice of Transfer/Discharge form and bed hold policy will be given to the resident or resident representative prior to the discharge or the transfer." *"If the resident is being transferred emergently, the form will be given as soon after the transfer as practicable." *"Transfer to the hospital for emergent care is considered a facility-initiated transfer."	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this deficiency are: 5 Whys 1.Staff turnover 2. Time management 3. Discontinued Weekly care plan review meeting. 4. Not following policies for continued monitoring for residents on dialysis. 5. Agency Utilization 1. Reviewed and revised resident 75's care plan to reflect dialysis management. All residents on dialysis are at risk for not having specialized services on the care plan. All residents on dialysis are at risk and all have had their care plans reviewed.	12/07/2023

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F 656	Continued From page 28 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. 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 (75) who received dialysis comprehensive care plan included information on his dialysis access, type of diet, and parameters for fluctuations in his weight. Findings include: 1. Observation and interview on 11/2/23 at 3:30 p.m. with resident 75 revealed: *He had just returned from his dialysis treatment. *Has been receiving dialysis for about 6 years. *His dialysis treatments were scheduled on	F 656	2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support Individualized care plan that is accurate and relevant for resident(s). The DON or designee will educate nursing staff on dialysis policy and procedure, including post-dialysis care and monitoring, care plan policy and educate CNA's on how to find Kardex. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked. 3. The DON or designee will audit 5 random care plans each week to ensure any specialized services required is on the care plan and any required monitoring is in place. Audits will be weekly for 4 weeks and then monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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

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F 656	Continued From page 29 Tuesday, Thursday, and Saturday mornings at [provider name] dialysis. *He had an upper left chest central venous catheter dialysis access. There was an intact gauze dressing over the insertion site. . *He stated the staff here do not take care of the dialysis access area. Interview on 11/6/23 at 10:00 a.m. with licensed practical nurse D revealed: *A communication sheet was sent with resident 75 when he went to dialysis. *When he returned the communication sheet is reviewed for any changes in his condition he might have had during his dialysis treatment. *His dialysis access site was not assessed when he returned from his dialysis treatments . *She was unsure what she would have done if he had any problems with his dialysis access. Interview on 11/8/23 at 10:00 a.m. with registered nurse/Minimum Data Set (MDS) coordinator E revealed: *His care plan did not provide individualized interventions for the following: -Monitoring of his dialysis access site. -What type of diet was ordered. -Why his weight was to have been monitored. -Which dialysis provider he received dialysis from. Review of resident 75's 2/11/22 dialysis care plan revealed his interventions included the following: *Monitor access site for bleeding. -It did not indicate where his access site was or what interventions were to have been initiated if there was bleeding. *Provide diet as ordered. -It did not indicate what type of diet he was to	F 656		

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F 656	Continued From page 30 have received. *Record resident 75's post dialysis weight when he returns from dialysis on Tuesday, Thursday, and Saturday. -There were no parameters set for any extreme weight loss or gain. *It indicated he received dialysis at [name of dialysis center]. -He actually received dialysis through [another name of a dialysis center]. Review of the provider's September 2019 Care Planning policy revealed: *"Interventions act as the means to meet the individuals needs (not to continue outmoded institutional practices)." *"The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. Assessment tools are used to help formulate the interventions (they are not THE intervention)."	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 657	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this deficiency are: 5 Whys 1. Staff turnover 2. Time management 3. Discontinued Weekly care plan review meeting. 4. Not following policies for continued monitoring for residents on dialysis. 5. Agency Utilization	12/07/2023

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F 657	Continued From page 31 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the provider failed to ensure care plans were revised to adequately address relevant needs and ensure accurate information for 8 of 31 sampled residents (1, 9, 10, 24, 64, 77, 87, 244). Findings include: 1. Observations and interviews on 11/2/23 at 9:52 a.m. and on 11/6/23 at 3:12 p.m. with resident 10 revealed he: *Was able to converse but his responses were not always consistent with the questions asked. *Had no complaints. *Was able to move about in his wheelchair. Review of the 10/13/23 quarterly MDS for resident 10 revealed: *His BIMS score was 3, which indicated he had severely impaired cognition. *No mood symptoms were coded. *The only behavior coded was "rejection of care."	F 657	1. Residents 1, 9, 10, 24, 64, 77 and 244's care plans have been reviewed and updated. Resident 87 was transferred to another skilled nursing facility on 11/14/23. All residents are at risk for not having an updated care plan. All care plans reviewed and revised to reflect individualized needs including mechanical lifts, sling type and size, and elopement prevention and intervention as required for individual resident, cultural preferences, diet preferences. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support Individualized care plan that is accurate and relevant for resident(s). The DON or designee will educate nursing staff on the care plan policy and educate CNA's on how to find Kardex. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked. 3. The DON or designee will audit 5 random care plans each week to ensure care plans adequately and accurately address relevant needs. Audits will be weekly for 4 weeks and then monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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F 657	Continued From page 32 Review of "Behavior Notes" between 8/22/22 - 11/1/23 revealed: *Multiple events of resident 10 "exit seeking" (wanting to go outside). *Staff response on most occasions was to redirect him away from the door and offer a snack. *In most instances, that intervention failed to change his desire to go outside, and sometimes created a behavioral reaction to the attempted redirection. *Refer to F 689, finding B1. An "Incident Note" on 4/4/23 in the EMR for resident 10 revealed the resident had exited the building without staff witness. Review of the care plan completed on 10/19/23 for resident 10 revealed the interventions had not been modified to accommodate his desire to go outside: *Focus: "impaired cognitive function/dementia or impaired though processes as evidenced by: BIMS Score less than 13," initiated 7/19/22, revised 8/10/22. -Intervention: "Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion," initiated 7/19/22. *Focus: "at risk for Elopement related to hx [history] of elopements and frequent exit seeking behaviors," initiated 7/14/22, revised 10/17/23. -Intervention: "Wanderguard on WheelChair," initiated 4/4/23, revised 4/10/23. -Intervention: "Moved to room closer to nurses station," initiated 5/15/23. -Intervention: "Lay eyes on [resident 10] where abouts hourly to ensure he is in building, assist	F 657		

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F 657	Continued From page 33	F 657		

him as needed otherwise ok to check you saw him at the time you checked," initiated 7/27/23.

Review of the care plan on 11/9/23 for resident 10 revealed the following changes had been made:
*Focus: "at risk for Elopement,"
-Intervention: "Referrals being sent to facilities for Alzheimer care, put on hold for fair hearing per ombudsman," revised 11/3/23.
-Intervention: "Lay eyes on [resident 10] where abouts hourly..." initiated 7/27/23, was revised on 11/7/23 to "Round on [resident 10] hourly to verify safety."

Interview on 11/6/23 at 4:05 p.m. and on 11/8/23 at 2:06 p.m. with LPN/unit manager Y about resident 10 revealed:
*When he had attempted to go out of the building the staff had intervened, "noticed him or heard the alarm."
*They "moved him closer so he can be monitored more closely."
*She had "not found a pattern" with his attempts to self-transfer and exit seek. It "varies" but is "daily at least."

2. Observation and interview on 11/6/23 at 3:16 p.m. with resident 24 revealed she:
*Was lying in her bariatric bed with the head of the bed raised about 45 degrees.
*Had just returned from being in the hospital for a few days.
*Was being treated for a fractured hip because she "fell out of bed."

Review of the 10/21/23 quarterly Minimum Data Set (MDS) assessment for resident 24 revealed:
*The Brief Interview for Mental Status (BIMS) was scored at 11, which indicated she had moderately

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F 657	Continued From page 34 impaired cognition. Review of care plan on 10/31/23 for resident 24 revealed: *Focus: "ADVANCE DIRECTIVE CODE STATUS (CODE STATUS: Full code, initiated 8/13/21, revised 12/12/22. -Intervention: "As indicated, document FULL CODE status on the Physician's Order Sheet (POS) in the EMR system," Review of the undated TWing rounding sheet revealed for resident 24: DNR [do not resuscitate]. 3. Observation and interview on 10/31/23 at 2:21 p.m. of CNA X and CNA OO who transferred resident 1 from her bed to her wheelchair using the full body lift. A full body sling size large was used. CNA OO was not sure who chose which size or type of sling a resident was to have used. She thought it might be licensed practical nurse (LPN)/unit manager J. They were not sure where to find the sling sizes for the residents. Review of resident 1's 9/19/22 care plan focus area for activities of daily living (ADL) revealed: *A 10/31/23 revised intervention "Transfers: Full body lift for transfers with assist of 2." *There was no information of what type of size of lift sling was to have been used. 4. Observation and interview on 10/31/23 at 3:45 p.m. of resident 77 during a transfer with a full body lift from her wheelchair to her bed. CNAs P and OO assisted with the transfer. A full body sling size large was used. That sling was soiled and a clean sling was brought into the room. Resident 77 stated she was glad the new, clean sling was not a split kind. She stated it hurt and	F 657		

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F 657	Continued From page 35 pinched her inner thighs when it was used. Review of resident 77's revised 10/23/22 care plan focus area for ADLs revealed: *A 10/23/22 intervention"Transfers: Total Dependence of 2 staff with hoyer (full body lift) lift." *There was no information of what type of size of lift sling was to have been used. 5. Observation and interview on 11/2/23 at 12:40 p.m. of resident 244 with CNA/CMA VV and CNA II transferring him in his room with a full-body mechanical lift from his wheelchair to the bed with LPN/Unit Manager M present in the room revealed: *Resident was seated in his wheelchair with a wanderguard fastened to the wheelchair and not on his body. *A blue sling with divided leg was used. *When asked about the sling, LPN/Unit Manager M stated the large sling with divided leg was the correct sling to be used. *After fastening the sling to the lift, CNA/CMA VV stepped away from the resident to operate the lift while CNA II remained with the resident guiding him over the bed as he was lifted and moved to the bed. *Once on the bed, CNA II unfastened the sling from the lift and with CNA II and CNA/CMA VV on opposite sides of the bed, both staff assist the resident to roll side to side to remove the sling from underneath the resident. Review of the Warren Hall rounding sheet revealed: *Resident 244 was one of the fourteen residents listed. *His transfer information stated "Hoyer, sling size Medium split leg".	F 657		

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*No mention was made of his wandering behavior/elopement risk.
*Information on this sheet had been pulled from the resident's care plan.

Review of resident 244's electronic medical record on 11/2/23 revealed:
*His 9/18/23 BIMS score was 0 indicating severe impairment.
*Resident had been assessed on 10/31/23 to use the full-body mechanical lift with a medium sling.

Review of resident 244's care plan on 11/2/23 revealed:
*An intervention for ADLs regarding his transfers that stated "total assist Hoyer and 2 assist, Hoyer sling size medium divide leg."
*An intervention for his wandering behavior and risk for elopement that stated "Wanderguard applied to right ankle."
6. Interview on 11/2/23 at 2:55 p.m. with director of nursing (DON) B revealed:
*On 10/4/23, DON B was approached by nurse practitioner (NP) JJ regarding concerns that the resident was showing signs of intoxication. NP JJ reported to DON B that the resident's eyes were red and glossy, smelled like alcohol, and was acting strange.
*After the above notification of resident's condition, DON B entered the resident's room and found that resident was lethargic, slurring his words, and was unable to keep eyes open.
*The DON noticed an empty bottle of hand sanitizer in the trash can.
*When asked, the resident denied drinking the hand sanitizer.
*The hand sanitizer bottle was a 250 milliliter (ml) bottle of Instant Hand Sanitizer with aloe and vitamin E.

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F 657	Continued From page 37 *Poison control was contacted, and it was recommended that the resident be transferred to the hospital and testing for methanol be completed due to certain hand sanitizers having contamination. *Emergency medical services (EMS) were called and when they arrived to the facility the resident denied drinking the hand sanitizer and stated that he used it to wash his hands. The resident refused to go to the hospital. *The resident's medical provider was notified of the refusal to go to the hospital and physician orders were received to educate and monitor the resident. *DON B educated the resident regarding the recommendations of poison control. The resident again denied drinking the hand sanitizer and stated he had used it to wash his hands and refused to be transported to the hospital. The resident was monitored by nursing staff for the rest of the night with no issues. *DON B stated that all bottled hand sanitizer had been removed from the facility and replaced with sanitizing hand wipes. Observation and interview on 11/8/23 at 10:07 a.m. with RN L revealed: *A bottle of hand sanitizer was sitting at the central nurse's station. *RN L stated that he was aware that resident 87 had ingested hand sanitizer but then stated that residents would not come back behind the nurse's station. Interview on 11/8/23 at 10:30 a.m. with nurse consultant HH and DON B revealed: *The only brand of hand sanitizer that was removed from the facility was the brand that was ingested by the resident (Instant Hand Sanitizer	F 657		

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with aloe and vitamin E). All other liquid hand sanitizer was still available and was being used by staff.
*DON B stated the Instant Hand Sanitizer with aloe and vitamin E was the only hand sanitizer that was removed because poison control stated it might have been contaminated with methanol.
*DON B was not aware if the hand sanitizer discovered on the central nurse's station was contaminated with methanol.
*Informal staff training was completed at each shift change regarding the removal of the hand sanitizer for approximately a couple weeks after resident 87 had ingested the hand sanitizer, but there were no processes in place for ongoing training of new staff or temporary staff.
*Nursing staff were allowed to carry personal bottles of hand sanitizer but there was no facility-specific training or any policy or procedure in place to inform staff of the risk of ingestion by the residents.
*They both agreed that there was still a potential risk for residents to ingest hand sanitizer.

Interview on 11/9/23 at 10:25 a.m. with social services designee Q revealed:
*She was aware of the resident's hand sanitizer ingestion and history of alcohol dependence and had noted that information in her admissions assessment on 10/1/23. This was entered into his care plan.
*Care plan interventions for resident 87 regarding his substance abuse and chemical dependency were updated after the resident's ingestion of hand sanitizer and that was to include social services to meet with resident weekly.
*When asked if any processes were put into place or completed to ensure the resident would not ingest hand sanitizer, she stated that staff

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F 657	Continued From page 39 completed training regarding the removal of the hand sanitizer. *No formal documentation was provided of the above training. Review of resident 87's 10/11/23 care plan that was initiated after the 10/4/2023 hand sanitizer ingestion revealed: *"Focus: -"SUBSTANCE ABUSE/CHEMICAL DEPENDENCY DISORDERS The resident has a history of substance abuse/chemical dependency Attempting to refuse blood or urine testing. On-going self-harmful/self-destructive behavior i.e. ingesting hand sanitizer for alcohol content." *"Interventions: -"Continue to offer Lionel support services through Mental Health Counseling and/or AA, currently declining services." -"Implement increasingly restrictive interventions in an effort to help the resident break addictive cycle. Interventions may include: supervision while in the community, restricted independent pass privileges, implementation of money guidance and budget controls to reduce/prevent access to substances." -"Meet with the IDT to discuss the extent of the resident's illness. The physician may consider a referral to the psychiatrist and/or write an order restricting "pass privileges." -"Social Services or designee to meet with resident weekly." Record review of resident 87's 10/11/23 care plan revealed that there were no interventions developed regarding the removal of hand sanitizer bottles in resident's environment regarding the risk of resident ingesting hand sanitizer.	F 657		

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F 657	Continued From page 40 Review of providers 9/2019 care planning policy revealed: *"Care plans are accessible to all direct-care staff, including the resident's physician/nurse practitioner. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes." *"Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur." 7. Interview on 11/6/23 at 9:03 a.m. with resident 64 revealed: *"For breakfast I received eggs, a slice of bread, and cereal." *"I cannot have pork due to my religion." *"They used to provide turkey sausage or turkey bacon but I have not had any for three months." *"I asked again last week for the turkey sausage or turkey bacon and they said they ordered it." Observation and interview on 11/6/23 at 11:50 a.m. with resident 64 in the dining room revealed: *She had a foil container that contained mutton that she was eating. *My family will bring food for my cultural preferences at least once a week. Interview on 11/6/23 at 3:37 p.m. with dietary manager N revealed: * I was out of turkey bacon and sausage for at least two to three months. *I could have gone to the store to purchase those products as there is no policy against that, I just didn't. Review of resident 64's 1/20/21 care plan revealed: *The only interventions related to her cultural and religious preferences had been listed as	F 657		

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F 657	Continued From page 41 interventions for her fluctuating blood sugars. 8. Observation on 10/31/23 at 11:29 a.m. of certified nursing assistants (CNAs) X and U getting resident 9 out of bed using the full-body lift: *Resident had a blue divided leg sling under her. *CNA X attempted to raise the resident out of the bed and the resident slide out of the sling and onto her bed the straps had been crossed between her legs. *CNA X identified that sling was too large for the resident. *CNA X retrieved a different sling, that one is green colored and full body for the lift. *Staff assisted with rolling the resident from left to right to place the new sling under her. *They hooked the sling to the lift. *Resident 9 was then lifted into her wheel chair. Review of the Blue hall rounding sheet revealed: *Information on this sheet had been pulled from the resident's care plan. *"Transfers: Use the hoyer full body sling." *Had not indicated the size of the sling. *Resident had been assessed on 10/31/23 to use the Hoyer lift with the large divided leg sling. Review of the provider's September 2019 Care Planning policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. " *"Interventions act ass the means to meet the individual's needs. The "recipe: for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, and how the individual resident goals are being	F 657		

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F 657	Continued From page 42 addressed and met." *"Care plans are accessible to all direct-care staff, including the resident's physician/nurse practitioner. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes." *"Care Plans should have been updated between care conferences to reflect current care needs of the individual resident as changes occur. When changes are made in the electronic health record (EHR) care plan dates, time and name/initial are automatically entered."	F 657		
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, record review, and policy review the provider failed to administer medications according to the physician's order for one of two sampled residents (84) during one of one medication pass with one of one certified medication aide (CMA) PP. Findings include: This requirement was NOT MET as evidenced by: 1. Observation on 11/7/23 at 7:50 a.m. with CMA PP administering medication to resident 84 revealed: *CNA PP was going to administer Klor-Con M20 Oral tablet Extended Release (potassium chloride microencapsulated crystals) after checking the medication against the November 2023	F 658	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. QIN offered their education resources on med administration if needed. The "5 Whys "related to this deficiency are: 5 Whys 1. Med Aide not following order as written. 2. Order did not have additional direction on Furosemide to prompt D/C of Klor-Con 3. Consultant pharmacy review failed to identify discrepancy. 4. PCP review failed to identify discrepancy. 5. Lack of education 1. Resident 84's Physician was contacted, and medication was discontinued. All residents are at risk for improper medication administration. The 6 rights of medication of administration are being followed.	12/07/2023

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F 658	Continued From page 43 medication administration record (MAR). *The physician's order on the MAR indicated to administer 20 mEq (milliequivalent) by mouth one time a day for a supplement while on a diuretic (furosemide) for localized edema. *When asked when the resident had taken his furosemide CMA PP stated that the resident's furosemide had been discontinued. *CMA PP consulted with licensed practical nurse (LPN)/unit manager J and CMA PP was instructed to hold the medication and LPN J would consult the resident's physician. Review of resident 84's electronic medical record (EMR) revealed: *A physician's order to discontinue furosemide on 09/5/2023 was noted by LPN QQ. *There were two medication regimen reviews completed by a pharmacist on 9/10/2023 and again on 10/13/23 that reported no irregularities identified. Interview on 11/9/23 at 1:46 p.m. with LPN/Unit Manager J, nurse consultant HH, and director of nursing (DON) B revealed: *The potassium supplement was not discontinued at the time the furosemide was discontinued. The resident continued to receive the potassium supplement after the furosemide had been discontinued. *LPN/Unit manager J stated the directions should have been changed on the MAR. *LPN/Unit manager J had received a physician's order to discontinue the resident's potassium on 11/7/2023. Review of the 11/7/23 physician's order for resident 84 revealed a note, "Potassium level was ok but on the higher end on lab 10/30/23."	F 658	2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support Medication administration following physician order(s). The DON or designee will review 6 rights of medication administration with nurses and med aides and review order entry with nurses. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked Consultant Pharmacist manager will complete Consultant pharmacist education no later than December 7, 2023. 3. The DON or designee will audit 5 random resident medication passes each week to ensure orders are being followed. Audits will be weekly for 4 weeks and then monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 658	Continued From page 44 Discontinue potassium. Review of provider's undated Medication Administration-General Guidelines Policy revealed that medications were to have been administered in accordance with the written orders of the prescriber.	F 658		
F 686 SS=H	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 observation, interview, record review, and policy review, the provider failed to ensure interventions that had been put in place were consistently implemented and documentation was consistent for four of four sampled residents (3, 37, 39, and 193) who developed pressure ulcers after admission to the facility. Findings include: 1. Interview on 10/31/23 at 10:30 a.m. with resident 193's wife revealed she had found a large blister on his right heel the previous night. She was surprised staff had not found it. She had	F 686	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys " related to this deficiency are: 5 Whys 1. Wound Nurse turnover 2. Agency utilization 3. Lack of oversight of system 4. Education gaps 5. Lack of Nurse oversight of CNAs to ensure interventions are in place. 1. Resident 193 was sent to Dermatology for further evaluation on 11/15/23. Dermatologist confirmed that identified areas of concern on his heels was bullous pemphigoid. Residents 37, 39, and 3 have had their interventions reviewed for appropriateness and to ensure they are implemented. All residents with wounds are at risk for not having interventions and wound care plans reviewed to ensure current interventions and orders are accurate and in place.	12/07/2023

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F 686	Continued From page 45 informed the nurse at that time. The nurse had placed a foam dressing over his right heel the morning of 10/31/23. They had given him heel protector boots. He had told her his heels were causing him pain. Observation and interview on 10/31/23 at 10:30 a.m. with resident 193 revealed: *He was seated in his wheelchair. *He had bilateral heel protector boots on. *The back part of his heels on both of his feet rested against the outer edge of the foot pedals. *He stated his heels hurt and liked to keep his feet off of the foot pedals. Observation and interview on 11/2/23 at 9:19 a.m. with licensed practical nurse (LPN)/wound nurse R and registered nurse (RN) L of resident 193's heels after his shower revealed: *A large intact blister on his left heel. *A large opened area with the skin from the blister attached to his right heel. *LPN/wound nurse R would be measuring and placing dressings on his heels after she had clarified the treatment order. *No dressing was applied to his heels at that time. Observation on 11/2/23 at 11:30 a.m. of resident 193 revealed he was seated in his wheelchair. He had slipper socks on both feet. He did not have his heel protector boots on. Review of a 11/2/23 11:10 a.m. progress note by LPN/Wound nurse R revealed: *She had contacted the dermatologist office on 11/1/23 regarding his bullous phemigoid (a rare skin condition that causes large, fluid-filled blisters. They develop on areas of skin that often	F 686	2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support Appropriate skin care assessment and prevention of pressure injury utilizing individualized approaches and interventions, for those with existing pressure injury or facility acquired injury, assessment reflects review of interventions for continuation or change. Education completed with Wound Nurse on Pressure Injury prevention, assessment of chronic wounds, residents at risk for pressure, best practices for pressure injury care plans, Moisture Associated Skin Damage, partial and full thickness wounds, wound identification, documentation, and pressure injury staging on 11/28/2023 and 11/29/2023 by wound care certified nurse from Gentell, our wound care partner. The DON or designee will educate all nursing staff on ensuring interventions are being followed and timely completion of skin evaluations and skin alteration assessments. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked. 3. The DON or designee will audit 5 random residents with skin impairments to ensure the following: Skin evaluations are completed timely and completely; care plan includes interventions and interventions are being followed.	

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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 686	Continued From page 46 flex such as the lower abdomen, upper thighs, or under the arms.) and the blisters on his heels. *The dermatologists nurse reported back to her that their team felt the blisters on his heels were a manifestation of his bullous pemphigoid due to recently finishing prednisone. *Resident 193 will see the dermatologist on 11/15/23 for a full review at that time. Observation and interview on 11/2/23 at 3:00 p.m. of a dressing change for resident 193 by LPN/wound nurse R and RN/Minimum Data Set (MDS) coordinator E revealed: *He was lying in bed without his heel protector boots on. *He had no dressing on either of his heels. *An Optifoam Gentle EX dressing was placed on each of his heels. *His left heel blister was intact and measured 3.0 centimeters (cm) in length by 3.8 cm in width. *His right heel had an open blister that was reddened and had no drainage. The measurements were 3.1 cm in length by (X) 4.8 cm in width X 0.1 cm in depth. *LPN/wound nurse R stated a new service "My Wound Care Plus" would be making an initial visit on 11/13/23. Either a physician or a nurse practitioner would come and assess resident's wounds and order treatments. *LPN/wound nurse R stated the blisters on his heels were from his bullous phemphigoid. *She agreed the dermatologist had not seen the blisters to ensure they were not pressure ulcers. *She agreed the blisters were full skin thickness and looked different than the other blisters he had. *She agreed she did not know a lot about bullous phempigoid.	F 686	Audits will be weekly for 4 weeks and then monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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Observation on 11/6/23 at 9:35 a.m. revealed resident 193:
*Seated in his wheelchair in his room and he was wearing his regular shoes.
*His heel-protector boots were lying on his bed.

Interview on 11/6/23 at 10:00 a.m. with certified nursing assistant (CNA) T revealed:
*She was a traveling CNA and picked up shifts at the facility and was under contract for thirteen weeks.
*She had not worked on the yellow hall, where resident 193's room was located, prior to today.
*Shift change rounds were completed with the night CNA.
*Used a report sheet when making rounds and could write more information on the sheet regarding the care of the residents.
*Stated she had given her report sheet to someone else.
*Found a report sheet for the yellow hall and agreed the information for resident 193 only included his code status and how he was to have been transferred.
*Stated it had not been reported to her that he had pressure ulcers to his heels, was to wear heel protectors, and was not to wear regular shoes.

*Observations on 11/6/23 at 11:00 a.m. and again at 12:01 p.m. revealed resident 193 was in the hallway by his room and then in the dining room. He was not have wearing his heel protector boots.

Continuous observation on 11/6/23 from 4:15 p.m. through 4:49 p.m. of resident 193 revealed he was lying in bed on his back. He did not have the heel protector boots on. His feet were slightly

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F 686	Continued From page 48 elevated on a pillow, but his heels were still touching the bed. He was only wearing socks. Interview on 11/6/23 at 4:57 p.m. with LPN D regarding resident 193's heel protector boots revealed: *She stated that resident 193 had his heel protector boots on today. *When she was informed of the above observations and the interview with CNA T she stated she was surprised by that. She was sure she had observed him with them on. *Report in the mornings for the CNA's was the off-going CNA would give report to the on-coming CNA. *The nurse would inform the CNAs if there had been any changes with the residents. *She would not review the residents conditions with the CNAs if they had not worked in the halls. *She thought the off-going CNA would have informed them of what care the residents required. Interview on 11/6/23 at 6:00 p.m. revealed LPN/unit manager J and RN/MDS coordinator E stated they had given CNA T education regarding resident 193's need for his heel protector boots. Observations on 11/7/23 at 8:05 a.m. and again at 10:00 a.m. revealed resident 193 did not have his heel protector boots on. He had regular shoes on and was seated in his wheelchair. The first observation in the dining room and the second one was in his room. The heel protector boots were observed lying on the floor between his bed and his bedside table. Interview on 11/7/23 at 11:16 a.m. with CNA W regarding resident 193 revealed:	F 686		

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F 686	Continued From page 49 *When asked why he did not have his heel protector boots on earlier. She stated she had initially been told he did not need them and then was told he did when she laid him down in bed. *She was not sure who had told her he did not need the heel protector boots. *She had not worked on the yellow hall prior to today. *She was a traveling CNA. *She had access to the resident Kardex but had not looked at it to check what each resident needed. Review of resident 193's electronic medical record (EMR) revealed: *He was admitted on 10/24/23 after a hospitalization. *His diagnoses included: Parkinson's and mild cognitive impairment. *A previous diagnosis of bullous pemphigoid disorder was added on 10/27/23 from his dermatologist. Review of resident 193's 10/24/23 nursing admission assessment revealed he had: *Bruising to the top front of his left hip, right shin, and left shin. *He had complaints of feeling pins and needles sensation in his feet. Review of resident 193's 10/24/23 admission Braden Scale (assessment used for the risk for developing pressure ulcers) and clinical evaluation documentation revealed his score was a 5 which placed him at high risk for developing a pressure ulcer. Review of resident 193's 10/24/23 baseline care plan revealed:	F 686		

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F 686	Continued From page 50 *Skin integrity had been triggered from his initial nursing assessment. *The interim focus area was "Resident has (Specify: potential for/an actual) impairment to skin integrity." Potential for or an actual skin impairment had not been specified. *Goals included: -"Resident will continue to have skin intact." *Interventions included: -"LOW RISK - Skin weekly. Report changes to the nurse." *Off load heals as ordered and turn and reposition every two hours and as needed had not been chosen as interventions. Review of resident 193's skin alteration evaluation's revealed: *On 10/27/23 he had a blister to the shin of his left leg and a skin tear to his right elbow. *On 10/29/23 closed blisters to his bilateral heels had been added. *On 11/5/23 the only documentation was for "other." Scattered blisters due to bullous pemphigoid diagnosis. Review of resident 193's 11/1/23 Braden Scale and clinical evaluation documentation revealed his score was a 13 which placed him at high risk for developing a pressure ulcer. Review of resident 193's 11/2/23 wound assessment for his right and left heel blisters revealed: *His left heel blister was intact and had not been classified as a pressure injury or staged. *His right heel blister was open and had not been classified as a pressure injury. It's clinical stage was listed as "Partial Thickness." *Both were facility acquired.	F 686		

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F 686	Continued From page 51 Review of resident 193's care plan for skin impairment revealed: *Focus revised on 11/2/23. -"[Resident] has an actual impairment to skin integrity skin tear to right hand and bulbous [bullous] pemphigoid. This is a chronic skin issue and will continue to develop blister to all areas of my skin and it is unpreventable. I am seen by [name of dermatology clinic]." *Goal had not been updated since 10/27/23. *Interventions: -Revised 11/2/23 "Coordinate care with [name of dermatology clinic] and primary care provider and determine plan of care and any treatment needed." -Revised 11/2/23 "High Risk-Skin weekly. Report abnormalities to the nurse." *There had been no interventions added to specify the treatment for his bilateral heel blisters. *There had been no interventions added to specify any preventative skin interventions for other skin conditions other than his bullous phemphigoid. Review of a 11/3/23 physician's order revealed resident 193's primary care physician deferred any wound care to Dakota Dermatology. Review of a 11/7/23 faxed communication to the dermatologist revealed "Resident has light bleeding to blister at right heel, ok to use collagen one a day until resolved or until seen by you clinic?" There had been no reply from the dermatologist by the end of the survey on 11/9/23. Review of resident 193's Kardex as of 11/6/23 revealed under resident care:	F 686		

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F 686	Continued From page 52 *Assist with application of appliances if needed. *High-risk skin inspections weekly, Report abnormalities to the nurse. *There were no specific instructions for his heel protector boots. Review of the CNA skin monitoring observation documentation from 10/25/23 through 11/6/23 for the question "Does the resident have a skin alteration?" Yes was only documented on 10/29/23, 10/31/23, 11/4/23, and 11/6/23. Interview on 11/8/23 at 3:59 p.m. with director of nursing (DON) B and regional nurse consultant HH revealed: *Wound rounds were done weekly. *DON B stated LPN/wound nurse R would be taking a wound care course. *Had not been aware resident 193's intervention for bilateral heel protector boots had not been consistently followed. *They were not aware LPN/unit manager J had provided education to CNA T regarding resident 193's heel protector boots. *Agreed after LPN/unit manager J had provided education to CNA T The intervention should have been entered on the Kardex. Review of the provider's 3/23/23 Pressure Injury Prevention policy revealed: *General preventative measures included: -Repositioning, need for a specialized mattress, wheelchair cushion, reducing friction, and shear. *Interventions and preventative measures would be implemented for resident with risk factors of moisture, friction and shear, bed-fast resident, chair-fast residents, immobility, bowel and/or bladder incontinence, poor nutrition, and impaired cognitive status.	F 686		

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F 686	Continued From page 53 *Additional clinical conditions, treatments, and abnormal laboratory values could also indicate a resident was at risk for a pressure injury. Those included: -Impaired/decreased mobility and decreased functional ability. -Conditions, such as end stage renal disease, terminal cancer, or diabetes. -Medications that could affect would healing. -Blood flow impairment. -Cognitive impairment. -A healed ulcer. The history of a healed pressure injury and its stage is important since areas of healed stage 3 or 4 pressure injuries are more likely to have recurrent breakdown. 2. Observation on 11/2/23 at 11:20 a.m. of resident 37 revealed: *The resident was sitting in her recliner with a walker next to the recliner and she was watching TV. The call light was attached to the recliner. *The resident was able to respond to questions asked appropriately but was confused as to why she was being asked questions. Interview on 11/2/23 at 11:25 a.m. with CNA I regarding resident 37's care revealed: *The resident was able to reposition herself. *Resident 37 would ambulate with a gait belt and assist of 1 staff member and a walker. *CNA I thought the pressure ulcer on the coccyx was healed. *Staff would attempt to assist the resident to the bathroom every 2 hours, but the times could be inconsistent from 1.5 hours to 2.5 hours dependent on staff availability. Review of resident 37's 10/2/23 care plan	F 686		

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revealed the following interventions: Apply a moisture barrier to the peri-area after an incontinent episode. The call light should be in reach. Remind, offer, and assist the resident with toileting as needed.

Review of resident 37's EMR revealed:
*The resident had diagnoses of the following:
-Unspecified dementia.
-Mild protein-calorie malnutrition.
-Iron deficiency anemia.
-Type II diabetes mellitus.
*Resident was on a constant carbohydrate diet.
*The November 2023 Medication Administration Record (MAR) for resident 37 revealed resident 37 was taking Preservision multivitamin 2 caps once daily for a supplement. No other supplements for the pressure ulcer had been ordered.
*A 10/11/23 Braden scale and clinical evaluation indicated resident 37 was at low risk for developing pressure ulcers with a score of 22.
*A 10/14/23 progress note revealed the following:
-A CNA reported a skin alteration for resident 37.
-The note reported a blanchable red area measuring 0.5 cm x 0.5 cm, intact area on the coccyx. -The progress note also reported redness to the bilateral groin area.
-The area was cleansed with soap and water, patted dry, and barrier cream was applied.
-The resident's physician and family were notified.
-The manager on call was also notified.
*A 10/19/23 progress note revealed a Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed without slough or bruising) coccyx pressure ulceration, which was previously thought to have been MASD (Moisture Associated Skin Damage).
-The area of redness/MASD measured 9.2 cm x

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5.8 cm.
-The opened pressure ulcer area measured 1 cm in length x 1 cm width x 0.01 cm depth.
-Intervention for the coccyx area included cleansing with normal saline or soap and water then covering with a bordered foam dressing every 3 days or as needed if soiled or removed.

Review of resident 37's 10/2/23 care plan revealed:
*The resident had a pressure ulcer to her L (left) lateral ankle and coccyx area.
*Interventions included:
-The wound treatment mentioned above.
-Keep skin clean and dry.
-Pressure relieving mattress.
-Reposition at least every 2 hours.
-Heel protection boots at bedtime.

Review of the October 2023 Treatment Administration Record (TAR) revealed:
*Wound care to the coccyx started on 10/19/23.
*Wash the area with soap and water or normal saline and cover with bordered foam dressing every three days and as needed if soiled or removed.

Telephone interview on 11/2/23 at 12:08 p.m. with resident 37's daughter revealed:
*She stated that she believed the pressure ulcer on her mother's coccyx was a result of not being toileted regularly.
*She stated that family had concerns about staff providing proper care to their mother specifically on the weekends.

Observation on 11/6/23 at 11:24 a.m. of LPN/wound nurse R completing skin monitoring on resident 37 revealed the area on the coccyx

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F 686	Continued From page 56 was healed. Interview on 11/9/23 at 09:21 a.m. with LPN/would nurse R regarding resident 37 revealed: *The initial pressure ulcer prevention interventions that were started on the 10/2/23 admission included the following: -Two-hours bathroom checks. -Pressure relieving mattress. *The resident had a blanchable reddened area on right side of the coccyx that was identified on 10/14/23 related to MASD due to incontinence. *A 10/16/23 wound round form revealed, that resident 37 had a reddened area on the coccyx measuring 9.2 cm in length x 5.8 cm in width x 0.01 in depth. *A moisture barrier cream was ordered on 10/16/23 to have been applied during bathroom changes. *New interventions and care changes were communicated to CNAs through morning stand-up huddles, the resident's care plan, and the Kardex. Review of resident 37's Kardex revealed there was no moisture barrier cream listed. *LPN/Wound nurse R stated that the barrier cream was best practice and stated she had no concerns that the intervention was getting done. Barrier cream use for the resident was not documented by the staff. *A 10/19/23 wound round form revealed a stage 2 pressure ulcer with an open area pressure ulcer measuring 1 cm x 1 cm x 0.01 cm. *The wound healed on 11/4/23. Interview on 11/9/23 at 11:05 p.m. with DON B, LPN unit manager J, and regional nurse	F 686		

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F 686	Continued From page 57 consultant HH revealed: *A grievance was filed by the resident's daughter-in-law on 10/13/2023. The grievance report indicated a concern that the family had not felt that the resident had been changed regarding her incontinence all morning and that she had not received breakfast. *When asked how interventions for bath rooming every 2 hours was being completed, regional nurse consultant HH stated they could not ensure that residents were toileted every two hours. 3. Observation on 10/31/23 from 11:09 a.m. through 2:11 p.m. revealed: *Resident 39 was lying in bed with a foot cradle supporting the blankets off of her feet. *Heel protector boots were lying on the sink counter in the resident's room. Observation and interview on 10/31/23 at 2:21 p.m. of CNA U performing personal care for resident 39 revealed: *CNA U stated that resident 39 stayed in bed much of the time throughout the day and night. *She was supposed to have been repositioned every 2 hours while she was in bed. *When asked about the heel protector boots, CNA U was not aware when resident 39 was to wear those heel protector boots. *CNA U used a rounding sheet to provide care for those residents she had been assigned to care for. *The rounding sheet that was used for resident 39's care had not listed the heel protector boots. Observation on 10/31/23 at 4:54 p.m. revealed resident 39 was lying in bed and was still not wearing those heel protector boots.	F 686		

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F 686	Continued From page 58 Review of the October 2023 TAR revealed that LPN MM had documented that resident 39's heel protector boots were on during the day of 10/31/2023. Review of resident 39's 7/11/23 care plan revealed: *The resident had the potential for impairment to skin integrity. *The intervention included heel protection boots should have been on at all times. Interview on 11/3/23 at 3:09 p.m. with LPN/unit manager M revealed CNAs would use the Kardex and the rounding sheet to provide care and implement interventions for the residents from the information listed on the Kardex and the rounding sheets. Review of resident 39's EMR revealed: *A 10/24/23 Braden scale and clinical evaluation indicated the resident scored a 12 and was categorized at high risk for skin breakdown. *A 06/22/23 Skin Evaluation indicating that resident 39 had a stage I pressure ulcer (a reddened, painful area on the skin that does not blanch when pressed) on her R (right) great toe measuring 0.8 cm in length and 0.5 cm in width and a stage I pressure ulcer on her R second digit that measured 0.5 cm in length and 0.3 cm in width. *A foot tent was ordered to keep the blankets off of her feet, heel lift boots were to be worn, and a low-loss air mattress to the bed. Interview 11/6/23 8:53 a.m. with CNA W was employed with a contract agency revealed: *She stated that today was her first shift on her assigned wing.	F 686		

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F 686	Continued From page 59	F 686		

*When asked how she would know what the care needs were for resident 39, she stated that she was given a rounding sheet with their resident's code status and how the resident's transfer.
*When asked about the heel protector boots sitting in the resident's wheelchair. She had no knowledge about them or if they needed to have been placed on the resident's feet.
*CNA W admitted she did not known much about the resident and was going to assist the resident out of bed until she was stopped by another staff member that explained to her that the resident stays in bed.

Observation on 11/6/23 at 9:58 a.m. revealed resident 39 lying in bed and the heel protection boots were still sitting in the resident's wheelchair in her room.

Interview on 11/6/23 at 9:59 a.m. with RN NN regarding resident 39 revealed:
*She had been employed for a month.
*She had no knowledge as to when the heel protector boots were supposed to have been on but reviewed the resident's EMR and stated that those heel protector boots should have been on at all times.
*When asked where that intervention was documented to ensure the heel protector boots were put on, RN NN reported that she had documented that the heel protector boots were on but acknowledged that she had not checked to ensure those heel protector boots were on prior to documenting in the EMR.

Interview and review of resident 39's Kardex on 11/7/23 at 9:44 a.m. with LPN/wound nurse R revealed.
*The heel protector boots should have been listed

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	435039	A. BUILDING _____ B. WING _____	C 11/09/2023

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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 686	Continued From page 60 on the Kardex so that the CNAs caring for resident 39 knew those boots should have been on at all times. *It was confirmed by LPN/wound nurse R that the heel protection boots were not listed on the Kardex. *LPN/wound nurse R stated that she would have completed a "teachable moment" with the CNA. That would have been an informal reeducation for the CNA regarding the heel protector boots. Interview on 11/9/23 at 10:32 a.m. with LPN unit manager M regarding resident 39's pressure ulcers to her toes revealed: *The cause of the resident pressure ulcers on her toes were from the friction of the resident's sheets. The resident would wrap herself in the sheets and the heel protector boots still left the toes exposed to the friction of the bed sheets. *The foot cradle was ordered and the pressure ulcers to the toes have since healed. *They were starting to use the rounding sheet more by adding more interventions for the residents. *She agreed that communication was an issue with ensuring that direct care staff implemented resident's care plan interventions. Interview on 11/9/23 at 11:05 a.m. with director of nursing (DON) B, LPN unit manager J, and regional nurse consultant HH revealed: *Unit managers were responsible to ensure that interventions and changes to the resident's care plans were communicated to direct care staff. *That was completed through the Kardex, rounding sheets, and staff stand-up huddles. *All direct care staff were given access to Point Click Care (the provider's electronic medical record).	F 686		

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F 686	Continued From page 61 *Managers would educate direct care staff on how to use Point Click Care and where to find the Kardex. -LPN unit manager J was attempting to develop a better system to communicate interventions to the direct care staff and was currently working with quality improvement on the issue. Review of the 3/23/23 Skin and Pressure Injury Prevention Program Policy revealed: *Nursing personnel who would have been providing care to the residents would have been instructed in the individual interventions for each resident. *Nursing personnel would monitor response to the resident's plan of care and ensure implementation of the resident's individualized plan of care. 4. Interviews and observations on 10/31/23 at 4:15 p.m., 11/2/23 at 9:45 a.m. and again at 3:40 p.m. with resident 3 revealed she: *Was in her room seated in a recliner chair watching television. *Was not able to carry on an extensive conversation during each visit, but responded to questions that indicated she had no concerns. Review of the 10/22/23 quarterly Minimum Data Set (MDS) assessment for resident 3 revealed: *The "Submission Information" for MDS was listed as "export ready," which indicated it had not yet been submitted. *Her Brief Interview for Mental Status (BIMS) was scored at 03, which indicated she had severe cognitive impairment. *No behaviors, mood indicators, or reports of pain were coded on the MDS. *She needed a helper to perform more that 50	F 686		

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F 686	Continued From page 62 percent of the effort with all mobility tasks. *She frequently incontinent of bladder but continent of bowel. *Skin conditions was marked as "No" pressure ulcer/injury and "Yes" for skin tears. Review of resident 3's care plan revealed "actual impairment to skin integrity stage I [one] pressure ulcer to right buttock, date initiated: 10/09/2023, revision on: 10/17/2023. Review of the Order Summary for resident 3 revealed order dates of: *4/13/23, Pressure relieving mattress. *7/13/23, "SKIN CARE: Apply bordered foam dressing for protection (sacrum) change q [every] 3 days or as needed every day shift every 3 day(s)." *10/17/23, "WOUND CARE: Cleanse open area to right buttock with wound cleanser and cover with bordered optifoam. Change dressing every 3 days and prn [as needed] if soiled. Reposition resident as frequent as possible and monitor area for any signs of infection and update provider if signs are present. Hospice nurse to assess weekly. one time a day every 3 day(s) for skin alteration AND as needed for skin alteration change prn if soiled." Review of the weekly Skin Evaluations revealed: *On 10/13/23, "Resident has alteration in skin integrity" was marked as "Yes." "Coccyx" was listed as the "Site" with a description of "redness" under the heading for "NON PRESSURE ULCER." There was no documentation in "Additional Skin/Treatment Note." "On 10/15/23, "Resident has alteration in skin integrity" was marked as "Yes." "Right gluteal fold" was listed as the "Site" with the "Type" of	F 686		

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F 686	Continued From page 63 "open area" under the heading for "PRESSURE ULCER." The measurements for Length [L], Width [W], and Depth [D] were blank, and the "Stage" was not selected. Review of Skin/Wound notes for resident 3, written by LPN/wound nurse R, revealed: *On 10/9/23, the first note to acknowledge the wound, "Reviewed open area to resident right buttock. Current measurement: 1.9 [centimeters (cm)] x [by] 1.7 x 1.01 cm. Applied wound care per current orders." *On 10/16/23, "Current measurement: 1.8 x 1.5 x 0.02 cm." *On 10/17/23, "Reviewed open area to resident right buttock with hospice nurse. Hospice nurse staged as a pressure I [one] injury ro right coccyx, continuing with plan of mepilex every 3 days. Amending wound rounds ot [to] show as stage I pressure injury." *On 10/23/23, "Reviewed pressure ulcer to resident right buttock with [hospice] RN. Current measurement 1x1.1x0.02cm." Review of "WOUND ASSESSMENT DETAILS REPORT" for resident 3, completed by LPN/wound nurse R, revealed the wound decreased in size but was consistently labeled as a skin tear instead of a pressure ulcer, as follows: *On 10/9/23, "right buttock," "Type Skin Tear," "Classification Type 3: Total Flap Loss," "Source: Facility-acquired," "Date identified: 10/3/23," "Clinical Stage: Full Thickness," "Size (cm): 1.90 x 1.70 x 0.01 (L x W x D)." *On 10/16/23, Type and Classification the same as 10/9/23, "Size (cm) 1.80 x 1.60 x 0.02 (L x W x D)." *On 10/23/23, Type and Classification the same as 10/9/23, "Size (cm) 1.10 x 1.10 x 0.02 (L x W x	F 686		

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F 686	Continued From page 64 D)." *On 10/30/23, Type and Classification the same as 10/9/23, "Size (cm) 1.00 x 1.10 x 0.02 (L x W x D)." *On 11/4/23, Type and Classification the same as 10/9/23, "Size (cm) 0.40 x 0.30 x 0.01 (L x W x D)." Interview on 11/8/23 at 4:18 p.m. with DON B and RNC HH revealed there was a discrepancy between the type and classification of skin tear or stage I pressure ulcer on the Skin Evaluations, Skin/Wound Notes, and the Wound Assessment Detail Reports. Interview on 11/8/23 at 5:04 p.m. with RN/MDS coordinator E revealed she: *Believed the coding of "skin tear" on the 10/22/23 "export ready" MDS was accurate. *The "first note" that identified it as a pressure ulcer was 10/23/23, which was after the assessment reference date (ARD) of 10/22/23 for the MDS. Interview on 11/8/23 at 5:32 p.m. with RN/MDS coordinator E and LPN/wound nurse R revealed they confirmed the wound was a pressure ulcer before the ARD and the MDS coding would have to be changed before it was submitted.	F 686		
F 689 SS=K	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	F 689	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are:	12/07/2023

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F 689	Continued From page 65 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, and policy review, the provider failed to ensure staff were competent to safely use the mechanical lift equipment and provided with accurate information about each resident's transfer equipment needs, including sling size, for eight of twelve sampled residents (1, 9, 24, 32, 33, 77, 79, 244). Findings include: 1. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing on 10/31/23 at 7:03 p.m. to administrator A for F689 Accidents related to accurate assessment and care planning for the use of mechanical lifts and body slings: *Multiple staff interviews revealed staff were unable to state where they would find the transfer recommendations for residents, which included the appropriate mechanical lift and the appropriate type and size of sling. * A Facility Reported Incident identified on 10/23/23, two agency certified nursing assistants (CNA) used a full-body total mechanical lift for a resident transfer with a fall from three feet to the floor resulting in a hip fracture. The last lift evaluation for resident was 7/12/22. Resident's care plan intervention, last revised 10/22/22, "requires assist of two with total lift..." but does not specify type of sling to be used. *Observation on 10/31/23 of a full-body mechanical lift transfer of a resident with an agency CNA and staff member using the wrong	F 689	5 Why's 1. Agency utilization 2. Lack of education/competencies 3. Lack of orientation for agency 4. Lack of supervisor oversight 5. Lack of timely completion of assessments 6. Care plans not updated timely A. POC for mechanical lifts 1. Director of Nursing (DON) or designee will provide education to all nursing staff on mechanical lift policy including the process for finding appropriate type and size of sling. 2. Resident's 1, 9, 24, 32, 33, 77, 79, 244 had mechanical lift assessment completed, care plans updated to reflect mechanical lift, sling type, and size. Identified all residents that utilize mechanical lift are at risk. All residents that utilize mechanical lift had new lift assessment completed. All residents that utilize a mechanical lift care plan was reviewed and updated to reflect appropriate mechanical lift and appropriate type and size of sling. DON or designee will complete a lift competency with all nursing staff, to include return demonstration, on mechanical lifts, how to identify type of mechanical lift, as well as type and size of sling. DON or designee will ensure new staff, including agency staff, receive education on the mechanical lift policy and competency with return demonstration will be completed prior to first shift worked.	

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F 689	Continued From page 66 type and size of sling resulting in the resident sliding out of the bottom of the sling onto her bed when the mechanical lift was being raised. *Provider did not have a system in place, including competencies demonstrated, to ensure agency staff receive orientation and training for using the full-body mechanical lift and multiple sizes and types of slings available. IMMEDIATE JEOPARDY REMOVAL PLAN On 11/1/23 at 3:03 p.m., administrator A provided the survey team with a written a plan for removal of the immediate jeopardy. The removal plan, after revisions, with guidance from the long-term care advisor for the South Dakota Department of Health, was approved by the survey team on 11/1/23 at 3:50 p.m.: *Director of Nursing (DON) or designee will provide education to all nursing staff on mechanical lift policy, Sling Selection Guideline, and Lift Assessments, and the process for finding appropriate type and size of sling and where to locate the information for each resident on Kardex or Care plan by end of day 11/1/2023 if unable to complete by end of day 11/01/2023 will be completed prior to next scheduled shift. *Identified 35 residents that utilize mechanical lift are at risk. All residents that utilize mechanical lift had new lift assessment completed 10/31/2023. All residents that utilize a mechanical lift care plan was reviewed and updated to reflect appropriate mechanical lift and appropriate type and size of sling 11/01/2023. DON or designee will complete a lift competency with all nursing staff, to include return demonstration, on mechanical lifts, how to identify type of mechanical lift, as well as type and size of sling by end of day 11/01/23 if staff unable to complete by end of day 11/01/23 will be	F 689	3. Guideline created for staff utilization and reference for appropriate sling type and size based on in house inventory of slings, manufacturer guidelines and resident assessment. All residents that utilize mechanical lift had new lift assessment completed. All residents that utilize a mechanical lift care plan was reviewed and updated to reflect appropriate mechanical lift and appropriate type and size of sling. DON or designee will complete a lift competency with all nursing staff, to include return demonstration, on mechanical lifts, how to identify type of mechanical lift, as well as type and size of sling. DON or designee will ensure new staff, including agency staff, receive education on the mechanical lift policy and competency with return demonstration will be completed prior to first shift worked. Upon admission/readmission/ quarterly/significant change or as needed a mechanical lift assessment will be completed, and care plan will be updated. Audits will be completed on 5 residents requiring mechanical lifts to ensure lift assessment is completed accurately and thoroughly, type and size of lift sling is on the care plan and Kardex. In addition, 5 nursing staff, to include agency staff, will be observed transferring a resident with mechanical lift to ensure the appropriate type and size of lift sling was utilized. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be reviewed by the DON or	

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F 689	Continued From page 67 completed prior to next scheduled shift. DON or designee will ensure new staff, including agency staff, receive verbal and written education on the mechanical lift policy and competency with return demonstration will be completed prior to first scheduled shift. *Guideline created for staff utilization and reference for appropriate sling type and size based on in house inventory of slings, manufacturer guidelines and resident assessment on 11/01/2023. All residents that utilize mechanical lift had new lift assessment completed 10/31/2023. All care plans for residents that utilize a mechanical lift were reviewed and updated to reflect appropriate mechanical lift and appropriate type and size of sling 11/01/2023. DON or designee will complete a lift competency with all nursing staff, to include return demonstration, on mechanical lifts, how to identify type of mechanical lift, as well as type and size of sling by end of day 11/01/2023 if unable to complete by end of day 11/01/2023 will complete prior to next scheduled shift. DON or designee will ensure new staff, including agency staff, receive education on the mechanical lift policy, Sling Selection Guideline and competency with return demonstration will be completed by end of day 11/01/2023 if unable to complete by end of day 11/01/2023 will complete prior to next scheduled shift. Upon admission/readmission/quarterly/significant change or as needed a mechanical lift assessment will be completed on residents, and care plan and Kardex will be updated. Audits will be completed by DON or Designee on 5 residents requiring mechanical lifts to ensure lift assessment is completed accurately and thoroughly, type and size of lift sling is on the care plan and Kardex. In addition, DON or Designee	F 689	designee with IDT and Medical Director at monthly QAPI for analysis and recommendation for continuation/ discontinuation/revision of audits based on findings. B. POC for Elopements: 1. Resident 55 discharged from facility. Resident 10 has wanderguard order placed in EMR, Monitoring order placed in TAR and Care plan reviewed and updated 11/7/2023. All door alarms checked and were found to be working appropriately 11/7/2023. All residents with wanderguards audited and physician order, assessment, monitoring location and functioning of WanderGuard bracelet, and care plan updated 11/7/2023. Contacted contractor for bid for wanderguard system on 11/7/2023. Contractor provided bid, however, contractor proposed another system that would work better with the layout of the facility. All doors will be maglocked and locked at all times (with required egress). This will eliminate the need for wanderguard bracelets and the inadvertent alarming when a resident with a bracelet is close to a door. The bid has been approved and system will be installed upon the contractor's first availability. Until this is installed, we will continue with the current wanderguard doors. Updated TELS document to specify wanderguard door alarm checks 11/7/2023.	

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F 689	Continued From page 68 will audit 5 nursing staff, to include agency staff, will be observed transferring a resident with mechanical lift to ensure the appropriate type and size of lift sling was utilized. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be reviewed by the DON or designee with IDT and Medical Director at monthly QAPI for analysis and recommendation for continuation/discontinuation/revision of audits based on findings. On 11/2/23 at 12:30 p.m., the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope was a level G. 2. Observation and interview on 11/6/23 at 3:16 p.m. with resident 24 revealed she: *Was lying in her bariatric bed with the head of the bed raised about 45 degrees. *Had just returned from being in the hospital for a few days. *Was being treated for a fractured hip because she "fell out of bed." *Had no concerns about how staff used the mechanical lift. *Stayed in bed now and pain was managed. *The only concern she reported was the "call light response is slow at night." Review of the 10/21/23 quarterly Minimum Data Set (MD)S assessment for resident 24 revealed: *The Brief Interview for Mental Status (BIMS) was scored at 11, which indicated she had moderately impaired cognition. *Four indicators of her mood were coded as present for "half or more" of a 14-day window, which gave her a severity score of 10, moderate	F 689	Wanderguard policy created 11/7/2023. All staff educated on wanderguard policy prior to next scheduled shift. 2. Layout of building, geographical location of building, climate/weather areas that cannot be changed. Facility to review recruitment and retention plan and will implement long-term care contracts to replace per diem contracts as able. 3. Educate all staff on new wanderguard policy and elopement policy prior to next shift. Educate staff on which residents are an elopement risk. Identified list of elopement risk resident's and where wanderguard is located on residents will be communicated through elopement binders placed at each nurses station. Each elopement binder will contain all at risk residents. All at risk residents will have PCP orders in place on EMR, will have monitoring records in place on TAR, care plans updated, and elopement risk assessment will be completed on Admission, Readmission, Quarterly, and with significant change. Review all residents on Admission, Readmission, Quarterly, and with Significant change. Staff will be informed with any changes of elopement binder through staff huddle. C. Fall Management 1. Resident 39 will continue to have bed	

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F 689	Continued From page 69 depression. *No behavior indicators were coded. *She had lower extremity impairments on both sides of her body. Review of the electronic medical record (EMR) for resident 24 revealed a "Late Entry" "Incident Note" dated 10/23/23 at 4:45 p.m., created on 10/24/23 at 7:40 p.m. that documented: *The nurse was called to the room by two CNAs and observed the "resident laying on the ground with the Hoyer [full-body mechanical lift] sling beneath her." *The nurse asked the CNAs about the transfer, and they "stated the Hoyer machine was tilting because the resident was leaning more to one side than the other on the Hoyer sling." -No injuries were observed, and no pain was reported at that time. Review of the facility investigation of the incident, completed on 10/27/23, revealed: *Resident 24 complained of pain in her left leg and head when she was laid down after dinner. *The medical provider was made aware of the symptoms as a result of the incident and sent orders to transfer her to the emergency room department. *Resident 24 was transferred on 10/23/23 at "approximately 10:00 p.m." and was admitted to the hospital with a fractured hip. *"Hoyer lift was removed from service and is being inspected by maintenance." *"Ceiling lift was inspected last night by unit manager and DON and was intact with not issues." *"Hoyer lift was inspected by maintenance and did not show any malfunctions or mechanical issues."	F 689	in low position, but no longer utilizes floor mat. Care plan updated 11/3/2023. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support fall management. The DON or designee will review fall interventions, care plans, and Kardex with all staff. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked. 3. The DON or designee will audit 5 random residents with fall risk to ensure the following: Fall risk evaluations are completed timely and completely, care plan includes interventions and interventions are being followed. Audits will be weekly for 4 weeks and then monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits. D. Ingestion of Hand Sanitizer 1. Resident 87 refused to be transferred to the hospital for evaluation and denied consuming hand sanitizer. He was monitored and did not have any adverse consequences as a result of possibly consuming hand sanitizer. Resident 87 was transferred to another skilled nursing facility on 11/14/2023. All residents are at	

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F 689	Continued From page 70 *"Sling was inspected that was used for the transfer and was intact with no fraying or tearing noted...an appropriate size for [resident]." *"After learning of resident's hip fracture, these [two CNAs] were interviewed again when they admitted that the resident fell three feet to the floor. Both work for [agency name]." *"Staffing agencies state their CNAs are competent on tasks such as transfers; however, going forward, we will ensure the agency staff are trained on operation of the facilitys [sic] transfer equipment prior to their shift worked." Review of the 7/12/22 admission Lift Evaluation V.1 [version one] UDAs [user defined assessment) for resident 24 revealed: *"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "No." *"A. 4. Level of Assistance" was marked "Dependent." *"B. 1. Is the resident able to bear at least 50% [percent] weight on at least 1 [one] leg?" was marked "No." *"B. 2. Can the resident sit upright without Physical Assistance? was marked "No." *"B. 3. Is the resident able to follow simple directions? was marked "Yes." *"B. 4. Resident has upper extremity strength to grip with at least one hand?" was marked "No." *"B. 5. Is Resident able to tolerate moderate pressure to mid to lower back? was marked "Yes." *"C. 1. Can resident tolerate being in a semi-reclined position? was marked as "Yes." *"D. 1. Type of lift required: Total Dependent (Bariatric)." *"D. 2. Sling Size: xl [extra large]"	F 689	risk of having access to hand sanitizer to consume. All portable liquid hand sanitizers have been removed from the facility and facility is utilizing disposable hand sanitizer wipes. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support appropriate assessment and use of mechanical lifts, appropriate risk assessment and adequate planning for safety of those identified for elopement and those residents who may be at risk for abnormal ingestion practices related to history. 3. The DON or designee will perform walking rounds each business day at various times to ensure there is no portable hand sanitizer in any area that can be accessed by any residents. Audits will be weekly for 4 weeks and then monthly for 2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 689	Continued From page 71 Review of the 10/22/22 quarterly OBRA [omnibus budget reconciliation act] MDS UDA - V3 [version three] Lift Evaluation section for resident 24 revealed: *B.2. Can the resident sit upright without Physical Assistance: was marked "Yes. (Sit to Stand). *The remaining sections were answered the same as on the 7/12/22 admission Lift Evaluation V.1 UDA. Review of the 4/19/23 quarterly and 7/21/23 annual OBRA MDS UDA - V3 Lift Evaluation sections for resident 24 revealed: *All of the sections were answered the same as on the 7/12/22 admission Lift Evaluation V.1 UDA, except item D.2. was blank. Review of care plan for resident 24 revealed: *Focus: "Assistance with ADL's [activities of daily living] (bed mobility, transfers...personal hygiene,...and toileting)," initiated 8/13/21, revised 7/21/22. -Intervention: "Ceiling lift for all transfers," initiated 10/29/21, revised and resolved 10/31/22. -Intervention: "Requires assist of 2 [staff] with the total lift to get in/out of bed, in/out of wheelchair," initiated 7/21/22, revised 10/22/22 -Intervention: "TRANSFERS - 2 person assist, HOYER - Ensure that sling is appropriate size and that sling is placed appropriately prior to transferring, sling size large," initiated 10/26/23. *Focus: "At risk for falls related to current medication use, poor safety awareness, disease process agitated behavior such as verbal and motor activity, anxiety disorder, arthritis, cognitive impairment, decline in functional status," initiated 10/26/23. -Intervention: "Ensure sling is positioned prior to	F 689		

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lifting and transferring surfaces," initiated 10/26/23.
*Focus: "Actual impairment to skin integrity Surgical incision to left hip and outer left knee," initiated 11/3/23.

Review of the "Transferring" section of the visual bedside Kardex report, as of 11/6/23, revealed resident 24:
*"Is dependent on staff for locomotions on and off unit in manual wheelchair."
*"Requires assist of 2 with the total lift to get in/out of bed, in/out of wheelchair."
*"TRANSFERS - 2 person assist, HOYER - Ensure that sling is appropriate size and that sling is placed appropriately prior to transferring, sling size large divided leg."

Review of the undated T-Wing unit rounding sheet [used by staff as a quick reference sheet] revealed for resident 24 revealed, "Hoyer - divided large sling."

Interview on 10/31/23 at 5:26 p.m. with DON B revealed:
*There was no "ceiling lift" in the building.
*The Kardex is in the Point Click Care (PCC) electronic medical record (EMR) software for staff to reference and it provided interventions from the care plan.
*The unit rounding sheets are a tool for care staff to use when they complete their care giving rounds during their shift.

Interview on 11/6/23 at 4:12 p.m. with licensed practical nurse (LPN)/unit manager Y revealed:
*The two CNAs "felt the Hoyer cradle was tipping."
*She was "in the building" at the time so she had

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F 689	Continued From page 73 the CNAs "show how they transferred" the resident. *"They demonstrated use of the lift appropriately." *The correction made after the incident was to "make sure they are using the divided leg sling, that wasn't specific before." *Resident 24 "is not wanting to get out of bed at this time. She doesn't tolerate pain very well." Interview on 11/8/23 at 4:18 p.m. with DON B and regional nurse consultant (RNC) HH revealed DON B: *Was not aware of the reference to the ceiling lift in the 10/27/23 investigation report. *Stated it must have been a typing error. 3. Observation and interview on 10/31/23 at 4:23 p.m. with resident 32 revealed: *There was a strong urine odor in the hallway outside her room and became stronger upon entering her room. Her call light was turned on. *She was sitting in a semi-reclined position in a geriatric bed that was raised higher than the standard level with a half siderail in the up position on both sides of the bed. *LPN UU answered her call light and resident 32 requested her eye drops and insulin shot. LPN UU replied she would come back to check resident 32's blood sugar. *After that, resident 32 replied she was not interested in talking. Observation and interview on 11/6/23 at 9:07 a.m. with resident 32 revealed: *She was lying flat on her bed, her eyes were open, and the television was on. *She started a conversation with this surveyor about not getting to have a "regular glass of chocolate milk" and being on "fluid restrictions"	F 689		

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F 689	Continued From page 74 but her doctor has not told her that." *She requested assistance getting her phone from the overbed table beside her bed, and one stuffed bear and three dolls from the chair in the corner of her room. *At 09:14 a.m., she asked this surveyor to raise the head of her bed and then got angry when told this surveyor could not help her raise the head of the bed but was able to help her turn on the call light. After the touch pad call light was placed in her hand, she turned on the call light. *While wafting, resident 32 asked this surveyor to retrieve several make-up items from the purse that was setting on the overbed table. *At 9:16 a.m., CNA I answered the call light and raised the head of the bed so that she was sitting in a mostly upright position, then helped her retrieve her make-up items. *After CNA I left the room, resident 32 answered a few questions including: -How safe do you feel while being transferred? "Scared. Not when I like the staff who are doing it. Don't like the black CNAs, I was raped by a black person years ago. They come in to change my pad without telling me." -Have you noticed an odor in your room and in the hallway? "Yes. I'm the source of the foul odor. When I have a bowel movement." -Do they clean you well when they change your pad? She did not answer this question. *Resident 32 agreed to let this surveyor observe the staff transfer her when she was ready to get up. Observation on 11/6/23 at 11:30 a.m. of CNA I and CNA KK get resident 32 out of bed revealed: *They changed her brief first, rolling her back and forth onto each side to remove the soiled brief, clean her, and then position the clean brief.	F 689		

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*Neither CNA responded to her complaints of "rolling too far, that was scary" and "Oh, it hurts,"
*CNA KK pushed the transfer sling under her and then they rolled her over so that CNA I could finish positioning the sling underneath her.
*Resident 32 said, "This is no fun." CNA KK said, "I can see where it's no fun."
*Resident 32 asked about lunch and CNA KK said, "Don't know what they are having for lunch."
*After positioning resident 32 in her wheelchair, and while CNA KK was taking the sling loops off the lift hooks, resident 32 exclaimed, "Ow, that hurt." CNA KK did not respond.

Interview on 11/6/23 at 11:46 a.m. with CNA KK revealed she replied, "This is my second day," when asked how she knew level of assistance to provide for residents using a mechanical lift. She walked away without asking the question.

Interview on 11/6/23 at 12:02 p.m. with LPN LL revealed:
*She did not believe she could answer questions about resident 32 as she was an agency LPN even though she had worked "here for a couple of months," it had been "off and on," and she had worked "on different units."

Review of the 9/7/23 annual MDS for resident 32 revealed:
*Her BIMS score was 10, which indicated she had moderately impaired cognition.
*There were no indicators coded for mood disorder,
*No behavior indicators were coded.
*She was totally dependent for bed mobility and transfer.
*She was always incontinent of bowel and bladder.

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F 689	Continued From page 76 Review of the 12/28/21 admission and the 6/7/22 readmission Lift Evaluation V.1 UDA for resident 32 revealed: *"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "No." *"A. 4. Level of Assistance" was marked "Dependent." *"B. 1. Is the resident able to bear at least 50% [percent] weight on at least 1 [one] leg?" was marked "No." *"B. 2. Can the resident sit upright without Physical Assistance? was marked "No." *"B. 3. Is the resident able to follow simple directions? was marked "Yes." *"B. 4. Resident has upper extremity strength to grip with at least one hand?" was marked "Yes." *"B. 5. Is Resident able to tolerate moderate pressure to mid to lower back? was marked "No." *"C. 1. Can resident tolerate being in a semi-reclined position? was marked as "Yes." *"D. 1. Type of lift required: Total Dependent (Full Body Lift)." *"D. 2. Sling Size: xl" Review of the 12/3/22 quarterly OBRA MDS UDA - V3 Lift Evaluation section for resident 32 revealed the following differences in coding from the 12/28/21 admission Lift Evaluation V.1 UDA. *"B. 2. Can the resident sit upright without Physical Assistance: was marked "Yes. (Sit to Stand). *"B. 4. Resident has upper extremity strength to grip with at least one hand?" was marked "No." *"D. 2. Sling Size: [blank]" Review of 10/31/23 quarterly Lift Evaluation V.1	F 689		

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F 689	Continued From page 77 UDA for resident 32 revealed: *All of the sections were answered the same as on the 12/3/22 quarterly OBRA MDS UDA - V3 Lift Evaluation except D.2. Sling Size: was "large." Review of the care plan completed on 10/2/23 for resident 32 revealed: *Focus: "Assistance with ADL's [activities of daily living] (bed mobility, transfers,...personal hygiene,...and toileting)," initiated 9/3/20, revised 7/13/22. -Intervention: "Bed mobility- extensive assist of two staff members," initiated 1/26/23. -Intervention: "Uses a Hoyer lift with assistance of two staff members with transfers. She often yells out during transfers with Hoyer. Take time and explain next steps to reassure her during transfers," initiated 1/9/22, revised 1/26/23. -Intervention initiated on 11/1/23: "Uses total mechanical lift with a large [emphasis added] divided leg sling.,". Review of the visual bedside Kardex report for resident 32, as of 11/6/23, revealed: *Under "Safety," "Hoyer lift for transfers. Sling size extra large [emphasis added]divided leg." *Under "Transferring," "Uses a Hoyer lift with assistance of two staff members with transfers. She often yells out during transfers with Hoyer. Take time and explain next steps to reassure her during transfers." Review of the undated T-Wing rounding sheet revealed for resident 32 revealed, "Hoyer - divided leg large [emphasis added] sling." Interview on 11/6/23 at 3:53 p.m. with LPN/unit manager Y about resident 32 revealed: *She "can make choices but needs support	F 689		

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F 689	Continued From page 78 making appropriate ones." *Reliability of any allegations reported by resident 32 was "50/50." *There had been no injuries or accidents related to transfers. "Sometimes [resident 32] will comment that staff don't know what they are doing. " *Resident 32 "says 'Ow' a lot when she is rolled from side to side. Her complaints are subjective. It depends on who is doing the transfer." *They communicate as a group during daily huddles or one-on-one depending on the priority of the change in the Kardex. *"We keep an eye on each other" through "walking rounds" and "weekly interviews with residents." 4. Observation on 10/31/23 at 4:02 p.m. of resident 33, while restorative aide (RA) TT and LPN/unit manager Y transferred him, revealed: *Resident 33 was seated on a sling in his wheelchair in his room. *RA TT and LPN/unit manager Y fastened the loops of the sling onto the hooks on a full-body mechanical lift. *Resident 33's position in the sling, as they lifted him from the wheelchair, was leaning to the left. *After they lowered him onto the bed, LPN/unit manager Y commented, "You went a little wonky." *The head of the bed was raised about 45 degrees. *Resident 33 was leaning far to the left. RA TT and LPN/unit manager Y physically repositioned him to sit more centered on the mattress. *When asked about the location of information regarding sling size for a resident, LPN/unit manager Y replied it is in each resident's care plan or on the lift assessment.	F 689		

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F 689	Continued From page 79 Observation and interview on 11/6/23 at 3:41 p.m. of resident 33 revealed he: *He was in sitting semi-reclined position in bed in his room with the television on. *The flat sheet between him and the mattress was all bunched up behind him exposing the upper and bottom right corners of the mattress. *His bed was lower to the floor than the standard height, and a fall mat was on the floor next to the bed. *He said he was not ready to get up yet. *There was a bowel odor in his room. Review of the 10/13/23 annual MDS for resident 33 revealed: *His BIMS score was 6, which indicated he had severely impaired cognition. *There we only behavior coded was "rejection of care." *He had impairment of both lower extremities. *He needed a helper to do all of the transfer activity. *The activity of sitting to standing was not attempted. *He was always incontinent of bowel and bladder. Interview on 11/6/23 at 4:26 p.m. with CNA KK revealed she replied, "Don't know," when asked about the bowel odor in resident 33's room, then she walked away. Interview on 11/6/23 at 4:28 p.m. with LPN LL revealed today was the first time she had worked with CNA KK. Review of the 7/14/23 quarterly OBRA MDS UDA - V3 Lift Evaluation section for resident 33 revealed: *"A. 3. Can Resident stand, pivot, & walk with no	F 689		

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assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "Yes-No Lift Needed (STOP HERE)"

Review of the 10/31/23 quarterly Lift Evaluation V.1 UDA for resident 33 revealed:
*"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "No"
*"A. 4. Level of Assistance" was marked "Partial Assist."
*"B. 1. Is the resident able to bear at least 50% [percent] weight on at least 1 [one] leg?" was marked "Yes."
*"B. 2. Can the resident sit upright without Physical Assistance? was marked "No."
*"B. 3. Is the resident able to follow simple directions? was marked "Yes."
*"B. 4. Resident has upper extremity strength to grip with at least one hand?" was marked "Yes."
*"B. 5. Is Resident able to tolerate moderate pressure to mid to lower back? was marked "Yes."
*"C. 1. Can resident tolerate being in a semi-reclined position? was marked as "Yes."
*"D. 1. Type of lift required: Total Dependent (Full Body Lift)."
*"D. 2. Sling Size: large"

Review of the care plan for resident 33 revealed:
*Focus: "assistance with ADL's due to right arm weakness and BKA [below knee amputation]," initiated 1/3/22, revised 6/5/22.
-Intervention: "transfers using Hoyer lift with 2 person assist," initiated 3/3/22, revised 10/17/23, then revised further on 11/1/23 to "transfers using total mechanical lift with 2 person assist, size Large divided leg sling."

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AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 689	Continued From page 81 *Focus: "altered skin integrity issues r/t [related to] PVD [peripheral vascular disease]," left heel (pressure), left ankle, left medical calf, left TMA site, and left dorsal foot (all vascular)," initiated 1/30/22, revised 11/1/23. -Intervention: "prosthetic leg to the right leg. WHC [wound healing clinic] orders to not wear prosthetic until rash and wound are healed...not always compliant with this, please educate me why I am not to wear," initiated 1/30/22, revised 11/11/22. Review of the visual bedside Kardex report for resident 33, as of 11/6/23, revealed: *Under "Transfers," "Using total mechanical lift with 2 person assist, size Large divided leg sling." Review of the undated T-Wing rounding sheet revealed for resident 33, "Hoyer - full body large sling." Interview on 11/06/23 at 4:03 p.m. with LPN/unit manager Y revealed: *Resident 33 is currently using a total lift because of the wounds on his left leg. *He is "pushing his wound doctor to let him stand on his leg again." *"We might be able to transition to the sit to stand." *He was admitted with the wounds, but "his wounds are healing." Interview on 11/09/23 at 10:48 a.m. with director of rehabilitation (DOR) Z revealed: *She was involved with the lift training that was conducted last week. *When residents come in for rehabilitation, the therapy department works towards the highest level of function and lowest level of staff support	F 689		

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needed before transferring them to long term care.
*She conducted quarterly screenings for all residents in accordance with the MDS schedule.
*She was also involved in "Patient At Risk meetings," and communicated with unit managers and other staff through emails or one to one conversations.

5. Observation on 10/31/23 at 11:29 a.m. of CNAs X and U getting resident 9 out of bed using the mechanical full-body lift:
*Resident had a blue divided leg sling under her.
*CNA X attempted to raise the resident out of the bed and the resident slide out of the sling and onto her bed the straps had been crossed between her legs.
*CNA X identified that sling was too large for the resident.
*CNA X retrieved a different sling that one is green colored and full body for the mechanical full-body lift.
*Staff are assisted with rolling the resident from left to right to place the new sling under her.
*They hooked the sling to the mechanical full-body lift.
*Resident 9 was then lifted into her wheel chair.

Interview with CNA X following the transfer regarding what type of sling to use with residents revealed:
*She would have decided what type of sling to use while transferring a resident.
*She would have changed the type of sling to use on a resident if she had not felt safe while performing the transfer with the full-body lift.

Interview on 10/31/23 at 2:53 p.m. with CNA U regarding the type and color sling to be used with

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F 689	Continued From page 83 residents using the full-body lift revealed: *They would be able to find that information in the resident's chart. *She had tried to locate that information but was unable to find that. Interview on 10/31/23 at 3:38 p.m. with CNA X regarding her training for the full-body lift use revealed: *She had not completed any competency for the full-body lift use. *She stated this is her fourth time working here. *If she does not feel comfortable using a type of sling, she will get a different one. *She does not know where in the chart the type of sling or sling size to be used on each resident that requires full-body lift use. Review of resident 9's care plan revealed: *She was dependent on staff for transfers. *She had required assistance of two with the use of the full-body mechanical lift. 6. Observation and interview on 10/31/23 at 2:21 p.m. of CNA X and CNA OO who transferred resident 1 from her bed to her wheelchair using the full body lift. A full body sling size large was used. CNA OO was not sure who chose which size or type of sling a resident was to have used. She thought it might be licensed practical nurse (LPN)/unit manager J. They were not sure where to find the sling sizes for the residents. Review of resident 1's 9/19/22 care plan focus area for activities of daily living (ADL) revealed: *A 10/31/23 revised intervention "Transfers: Full body lift for transfers with assist of 2." *There was no information of what type of size of lift sling was to have been used.	F 689		

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F 689	Continued From page 84 7. Observation and interview on 10/31/23 at 3:45 p.m. of resident 77 during a transfer with a full body lift from her wheelchair to her bed. CNAs P and OO assisted with the transfer. A full body sling size large was used. That sling was soiled, and a clean sling was brought into the room. Resident 77 stated she was glad the new, clean sling was not a split kind. She stated it had hurt and pinched her inner thighs when it was used. Review of resident 77's revised 10/23/22 care plan focus area for ADLs revealed: *A 10/23/22 intervention "Transfers: Total Dependence of 2 staff with Hoyer (full body lift) lift." *There was no information of what type of size of lift sling was to have been used. 8. Observation on 10/31/23 at 3:15 p.m. with CNA OO and CNA P transferring resident 79 from her wheelchair to her bed using the mechanical lift revealed: *A blue sling was placed underneath resident 79 in her wheelchair. *When asked how CNA OO knew what sling size to use transferring resident 79, CNA OO was unaware of what sling size resident 79 should have been using or where she would find that information. Interview on 10/31/23 at 4:03 p.m. with CNA P and CNA/activities director C revealed: *The resident transfer information was found in the Kardex. *Both staff were unable to locate the Kardex in PCC to find out how resident 79 was transferred and the appropriate sling size to have used.	F 689		

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F 689	Continued From page 85 Interview on 10/31/23 at 4:06 p.m. with LPN/Wound Nurse R revealed that she was unable to locate where Kardex was located to find out how resident 79 was transferred. Interview on 10/31/23 at 4:08 p.m. with LPN/unit manager M revealed: *She was able to locate the Kardex for Resident 79, but the Kardex only indicated that the resident used a full mechanical lift with 2 staff assist with transfers. The style and the size of sling that was to have been used was not documented in the Kardex. *She stated that all the residents who use a sling have their own but was unable to communicate what sling size resident 79 used or where she would find the information regarding transferring resident 79. *She stated that the sling size was not included in the care plan but agreed that it should have been in the resident's care plan. *When asked how staff would know which sling to use, she stated that the CNAs would ask the nurse or a seasoned CNA which sling they should have used. *She stated that rehabilitative services staff were responsible for evaluating residents for proper sling size and transfer recommendations. Interview on 10/31/23 at 4:49 p.m. with DOR Z revealed: *The rehabilitation staff did not assess residents for sling size or lift recommendations on admission to the facility, and they would have used the recommendation the resident had from the hospital provided. *Physical therapy would assess a resident for sling size when a referral was made by the nursing staff or the resident.	F 689		

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F 689	Continued From page 86 Interview on 10/31/23 at 5:33 p.m. with DON B revealed that the CNA lift competency form that was used for new staff was not completed consistently and that temporary and contracted direct care staff were able to sign up for shifts without having to complete the CNA lift competency before providing care to the residents. Review of the CNA Legacy Health Care (LGHC) Lift Evaluation UDA (User defined assessment) Policy stated that residents would have been evaluated at admission, quarterly, annually, and if the resident had a significant change in condition. 9. Observation and interview on 11/2/23 at 12:40 p.m. of CNA/CMA VV and CNA II while they transferred resident 244 in his room with a full-body mechanical lift from his wheelchair to the bed with LPN/Unit Manager M present in the room revealed: *A blue sling with divided leg was used. *Whenasked, LPN/Unit Manager M stated that was the correct sling to be used. *After fastening the sling to the lift, CNA/CMA VV stepped away from the resident to operate the lift while CNA II remained with the resident guiding him over the bed as he was lifted and moved to the bed. *Once on the bed, CNA II unfastened the sling from the lift and with CNA II and CNA/CMA VV on opposite sides of the bed, both staff assisted the resident to roll from side to side to remove the sling from underneath the resident. Review of the Warren Hall rounding sheet revealed: *Resident 244 was one of the fourteen residents	F 689		

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listed.
*His transfer information stated "Hoyer, sling size Medium split leg".
*Information on this sheet had been pulled from the resident's care plan.

Review of the resident's electronic medical record on 11/2/23 revealed:
*His 9/18/23 BIMS score was 0 indicating severe impairment.
*Resident had been assessed on 10/31/23 to use the full-body mechanical lift with a medium sling.
*The resident's current care plan had an intervention regarding his transfers that stated, "total assist Hoyer and 2 assist, Hoyer sling size medium divide leg."

B. Based on observation, interview, record review, and policy review, the provider failed to ensure staff provided adequate supervision with person-centered interventions, and adequately understood the door exit system to prevent unwitnessed elopements for two of two sampled residents (10 and 55).
Findings include:

1. IMMEDIATE JEOPARDY NOTICE

Notice of immediate jeopardy was given verbally and in writing on 11/7/23 at 2:02 p.m. to administrator A for F689 Accidents related to adequate supervision for residents at risk for elopement.

*Report of a resident who exited the building on 4/4/23, review of record revealed no physician's order and no monitoring of the Wanderguard bracelet on resident as identified on the care plan. Door alarm he went out of by room 224 was

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F 689	Continued From page 88 found to be off at that time. *Another resident was observed outside of exit door by room 205 with door alarm going off on 11/6/23 and staff were attempting to redirect the resident back into the building. *Review of six residents identified by facility as having Wanderguard bracelets revealed inconsistent documentation regarding physician order, assessment, monitoring location and functioning of Wanderguard bracelet, and care plan. *Only three of the ten exit doors have the Wanderguard locking mechanism. *Documentation of monitoring of Wanderguard door alarms was weekly and door alarms were daily. This documentation was not clear regarding monitoring the function of door alarms from the Wanderguard alarms. *Failed to have an elopement policy that addressed the Wanderguard system and failed to have a Wanderguard policy. IMMEDIATE JEOPARDY REMOVAL PLAN On 11/7/23 at 4:11 p.m., administrator A provided the survey team with a written plan for removal of the immediate jeopardy. The removal plan, after revisions, with guidance from the long-term care advisor for the South Dakota Department of Health, was approved by the survey team on 11/7/23 at 4:35 p.m.: Provider's Immediate Jeopardy Removal Plan reflected: *[Resident name] has Wanderguard order placed in EMR, monitoring order placed in TAR and Care plan reviewed and updated 11/7/23. All door alarms checked and were found to be working appropriately 11/7/23. All residents with	F 689		

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F 689	Continued From page 89 Wanderguard audited and physician order, assessment, monitoring location and functioning of Wanderguard bracelet, and care plan updated 11/7/23. Contacted contractor for BID for Wanderguard system 11/7/23. Updated TELS document to specify Wanderguard door alarm checks 11/7/23. Wanderguard policy created 11/7/23. All staff educated on Wanderguard policy prior to next scheduled shift. *Layout of building, geographical location of building, climate/weather areas that cannot be changed. Facility to review recruitment and retention plan and will implement long-term care contracts to replace per diem contracts as able. *Educate all staff on new Wanderguard policy and elopement policy prior to next shift. Educate staff on which residents are an elopement risk. Identified list of elopement risk resident's and where Wanderguard is located on residents will be communicated through elopement binders placed at each nurses station. Each elopement binder will contain all at risk residents. All at risk residents will have PCP orders in place on EMR, will have monitoring records in place on TAR, care plans updated, and elopement risk assessment will be completed on Admission, Readmission, Quarterly, and with significant change. Review all residents on Admission, Readmission, Quarterly, and with Significant change. Staff will be informed with any changes of elopement binder through staff huddle. On 11/8/23 at 3:30 p.m., the survey team determined the immediacy was removed. After the immediacy was removed, the severity and scope was a level E. 2. Observation on 11/06/23 at 4:30 p.m. of resident 55 being assisted back into the building	F 689		

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F 689	Continued From page 90 revealed: *Staff had been alerted by the door alarm at the end of the yellow hallway. *The resident's wander guard had not alarmed. Interview on 11/6/23 at 4:45 p.m. with LPN/unit manager Y regarding Wanderguard alarms revealed: *The only door that would have alarmed would have been the main entrance to the building. *The other exit door would have only had door alarms. Interview on 11/7/23 at 9:35 a.m. with director of maintenance BB regarding wander guard alarmed doors revealed: *There had been three doors with wander guard alarms including: -The main entrance door. -Two exit doors on the T-wing. *He would have tested the wander guard doors weekly with a wander guard pendant in his pocket. *If he had a door that would not have alarmed, he would have checked the batteries and change them as needed. *If door had not alarmed after the batteries had been changed, he would have informed the administrator. *All other exit doors would have alarmed if the door had been opened. -He would have checked the door alarms daily. Record review of resident 55's EMR revealed she: *Had an elopement on the following days: -On 6/13/23 at 4:30 p.m. when the wander guard and door alarmed. -On 8/10/23 at 6:11 p.m. when the resident	F 689		

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walked out the yellow hallway door.
-On 9/5/23 at 3:36 p.m. when the resident exited the door near her room.
-On 9/13/23 at 2:00 p.m. when the resident exited out the yellow hallway door.
-On 10/7/23 at 3:30 p.m. when the resident exited out the yellow hallway door.
-On 10/12/23 at 4:12 p.m. when the door alarmed, and the resident exited the building.
-On 10/15/23 at 5:30 p.m. when the resident had exited the building.
-On 10/30/23 at 2:47 p.m. when the door alarmed, and the resident had exited the building.
-On 11/6/6/23 at 4:30 p.m. when the door alarmed, and the resident exited out the yellow hallway door.
*Had an elopement risk evaluation on the following days:
-On 6/13/23 indicating she had been high risk.
-On 8/10/23 indicating she had been high risk.
-On 9/13/23 indicating she had been low risk.
-On 9/14/23 indicating she had been high risk.
-On 9/15/23 indicating she had been high risk.
-On 10/7/23 indicating she had been high risk.
-On 10/12/23 indicating she had been low risk.
-On 10/15/23 indicating she had been high risk.
-On 10/30/23 indicating she had been high risk.
-On 11/6/23 indicating she had been high risk.
-On 11/7/23 indicating she had been high risk.
*On 9/14/23 a physician's order had been obtained for the use of a wander guard.

Review of resident 55's care plan revealed:
*"Focus: has impaired cognitive function/dementia or impaired thought processes related to or as evidence by: unspecific dementia without behavioral disturbances."
*"Goal: will maintain current level of cognitive function and communication ability through the

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F 689	Continued From page 92 next review period." *"Interventions: Wander guard to left ankle to alert staff of exiting without assist for safety." *"Focus: require assistance with activities of daily living (ADL) dressing, walking, bathing, bed mobility, personal hygiene, eating and toileting." *"Goal: will be assisted with ADL's as needed through next review period." *"Interventions: Elopement risk-has wander guard to ankle, respond to alarm as indicated." *"Focus: is potential for elopement. History of attempts to leave the facility unattended, and wandering into other resident's room invading personal space, impaired safety awareness. Resident wanders aimlessly." *"Goals: will remain safe within the facility." *"Interventions: apply personal safety alarm and/or wander alert per physician's order. Approach from the front and walk in step with resident before attempting to redirection. Has wander guard to ankle, respond to alarm as indicated. If exit seeking keep photographs of the resident on the unit and at the front desk." 3. Observation and interview on 11/2/23 at 9:52 a.m. with resident 10 revealed: *He was leaning to the right with his head down and his back to the hallway while seated in his wheelchair that was adjacent to his recliner. *When asked if he was uncomfortable and wanted to sit in his recliner, he shifts his torso slightly so that he was a bit more upright and denied needing his recliner. *A visitor showed up while visiting with him. He called her his "ex" and she rolled her eyes. *When asked if he had any concerns, he said something about getting out of here. The visitor then said, "he's always trying to go somewhere." He replied, "this is a good place to be."	F 689		

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F 689	Continued From page 93 Review of the 10/13/23 quarterly MDS for resident 10 revealed: *His BIMS score was 3, which indicated he had severely impaired cognition. *No mood symptoms were coded. *The only behavior coded was "rejection of care." *He had no impairment of both upper and lower extremities. *He needed a helper to do more than half of all mobility activities. Review of the 7/13/22 admission Lift Evaluation V.1 UDAs for resident 10 revealed: *"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "YES-NO Lift Needed (STOP HERE)." Review of the OBRA MDS UDA - V3 Lift Evaluation section for resident 10 revealed: *The 10/27/22 annual was coded as: -"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from staff with no risk of falling or injury to staff?" was marked "YES-NO Lift Needed (STOP HERE)." *The 5/12/23 quarterly was coded as: -"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from staff with no risk of falling or injury to staff?" was marked "NO-Continue to assessment below." -"A. 4. Level of Assistance: Partial Assist." *"B. 1. Is the resident able to bear at least 50% [percent] weight on at least 1 [one] leg?" was marked "Yes." *"B. 2. Can the resident sit upright without Physical Assistance? was marked "Yes (Sit to Stand)." *"B. 3. Is the resident able to follow simple	F 689		

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F 689	Continued From page 94 directions? was marked "Yes." *"B. 4. Resident has upper extremity strength to grip with at least one hand?" was marked "Yes." *"B. 5. Is Resident able to tolerate moderate pressure to mid to lower back? was marked "Yes." *"C. 1. Can resident tolerate being in a semi-reclined position? was marked as "Yes." *"D. 1. Type of lift required: Partial Dependent (i.e. [that is], Sit to Stand Lift)." *"D. 2. Sling Size: [blank]" Review of the 10/31/23 quarterly Lift Evaluation V.1 UDAs for resident 10 revealed: *"A. 3. Can Resident stand, pivot, & walk with no assistance or with limited assistance from the staff with no risk of falling or injury to staff?" was marked "NO-Continue to assessment below." *The remaining questions were coded as the 5/12/23 quarterly OBRA MDS UDA - V3 Lift Evaluation, except for "D. 2. Sling Size: large." Review of the care plan completed on 10/19/23 for resident 10 revealed: *Focus: "impaired cognitive function/dementia or impaired though processes as evidenced by: BIMS Score less than 13," initiated 7/19/22, revised 8/10/22. -Intervention: "Keep my routine consistent and try to provide consistent care givers as much as possible in order to decrease confusion," initiated 7/19/22. *Focus: "requires assistance with ADL's," initiated 7/14/22. -Intervention: "Transfers with stand aide x1 assist," initiated 10/24/22. -Intervention: "non-compliant with assistance with transfers...often tries to self-transfer into bathroom," initiated 11/7/22.	F 689		

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F 689	Continued From page 95 *Focus: "at risk for Elopement related to hx [history] of elopements and frequent exit seeking behaviors," initiated 7/14/22, revised 10/17/23. -Intervention: "Wanderguard on WheelChair," initiated 4/4/23, revised 4/10/23. -Intervention: "Moved to room closer to nurses station," initiated 5/15/23. -Intervention: "Lay eyes on [resident 10] where abouts hourly to ensure he is in building, assist him as needed otherwise ok to check you saw him at the time you checked," initiated 7/27/23. Focus: "at risk for falls related to: Disease process: Dementia, antidepressant use, incontinence," initiated 7/26/22, revised 8/22/23. -Intervention: "mobility with w/c at this time to move around room and facility," initiated 7/26/22, revised 5/9/23. -Intervention: "often tries to self-transfer into bathroom," initiated 11/23/22. -Intervention: "Resident will have frequent rounds/checks completed," initiated 4/3/23, revised 5/9/23. -Intervention: "monitor for increased behaviors r/t self-transferring/care," initiated 7/6/23. -Intervention: "Low bed when in bed," initiated 7/19/23. Observation and interview on 11/6/23 at 3:12 p.m. with resident 10 revealed: *He was sitting in his wheelchair in the doorway of his room facing the hallway. *When asked how he was doing, he replied, "babysitting Marlys." *He put his hand on the left brake plastic knob on his wheelchair and made a comment about it being better than the brake handle on the right, which had no plastic knob on it. *Visual glance at his ankles, wrists, and around the wheelchair did not reveal the presence of a	F 689		

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F 689	Continued From page 96 Wanderguard bracelet. Review of the care plan on 11/9/23 for resident 10 revealed the following changes had been made: *Focus: "requires assistance with ADL's," Intervention: "Transfers with stand aide x1 assist," had an addition of "large size sling." revised on 11/1/23. *Focus: "at risk for Elopement," -Intervention: "Referrals being sent to facilities for Alzheimer care, put on hold for fair hearing per ombudsman," revised 11/3/23. -Intervention: "Lay eyes on [resident 10] where abouts hourly..." initiated 7/27/23, was revised on 11/7/23 to "Round on [resident 10] hourly to verify safety." Review of completed UDA list of "Elopement Risk Evaluation(s)" for resident 10 revealed the "Category" and "Score" as follows: *On 8/23/22: High Risk, 7.0. *On 4/4/23: Low Risk, 0.0. *On 7/20/23: High Risk, 5.0 *On 10/30/23: High Risk, 6.0. Review of a 4/4/23 "Incident Note" in the EMR for resident 10 revealed: *"Resident found outside blue hall, after staff heard resident knocking to come back inside." *"Resident stated he was looking for his wife and her boyfriend." *"Staff reported that he was sitting in his w/c when she went into another resident's room but was gone when he [she?] came back out, she assumed he went back to his room." *"She went in another room and heard knocking." *"Screamer alarm was in off position, so alarm did not sound." *"All door alarms checked, and blue hall alarm	F 689		

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F 689	Continued From page 97 turned to on position." Review of "Behavior Notes" in the EMR for resident 10 revealed wandering or elopement behavior had been documented on: *8/22/22 at 3:18 p.m. writer "heard door alarm sound [location not noted]." *7/20/23 at 7:42 a.m. "actively going out the east exit door," 2:37 p.m. "by the doors by the delivery room on the east hall," and 3:59 p.m. "outside the doors of the east wing delivery room and wander guard set off the alarm." *7/28/23 at 3:26 p.m. "Nurse redirected and put resident near nurses station and away from exit door [location not identified]. Resident resistant and put one wheelchair brake on when moving away from the door." *8/8/23 at 3:41 p.m. "attempting to go out side door near the East nurse's station multiple times. Nurse intervened and notified resident he cannot go outside by himself. Nurse attempted to redirect resident, resident resorted to yelling at nurse [swear words]...Resident kept pushing on the door a couple of more times and another staff member redirected him to his room." *9/7/23 at 0:46 a.m. "exit seeking near entrance by maintenance office...Tried to redirect resident to come closer to nurses station...Resident stated, 'I'm going outdoors!' Staff tried to redirect...patient stated, [swear words]." and 10:58 a.m. "exit seeking...redirected to come to nurses station...went to T wing hall and had to be redirected back to his room." *9/13/23 at 8:55 p.m. "started roaming hallways asking for the front door to get outside...explained to resident that its getting late and he should probably allow staff to help him get ready for bed. Resident started using gibberish sentences....15 minutes later, left side entrance door alarm	F 689		

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F 689	Continued From page 98 sounded at the nurses station...redirected and rolled back to nurses station. Resident then started forcefully pushing back in wheelchair while being rolled by staff." *9/30/23 at 6:42 p.m. "exit seeking...redirected resident to nurse station...follow nurse into another resident's room...residents from that room told resident to leave their room which resident did....resident went down T wings hall to exit seek. Nurse redirected resident from exit seeking back to nurses station." *10/1/23 at 3:08 p.m. "exit seeking when redirected by nurse, resident said, 'why don't you come get me' Nurse had to go get resident have him be by the nurses station and provided snack for resident." and 6:41 p.m. "continuously exit seeking [locations not noted]." *10/5/23 at 6:57 a.m. "received call from warren nurse stated that resident was sitting out in the door open and the alarm going off. Warren nurse states that he did not make it outside that resident was sitting inside with door open. This nurse went to grab resident from warren and wheeled his chair back to east nurses station and tried to redirect resident letting him know that he needed to stay put...already talked about exit seeking earlier in the morning and proceed to look for a door to open and would not move away from open door despite alarms going off. Nurses had to move resident physically away from the door and close to east nurse station." *11/1/23 at 7:35 a.m. "exit seeking by housekeeping's office waiting for someone to open the door for him." Review of the documentation for "Ensure Wander guard is in place on wheelchair each shift every shift," Start date 4/4/23 on the Treatment Administration Record (TAR) for resident 10	F 689		

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F 689	Continued From page 99 revealed: *On October 2023 -18 of 31 morning shifts were not documented. -8 of 31 night shifts were not documented. -"LOC" [location] was coded every time with a "x.' *On November 1-8, 2023 -2 of 8 morning shifts were not documented. -8 of 8 night shifts were documented. -"LOC" [location] was coded on 11/7/23 and 11/18/23 as "chair" for both morning and night shifts, all other were coded a "x.' Review of Task documentation for resident 10 revealed: *A Task labeled "Time Study." *Question 1 for that task was labeled "1:1 [one to one] Sitter." *Looking back at 30 days of documentation from 11/9/23 revealed "No Data Found." Interview on 11/6/23 at 12:13 p.m. with agency LPN LL about resident 10 confirmed he had a Wanderguard bracelet under his wheelchair "because he will clip it off." Interview on 11/6/23 at 4:05 p.m. with LPN/unit manager Y about resident 10 revealed: *She confirmed the Wanderguard was on his wheelchair. *All exit doors have a "screamer" alarm. *The exit door alarms are "audited everyday during walking rounds to make sure the alarms are on." *The "charge nurse has to use the key to turn it on or off." *Other times when he had attempted to go out of the building the staff had intervened, "noticed him or heard the alarm." *He "self-transfers frequently."	F 689		

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F 689	Continued From page 100 *They "moved him closer so he can be monitored more closely." Interview on 11/8/23 at 2:06 p.m. with LPN/unit manager Y about resident 10 revealed: *ADM A "just talked with me about monitoring [resident 10] each hour." *She had "not found a pattern" with his attempts to self-transfer and exit seek. It "varies" but is "daily at least. He doesn't have good balance and doesn't realize that." Interview on 11/9/23 at 1:07 p.m. with DON B and RNC HH abut resident 10 revealed: *When asked if the care plan specified when it was necessary to document the 1:1 sitter time study: -DON B looked and replied, "No, it is not on the care plan. It might be a PCC issue. -RNC HH looked and reported that task was "created 7/13/22, then again 10/18/23." *When asked about the gaps in documentation, no response was given by DON B. -RNC HH mentioned the PCC dashboard. *When asked if DON B had been using the PCC dashboard to monitor staff to ensure interventions were being completed, he replied, "Yes." -RNC HH added he can verify that the TAR was complete. C. Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure fall management and documentation protocols had been followed for one of two sampled residents (39). Findings include: 1. Observation on 10/31/23 from 11:09 a.m. through 2:11 p.m. revealed resident 39 was lying	F 689		

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F 689	Continued From page 101 in her bed that was not in the low position and no floor mat was placed near the bed. Interview on 10/31/23 at 2:21 p.m. with certified nursing assistant (CNA) U revealed: *CNA U stated that resident 39 stays in bed most of the time and was to have been repositioned every 2 hours. *CNA U was not aware if the floor mat was supposed to have been used. Review of resident 39's electronic medical record (EMR) revealed the following: *A 9/25/23 Fall Risk Evaluation indicated that the resident was categorized as high risk for falls. *The 09/27/23 care plan revealed the following: -Resident 39 was at risk for falls due to poor safety awareness, disease process, decline in functional status, fatigue, and weakness. -Interventions included a floor mat placed next to bed and the bed was to have been placed in the low position. Observation on 10/31/23 at 4:54 p.m. revealed resident 39 was lying in her bed with the bed was not in the low position setting and the floor mat not in place. *Interview on 11/02/23 at 3:31 p.m with CNA II regarding resident 39 revealed: *CNA II stated that when they placed the floor mat by the bed, after some time they would find it moved away from the bed. CNA II stated that staff believed that the resident was moving the floor mat because she did not like it and could not get to her tray when the floor mat was placed next to the bed. *When asked if the bed should have been in the low position, CNA II stated yes and then lowered	F 689		

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the residents' bed into the correct position.

Interview on 11/03/23 at 3:09 p.m. with licensed practical nurse (LPN) unit manager M revealed:
*CNAs would use the Kardex and the rounding sheet to know how to provide care and implement interventions for the residents.
*They do not use the floor mat for resident 39 anymore because the resident would move the floor mat, and that was determined to have been a safety concern.

Review of resident 39's 9/27/23 care plan revealed that the floor mat placed next to the bed was still an intervention but the Kardex and not listed the use of the floor mat of the bed in low position.

Observation on 11/06/23 from 11:16 a.m. through 1:49 p.m. with resident 39 revealed she was lying in her bed with the bed in the regular position.

Observation on 11/08/23 at 3:50 p.m. revealed resident 39 with bed not in the regular position. The resident was lying in bed with her head leaning over the side of the bed. A CNA was informed of her current position.

Observation on 11/08/23 at 5:25 p.m. revealed resident 39 was lying in her bed with the bed in the regular position.

Review of fall management policy revealed:
*The procedure for fall management was to assess and review resident's risk factors for fall and injuries upon admission, with a significant change in condition, quarterly, annually or after a fall. The procedure also listed steps to implement goals and interventions based on individual needs

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F 689	Continued From page 103 and identified risks and to communicate those interventions to the caregiving teams. The process of how to update and communicate interventions was not detailed in the policy. Interview with DON B and LPN/Unit Manager J revealed: *Unit managers were responsible to document interventions into the care plan. *Resident Kardex, rounding sheet, and shift change stand up reports were how resident conditions changes were communicated on the care plan. D. Based on observation, interviews, record review and policy review, the provider failed to implement interventions for one of one sampled resident (87) to reduce the risk of the ingestion of hand sanitizer who had a known history of ingesting hand sanitizer and a known history of alcohol dependency. Findings include: 1. Interview on 11/2/23 at 2:55 p.m. with DON B revealed: *On 10/04/23, DON B was approached by Nurse Practitioner (NP) JJ regarding concerns that resident (87) was showing signs of intoxication. NP JJ reported to DON B that resident (87)'s eyes were red and glossy, smelled like alcohol, and was acting strange. *After being notified of resident 87's condition, DON B entered resident's room and found that resident was lethargic, slurring his words, and was unable to keep eyes open. *While in residents' room, DON B noticed an empty bottle of hand sanitizer in the trash can. *When asked by staff, resident 87 denied drinking the hand sanitizer.	F 689		

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F 689	Continued From page 104 *The hand sanitizer bottle that was found in the trash can was a 250 ml bottle of Instant Hand Sanitizer with aloe and vitamin E. *Poison control was contacted, and it was recommended that the resident be transferred to the hospital and testing for methanol be completed due to certain hand sanitizers having contamination. *DON B stated that emergency medical services (EMS) were called and that resident 87 denied drinking the hand sanitizer to the EMS staff and resident stated he used it to wash his hands. Resident 87 refused to go to the hospital. *DON B stated that resident's medical provider was notified of the refusal to go to the hospital and *DON B received orders to educate and monitor the resident. *DON B reported that he educated resident 87 regarding the recommendations of poison control. The resident again denied drinking hand sanitizer and stated he used it to wash his hands. He again refused to be transported to the hospital. Resident was monitored for the rest of the night with no issues. *DON B stated that all bottled hand sanitizer had been removed from the facility and replaced with sanitizing hand wipes. Observation on 11/8/23 at 10:07 a.m. revealed a bottle of hand sanitizer sitting at the central nurse's station. Interview on 11/8/23 at 10:07 a.m. with RN L revealed that RN L was aware of resident 87 ingesting hand sanitizer but stated that residents don't come back behind the nurse's station. Interview on 11/8/23 at 10:30 a.m. with DON B and nurse consultant HH revealed:	F 689		

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*The only brand of hand sanitizer that was removed from the facility was the brand that was ingested by resident (Instant Hand Sanitizer with aloe and vitamin E). All other liquid hand sanitizer is still available and being used.
*DON B states they only removed the Instant Hand Sanitizer with aloe and vitamin E because poison control stated if may be contaminated with methanol.
*DON B could not tell me if the hand sanitizer discovered on the central nurse's station was contaminated with methanol.
*When asked what would staff do if a resident ingested the bottle of hand sanitizer that was found at the nurse's station, nurse consultant HH stated they would call poison control.
*Informal training regarding the removal of hand sanitizer was completed for all staff at shift change for approximately a couple weeks after the incident, but nothing is in place for ongoing training of new staff or temporary staff after that.
*Staff are allowed to carry person bottles of hand sanitizer but no facility specific training or policy in place to let staff know of the risk of ingestion by residents.
*Nurse consultant HH and DON B agreed that there is still a potential risk for resident to ingest hand sanitizer.

Interview on 11/9/23 at 10:25 a.m. with social services designee (SSD) Q revealed:
*Resident 87 was assessed, and she was aware of the resident's alcohol related accident and history of alcohol dependence.
*SSD Q stated that she noted this in his admissions assessment on 10/1/23.
*Care plan interventions for resident 87 regarding substance abuse and chemical dependency were updated after the resident's ingestion of hand

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AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 689	Continued From page 106	F 689		

sanitizer to include social services to meet with resident weekly.
*When asked if any interventions were completed to ensure the resident did not ingest hand sanitizer, social services coordinator stated that staff completed a training regarding the removal of the hand sanitizer concerning resident 87.

Review of resident 87's 10/11/23 care plan revealed:
*"Focus:
-"SUBSTANCE ABUSE/CHEMICAL DEPENDENCY DISORDERS The resident has a history of substance abuse/chemical dependency Attempting to refuse blood or urine testing. On-going self-harmful/self-destructive behavior i.e., ingesting hand sanitizer for alcohol content."
*"Interventions:
-"Continue to offer resident support services through Mental Health Counseling and/or AA, currently declining services."
-"Implement increasingly restrictive interventions in an effort to help the resident break addictive cycle. Interventions may include: supervision while in the community, restricted independent pass privileges, implementation of money guidance and budget controls to reduce/prevent access to substances."
-"Meet with the IDT to discuss the extent of the resident's illness. The physician may consider a referral to the psychiatrist and/or write an order restricting "pass privileges."
-"Social Services or designee to meet with resident weekly."
*Review of resident 87's 10/11/23 care plan revealed that there were no interventions developed regarding the removal of hand sanitizer bottles in resident's environment regarding the risk of resident ingesting hand

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F 689	Continued From page 107 sanitizer. Review of providers 09/2019 care planning policy revealed: *"Care plans are accessible to all direct-care staff, including the resident's physician/nurse practitioner. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes." *"Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur."	F 689		
F 692 SS=E	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692	F692 Nutrition/Hydration Status Maintenance Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Whys 1. Process owner 2. No established system to document supplements. 3. No follow up to ensure resident consumed supplements. 4. Not entered correctly in orders to complete documentation effectively. 5. Supplements dispersed by dietary versus nursing. 1.Residents 6 and 193 are receiving their nutritional supplements as ordered and the amount of supplement consumed is being recorded in the medical record. Resident 26's supplement was discontinued on 11/16/2023 per resident request.	12/07/2023

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F 692	Continued From page 108 Based on observation, interview, record review, and policy review, the provider failed to ensure three of three sampled residents (6, 26, and 193): *Received nutritional supplements as ordered and/or recommended for weight loss prevention and wound healing. *Had amounts of the nutritional supplement documented in their medical record. Findings include: 1. Observation and interview on 11/2/23 at 9:44 a.m. of resident sitting up in her bed revealed: *She had an thin, frail appearance. *She would get up at 11:00 a.m. for lunch. Review of resident 6's electronic medical record (EMR) revealed: *On 7/30/23 her recorded weight was 164 pounds. *On 10/30/23 her record weight was 143 pounds which is a -12.80% weight loss. * On 8/15/23 a physician's order had been obtained for ensure plus or boost 8 ounces (oz) to be given three times per day with meals. *She had weight warning progress notes on the following days: -8/4/23 current weight was 164.0 the resident's son, provider and dietitian had been notified of the weight loss due to poor appetite. -8/14/23 current weight was 163.0 an update had been sent to the dietitian. -8/30/23 current weight was 141.0 the dietitian had been notified and will await any recommendations. -9/4/23 current weight was 144.0 weekly monitoring and dietitian is following the resident and her family had been re-educated on hospice. -9/7/23 current weight was 143.0 weekly	F 692	All residents taking a nutritional supplement are at risk. Supplements scheduled for between meals to be administered and documented by nursing as percentage consumed. All residents are receiving their ordered supplements and amount consumed is being recorded. 2. DON or designee will educate Nursing staff on nutritional supplement documentation reflecting the supplement being given and the amount being consumed no later than December 7, 2023. Those staff not present for education sessions will be educated prior to their first shift worked. 3. The DON or Designee will audit 5 random residents taking a supplement to ensure the amount consumed is documented. The audits will be weekly x 4 weeks and then monthly x 2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 692	Continued From page 109	F 692		

monitoring and dietitian notified.
-9/11/23 current weight was 145.0 weekly monitoring.
*She had been evaluated by the registered dietitian (RD) on the following days:
-9/20/2023 had reviewed the resident's weights and the percentage of meal intake which had been 50-75%.
--Recommendation to continue supplement of Ensure/Boost 8 oz three times per day.
-10/31/23 had reviewed the resident's weights and percentage of meal intake which had been 50-100%.
--Recommendation to continue supplement of Ensure/Boost 8 oz three time per day. Resident accepts the nutrition supplement well, but occasionally does not finish it.

Review of resident 6's care plan initiated on 2/21/22 revealed:
*"Focus: is at risk for alteration in nutritional status related to poor appetite, a therapeutic and mechanically altered diet."
*"Goals: would like to keep her weight in the 150 pound plus or minus 5 pounds range through the next review date."
*"Interventions: can eat independently, but likes her food close to her on her lap. Monitor resident for difficulty of chewing or swallowing, assess for signs of choking and or aspiration.
Obtain weight monthly on the 7th. Report significant change to physician. Provide diet as needed."
*Had not mentioned her nutritional supplement of Ensure/Boost 8 oz three times per day.

Interview on 11/6/23 at 9:37 a.m. with licensed practical nurse (LPN) D regarding resident's house supplements revealed:

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F 692	Continued From page 110 *Dietary would have given the house supplement at meal time and then documented the amount taken. *She would have documented the amount of cubic centimeters (ccs) that dietary had recorded on the medication administration record (MAR). *Nursing staff would not have given the supplement, but they would have signed off that it had been given on the MAR. Interview on 11/6/23 at 9:38 a.m. with dietary aide FF and dietary manager N regarding the documentation of supplements provided to the resident's revealed: *They would have documented the amount of fluids taken at that meal time. *They had not documented the amount of supplement taken separately from all the other fluids taken in at that meal time. Interview on 11/6/23 at 9:50 a.m. with LPN D regarding the amount of supplement that had been recorded by dietary revealed: *She had not been aware that amount of fluids documented included all the fluids at that meal time. *She agreed that the documented fluid amount on the MAR had not indicated the specific amount of the supplement taken. Interview on 11/6/23 2:57 p.m. with RD DD and with regional certified dietary manager (CDM) EE regarding the documentation of amount of supplement taken in at meal time revealed: *They would have expected the nursing staff to document the amount of supplement the resident had taken. *RD DD agreed that they do not have a way to document the amount of supplement that had	F 692		

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F 692	Continued From page 111 been taken separately and to monitor the effectiveness of the intervention. Interview on 11/6/23 3:51 p.m. with director of nursing (DON) B regarding nursing staff signing off administration of supplement that wasn't given by them revealed: *Staff should not have been signing off tasks that they had not performed. *Agreed that they would not have an accurate way to assess if the intervention is working or not without an accurate amount of the supplement that had been taken by the resident. Observation and interview on 11/9/23 at 9:00 a.m. with resident 6 regarding her breakfast meal revealed: *She had eaten 75-100% her breakfast. *She had not been provided a house supplement of Ensure/Boost 8 oz. Review of resident's MAR on 11/9/23 revealed: *The Ensure/Boost 8 oz to be given three times per day had signed off as given for breakfast. Review of the provider's undated Weight Management Guidelines revealed: *"Nursing should notify the physician and family of significant or severe weight loss." *"All planned, unplanned, and unavoidable weight loss should be care planned and have nutritional goals and approaches. The RD, resident and family must approve planned weight loss." *"follow Best Practice guidelines for interventions. Obtain the resident's preferences regarding interventions and individualize. Try food first." 2. Interview on 11/6/23 at 3:52 p.m. with DON B revealed:	F 692		

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F 692	Continued From page 112 *He agreed resident 193 was to have received eight ounces of a nutritional supplement daily. *Nursing documented the resident received the nutritional supplement. *Nursing documentation was based off of what dietary had documented on the intake record. *The amount of the nutritional supplement and other fluids the resident received were not recorded as separate entries in the intake record. Observation and interview on 11/8/23 at 9:30 a.m. dietary aide (DA) S revealed: *She was documenting the what the residents had eaten and drank. *DA's document the percentage of what was eaten and amount of fluids drank. *The fluids the resident drank included any nutritional supplement they were supposed to receive. *She stated the CNAs document what the assisted dining residents ate and drank. Interview on 11/8/23 at 9:45 a.m. with CNA P revealed she had assisted resident 193 with his breakfast this morning, He had not received any nutritional supplement to drink. 3. Observation and interview on 11/8/23 at 8:25 a.m. with resident 26 at breakfast in the dining room revealed: *She had no supplement on her table. *She did not get a supplement this morning. Interview on 11/8/23 at 8:25 a.m. with dietary manager N revealed: *She refuses it, she doesn't like it and pushes it away. *She had not documented it in her progress note.	F 692		

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F 692	Continued From page 113 Record review on 11/7/23 at 2:52 p.m. resident 26 revealed house supplement amounts consumed were not recorded on her medication administration record.	F 692		
F 725 SS=H	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure	F 725	Root Cause Analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plans Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Why's 1. Agency utilization 2. Lack of orientation/competencies 3. Lack supervision/oversight 4. Lack of education 5. Inadequate data collection for grievance resolutions A. Accurate Information provided to staff about each resident's transfer equipment needs 1. Resident 1, 9, 24, 32, 33, 60, 77, 79, 244 have had their transfer status evaluated and updated. All residents who use a mechanical lift at risk for improper transfer technique. All nursing staff (including agency) have completed competency on mechanical lifts and slings. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate assessment and use of mechanical lifts; Individualized care	12/07/2023

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F 725	Continued From page 114 sufficient nursing staff to provide care or complete/accurate documentation for 41 of 54 residents reviewed during the survey (1, 3, 5, 6, 7, 9, 10, 11, 12, 19, 23, 24, 26, 28, 32, 33, 36, 37, 38, 39, 46, 53, 58, 60, 62, 64, 67, 71, 72, 73, 74, 75, 77, 79, 81, 84, 87, 91, 193, 244, and 253). The census of the facility was 95 at the time of the survey. These failures placed residents at risk for unmet care needs and negative outcomes. Findings include: 1. The provider failed to ensure staff were provided with accurate information about each resident's transfer equipment needs, including sling size, and were competent to safely use the mechanical lift equipment for nine of twelve sampled residents (1, 9, 24, 32, 33, 60, 77, 79, 244). Refer to F689 Base A. 2. The provider failed to ensure staff provided adequate supervision, appropriate interventions, and adequately understood the door exit system to prevent unwitnessed elopements for two of two sampled residents (10 and 55). Refer to 689 Base B. 3. Interview on 10/31/23 at 10:30 a.m. with resident 6 regarding call light response time revealed: *It had taken an hour and an half [90 minutes] one time to answer her call light. *Staff would have answered her light then would have returned later to help her. Interview on 11/6/23 at 10:10 a.m. with sixteen residents (5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who attended resident council meetings replied with the following:	F 725	plan that is accurate and relevant for resident(s). Education and competencies provided by DON or designee to all nursing staff on 10/31/23 or prior to next shift worked. 3. Administrator or designee will review staffing each business day morning to ensure adequate staffing levels. On call nurse will manage off hour staffing concerns. Audits will be weekly x 4 weeks and monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits. B. Supervision, appropriate interventions, and understanding the door exit system to prevent elopement. 1. Resident 10 is being supervised for exit seeking behavior. Resident 55 has been transferred to another skilled nursing facility on 11/23/2023. Resident 6's call light is being answered timely. All residents identified as exit seeking having the potential to elope are at risk for lack of supervision. All nursing staff (including agency) have completed competency wander guard/door policy. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate risk assessment and adequate planning for safety of those identified for elopement;	

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F 725	Continued From page 115 *When asked if the residents received the help and care they needed without waiting a long time, the residents stated, -"Call light buttons are not being answered. -"It can be 3-4 [three to four] hours at night. -"The staff "stick their hand through the doorway and turn off the call light and walk away." *When asked about receiving snacks at bed time or when requested, the response was "No." Refer to F809. *When asked if they felt the rights of the residents were respected and encouraged, the response was "No." Examples provided by the residents included: -Not receiving timely meal trays when choosing to eat in the resident's room. -Not getting a bath or shower when requested, and having to take a bath or shower when staff "offer to do it" or it would be "marked as a refusal." -Not getting enough opportunities to do restorative exercises. -Tired of being asked every shift if the resident had a bowel movement during the day when they should know because they had to help the resident use the toilet. Refer to F561 Review of the handwritten Resident Council Minutes for six months revealed concerns related to nursing services had been reported as follows: *On 6/14/23: -Call lights: "Staff will shut off light and not come. Sometimes not getting them [bathes]." -Nursing: "sometimes nurses dont [do not] help if CNA [certified nursing assistants] not around." -Snacks: "Feels staff ignor [ignore] snacks - not getting." -Therapy: "would like one more restorative.	F 725	Individualized care plan that is accurate and relevant for resident(s). Education provided by DON or designee to all staff on 11/7/2023 or prior to next shift worked. 3. Administrator or designee will review staffing each business day morning to ensure adequate staffing levels. On call nurse will manage off hour staffing concerns. Audits will be weekly x 4 weeks and monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits. C. Call light Response/Resident rights respected. 1. Resident 5,6, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 64, 67, 71, 73, 74, 81, call lights are being answered timely, meals and snacks being offered timely has been determined through audits. All residents are at risk for lengthy call light wait times, not having timely meal delivery, not being offered HS snacks. Implement new resident council minutes format to optimize resident council meeting times and cover more areas. Educate residents on new format and grievance process on 11/29/2023. All residents will be asked on menu preferences daily for the next day's menu. Condiments will be placed on tray carts for room trays. Room trays will be served out of each respective dining room. If resident is unavailable room tray will be held until resident is available. MOD schedule modified and implemented to cover into the evening hours to ensure HS snacks are offered. All residents with Grievances will be reviewed for last 30 days to ensure thorough	

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F 725	Continued From page 116 Walking programs - sometimes not happening." *On 7/12/23: -Call lights: "Still shutting call light off and not answering, staff visiting at station instead of answering call lights." and -Nursing: "some [staff] good, some not so good - set at desk, grumpy." -Snacks: "Some [residents] state [they are] getting (East) [snacks], some [residents] state [they are] not getting." *On 8/9/23: -Call lights: Under "Resolved" column - "better, but still some"' -Nursing: "would like to walk outside of therapy - restorative." *On 9/13/23: -Call lights: "Same concerns - too long. Shutting light off and not returning" -Nursing: "some say they [staff] are going to do something - didn't come back." *On 10/11/23: -Activities: "snacks [-] if [activity coordinator C] not here dont [do not] always get done." -Call lights: "Still issue [,] turn off and waiting long times over an hr [hour]. Residents are missing activities cause of it." -Kitchen: "Late w/meals [with meals] - room trays, nurses aides not willing to warm up food." -Nursing: "Nurses & [and] aides [CNAs] still issues with saying come back and dont [do not]. "Snacks at night late. Issues with water pass during day." Refer to F565. Interview on 11/06/23 at 9:03 a.m. resident 64's response to call lights revealed: *CNA not very good, she stands outside my door but doesn't come in to help me. *No shower since last Friday	F 725	investigation and resolution per Grievance policy. Reviewed and revised Dining room services policy. Facility has an active recruitment and retention plan: jobs posting on various websites/online recruiters/job postings, job opening discussed during morning meeting, sign on bonuses, referral bonuses, and pick-up bonuses. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Fall risk and management; Those residents who may be at risk for abnormal ingestion practices related to history; Resident choice and mitigating resident grievances. Education provided by DON or designee to all staff on grievance policy and procedure, meal preferences and condiments placed on room tray carts for room trays, room trays to be served out each respective dining room, trays not delivered when resident is not available, bowel movements, bathing, restorative exercises to be completed by December 7, 2023. Managers educated by Administrator on new MOD expectations by December 7, 2023. Resident council education provided to Administrator, Social Services Designee, Activities Director. 3. Administrator or designee will review staffing each business day morning to ensure adequate staffing levels. On call nurse will manage off hour staffing	

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AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 725	Continued From page 117 *No help here, no shower given on Monday. Observation and interview on 11/06/23 at 11:04 a.m. with CNA W from Clipboard Health-while transferring resident 64 revealed: *CNA W had picked up shifts the last two months. *Did not get orientation. *She learns as she goes. Interview on 11/8/23 at 2:20 p.m. RN F revealed: * Responsible for 23 or more residents,. *One nurse in the building on night shift when another nurse goes home sick,. *One nurse is responsible for 17 skin assessments, medication administration, physician orders, CNA's and phone calls. Interview on 11/6/23 at 4:48 p.m. with Administrator (ADM) A revealed they have been conducting call light audits since call light reports are not available with the call light system in the building. Review of fifteen (15) call light audit forms provided by ADM A completed between July 18, 2023 and November 5, 2023 revealed: *The quantity of audit forms did not meet the expected "Instructions" stated on the form, "Daily x [times] 4 weeks." *Call light observations recorded 61 times included: -36 observations were noted with a.m. (morning) times. -3 observations were noted as p.m. (afternoon) times. -22 observations did not specify whether the observations were a.m. or p.m. *Recorded room locations included 4 on Warren (100 rooms), 28 on Center (200 rooms), 25 on	F 725	concerns. Audits will be weekly x 4 weeks and monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits. Facility Acquired Pressure Ulcers 1. Resident 3, 37, 39, 193, have wound intervention in place. All residents with wounds not having appropriate interventions implemented for prevention. All residents wound care plans reviewed to ensure current interventions and orders are accurate and in place. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate skin care assessment and prevention of pressure injury utilizing individualized approaches and interventions, for those with existing pressure injury or facility acquired injury, assessment reflects review of interventions for continuation or change; Individualized care plan that is accurate and relevant for resident(s). Education completed with Wound Nurse on Pressure Injury prevention, assessment of chronic wounds, residents at risk for pressure, best practices for pressure injury care	

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F 725	Continued From page 118 East (300 rooms), and 3 rooms that were not specified by room number. *Of the 61 observations, 51 observations met the criteria for the acceptable call light time of "answered in under 10 minutes." *Observations that did not meet the criteria included: -7/19/23, room 213 at 10:40 a.m. - 10:57 a.m. for 17 minutes and room 223 at 10:57 a.m. - 11:30 a.m. for 33 minutes. Comments were noted as "1:1 [one to one] caretaker hired by family had to request help" and "[staff name] on break until 10:55 a.m." -9/3/23, room 307 at 9:50 a.m. - 10:02 a.m. for 12 minutes. There were no "Comments" or "Summary of findings" recorded. -9/9/23, room 208 at 8:32 - 8:53 (a.m. or p.m. not specified) for 21 minutes. The "Summary of findings" noted, "Center aides cannot seem to work together." -9/10/23, room 329 at 8:09 - 8:37 (a.m. or p.m. not specified) for 28 minutes and 307 at 8:12 - 8:23 (a.m. or p.m. not specified) for 11 minutes. The "Summary of findings" noted, "329 took a while due to 2 CNA's in 2 assist room & 1 CNA in [resident initials] room." -9/30/23 - 10/1/23, room [resident initials] at 8:00 a.m. - 8:21 a.m. for 21 minutes. There were no "Comments" or "Summary of findings." -10/7/23, room 215 at 9:00 a.m. - [call light time turned off had a dash mark]. "Comments" noted "Aid [CNA] never shut light off." -10/28/23, room 305 at 9:39 - 9:52 (a.m. or p.m. not specified) for 13 minutes. There were no "Comments" or "Summary of findings." -11/4/23 - 11/5/23, room 230 at 9:05 - 9:30 (a.m. or p.m. not specified) for 25 minutes and room 208 at 9:02 - 9:12 (a.m. or p.m. not specified) for 10 minutes, and room 317 at 5:38 -5:51 (a.m. or	F 725	plans, Moisture Associated Skin Damage, partial and full thickness wounds, wound identification, documentation, and pressure injury staging on 11/28/2023 and 11/29/2023. All nursing staff will be educated on ensuring interventions are being followed and timely completion of skin evaluations and skin alteration assessments. 3. Administrator or designee will review staffing each business day morning to ensure adequate staffing levels. On call nurse will manage off hour staffing concerns. Audits will be weekly x 4 weeks and monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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F 725	Continued From page 119 p.m. not specified) for 13 minutes. There were no "Comments" or "Summary of findings." Interview on 11/9/23 at 10:40 a.m. with ADM A and review of "Weekend MOD [manager on duty] Checklist," MOD schedule, and November 2023 "On Call" nurse schedule revealed: *The MOD is expected to be in the building for three to four hours on the weekend, and should include being present for at least one meal. *The MOD is also on call for the weekend. *The on call nurse is scheduled to be the "evening manager" on weekdays in the building through the evening shift change and available every weekend. *The MOD checklist listed "general duties" to be addressed included: -Any staffing issues -Door alarms working -Wanderguard system working -Any customer complaints -Meals served timely (7:15 a.m., 11:15 a.m., 5:15 p.m.) -Ensure water pass occurs (10:00 a.m., 2:00 p.m., 10:00 p.m.) -Snack pass (2:00 p.m., 8:00 p.m.) -Call lights answered timely (Less than 5-8 minutes) 4. The provider failed to ensure interventions that had been put in place were consistently implemented and documentation was consistent for four of four sampled residents (3, 37, 39, and 193) who developed pressure ulcers after admission to the facility. Refer to F686. Review of the provider's Facility Assessment revealed: *It had updates of 10/23/22, 4/16/23, 6/30/23, and	F 725		

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F 725	Continued From page 120 7/13/23. *It had been reviewed with the quality assurance/performance improvement (QAPI) committee on 10/25/22 and 8/16/23. *Staff that had been involved in completing the assessment included: Administrator A, DON B, Governing Body Representative/regional director of operations, medical Director social service designee Q, business office manager H, dietary manager N, licensed practical nurse/unit managers J, M, and Y, human resource director GG, and Minimum Data Set coordinator E. *The provider is licensed for 110 residents with an average daily census of 90 residents with approximately 15% being short-term residents (13-14 residents). *Pertinent facts considered when determining staffing and resource needs are the residents sleep schedule, bathing schedule, dietary needs, weekend activities, community outings, and religious preferences. "Based on the provider's resident population and resident needs for care and support, their approach to staffing was ensure they had sufficient staff to meet the needs of the residents at any given time and to simultaneously meet the requirements of Centers for Medicare and Medicaid Services regulations F725, F741, F802, and F839. their staffing plan included: -One full-time DON." -"The ratio of registered nurses (RN) and LPNs to certified nursing assistants (CNA) shall be sufficient to assure professional guidance and supervision in the nursing care of the residents. Facility retains sufficient staffing to maintain a 24-hour licensed nurse (8-hours are a RN, 7 days a week)." -"CNAs and Restorative Aides [RA] are scheduled based on resident needs and current census.	F 725		

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F 725	Continued From page 121 The typical staffing level for each shift as follows: --CNAs and RAs: Day shift 9-10 scheduled Night shift: 5-6 scheduled. --CNAs and RAs are scheduled for 12, 8, or 4 hours shifts. --Qualified Medication Aides (QMA) are scheduled to support the nurses and CNAs. QMAs are scheduled 12, 8, or 4 hour shifts. QMAs are scheduled 1-3 per day depending on resident needs and current census." -"The facility provides enough support personnel to safely and effectively carry out the functions of the food and nutrition service. The minimum staffing consists of one cook and one dietary aide per meal. Based upon the licensed occupancy , the Dietary Manager may serve as a member of the line staff to meet this requirement." Interview on 11/9/23 at 1:31 p.m. with DON B and RNC HH revealed they agreed there was a need to address sufficient staffing and competencies related to the repeated pattern of concerns of timeliness to call lights and room trays and snack delivery. Refer to F561, F565, F802, and F809.	F 725		
F 726 SS=H	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726	Root Cause Analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plans Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Why's 1. Per diem staff- short time frame between shift pick ups 2.Management not notified of short shift pick ups 3. Agency Utilization 4. Orientation lacking required components.	12/07/2023

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F 726	Continued From page 122 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of provider policy and Facility Assessment, the provider failed to ensure nursing staff were verified as competent to perform tasks in accordance with the provider's policies prior to performing them and had adequate knowledge and access to resident information to meet resident needs for 41 of 54 residents reviewed during the survey (1, 3, 5, 6, 7, 9, 10, 11, 12, 19, 23, 24, 26, 28, 32, 33, 36, 37, 38, 39, 46, 53, 58, 60, 62, 64, 67, 71, 72, 73, 74, 75, 77, 79, 81, 84, 87, 91, 193, 244, and 253). Findings include: 1. Interview on 10/31/23 at 5:32 p.m. with director of nursing (DON) B revealed: *When asked how they verified the competencies of agency staff, he replied, "Good question."	F 726	5. Lack education and competencies for house nursing and dietary staff. 1. All deficient practices cited have been corrected. All residents are at risk to not have sufficient nursing staff with the appropriate competencies to provide nursing and related services. Implemented Huddle policy on 11/08/23. Transitioning short-term per diem agency staff to extended contracted staff for continuity of care. Implemented new orientation packet and competencies for new contracted staff. All nursing staff (including agency) have completed competency on mechanical lifts. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate assessment and use of mechanical lifts; Appropriate risk assessment and adequate planning for safety of those identified for elopement; Fall risk and management; Those residents who may be at risk for abnormal ingestion practices related to history; Appropriate skin care assessment and prevention of pressure injury utilizing individualized approaches and interventions, for those with existing pressure injury or facility acquired injury, assessment reflects review of interventions for continuation or change; Resident choice and mitigating resident grievances; Adequate notification to ombudsman of resident transfer and bed-hold policy at time of transfer; Individualized care plan that is	

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F 726	Continued From page 123 *He understood that agency staff who picked up shifts through the [name of agency] app (an electronic recruitment and scheduling app) were "their own independent contractor." *The agency app made it possible for agency staff to pick up a shift on a moment's notice. *He confirmed there was a need to determine how they would verify competencies at the time the agency contractor showed up for the shift they picked up. Observation and interview on 11/6/23 between 6:00 p.m. and 6:30 p.m. at East nurses desk, with dietary manager (DM) N while room trays were being delivered, revealed: *A cart with wheels was setting across from the nurses desk with mugs on the top tray of the cart that were filled with water. *When asked about the mugs -Agency certified nursing assistant (CNA) KK replied that she did not know the reason for the cart of water mugs. She explained this was the second day she had worked there. -Agency licensed practical nurse (LPN) LL replied she had not been aware the cart was there. She confirmed it looked like the water mugs were new since there were no straws in them. -DM N confirmed the water mugs had been filled by dietary staff for the 3:00 p.m. water pass, and it appeared they had not been passed. Observation and interviews on 11/9/23 between 8:45 a.m. - 9:10 a.m. revealed: *An overhead announcement was heard for "all staff to Center for daily huddle." *Housekeeping supervisor AA confirmed the routine practice had been for daily "stand-up" in the conference room for managers followed by an "all staff huddle" at Center during the weekdays.	F 726	accurate and relevant for resident(s); Medication administration following physician order(s); Nutritional supplement documentation reflects being given and the amount being consumed. Education provided by DON or designee to all staff on grievance policy and procedure, meal preferences and condiments placed on room tray carts for room trays, room trays to be served out each respective dining room, trays not delivered when resident is not available, to be completed by December 7, 2023. Managers educated by Administrator on new MOD expectations by December 7, 2023. Resident council education provided to Administrator, Social Services Designee, Activities Director. Education completed with Wound Nurse on Pressure Injury prevention, assessment of chronic wounds, residents at risk for pressure, best practices for pressure injury care plans, Moisture Associated Skin Damage, partial and full thickness wounds, wound identification, documentation and pressure injury staging on 11/28/2023 and 11/29/2023. All nursing staff will be educated on ensuring interventions are being followed and timely completion of skin evaluations and skin alteration assessments. 3. DON or designee will audit 5 random Nursing staff (including agency) for completed orientation and competencies weekly x 4 weeks, then monthly x 2. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits.	

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F 726	Continued From page 124 *LPN/unit manager J reported that ADM A prepared the daily huddle information on a typed sheet, staff would sign-off on the "Staff In-Service Sheets," and that information and the sign off sheets were kept in a binder at the Center nurses desk. *LPN/unit manager Y reported the daily huddle "today was earlier than usual" and it worked better when the breakfast meal was done. Interview on 11/9/23 at 9:19 a.m. with DON B revealed: *The Daily Stand Up Meeting sheet was reviewed during the daily huddles on weekdays. *Nursing department staff used the unit sheets that listed the residents in two columns for shift to shift report. Review of the unit sheets for East and T-Wing revealed the only resident specific information listed included each resident's advance directive code status and the assistance and equipment needs for transferring each resident between surfaces. Review of daily huddle reports for two weeks from the Center binder revealed "Staff In-Service Sheets" with signatures and "Daily Stand-Up Meeting" typed sheets that included the following topics: *10/26/23 Night shift, topics: admissions, discharges, room and dining changes, resident appointments, MDS [Minimum Data Set] interviews due and care conferences, influenza vaccine, dining room to chart meals, bathing preferences, sling and Hoyer [mechanical lift] use *10/30/23 at 10:00 a.m., topics: admissions, discharges, room and dining changes, resident appointments, MDS [Minimum Data Set]	F 726		

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F 726	Continued From page 125 interviews due and care conferences *10/30/23 NOC [night] shift, topics: Hoyer [mechanical lift] use, bath preferences, and walkie-talkies. *10/31/23 at 10:00 a.m., topics: discharges, pending admissions, room and dining changes, resident appointments, MDS [Minimum Data Set] interviews due and care conferences, and a separate typed page that listed 6 bulleted items: 1 bullet addressed a specific resident, 2 bullets addressed operational topics, 1 bullet addressed a policy, and 2 bullets addressed care needs including, "Please attempt to complete some baths today per schedule." *11/8/23 at 6 p.m., topics: discharge, change of conditions, and "Misc" [miscellaneous] that included elopement and Wanderguard training, mechanical lift training, new flooring being installed on East . *11/9/23 with no time listed, topics: discharge, room and dining changes, resident appointments, care conferences, risk events, change of conditions, and the same "Misc" [miscellaneous] as 11/8/23 with the addition of "Fire Watch initiated this morning." Interview on 11/9/23 at 9:37 a.m. with ADM A confirmed there were gaps in the daily huddle documentation because "we were doing one on one trainings related to the survey team findings." Interview on 11/9/23 at 1:31 p.m. with DON B and regional nurse consultant (RNC) HH agreed there was a need to address sufficient and competent staffing in nursing and/or dietary. Review of the Facility Assessment, last updated on 7/13/23 and last reviewed by the QAPI (quality assurance and performance improvement)	F 726		

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F 726	Continued From page 126 committee on 8/16/23, revealed: *Purpose: "The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies...Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical., and psychosocial well-being." *Guidelines for Conducting the Assessment: "4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions." *"Part 1: Our Resident Profile:" -"1.1. Licensed number of residents: 110 total with possibility of 110 maximum." -"1.2. Average daily census: 90 residents, of which approximately 15% [percent] are short-term." -"1.5. Major Rug-IV [resource utilization groups-four] Categories that give an overall picture of acuity levels." --"Major Rug-IV Categories:" Percent of population Rehabilitation: 19%, Extensive Services 47%, Special Care 32%, Clinically Complex 34%, Behavioral Symptoms and Cognitive Performance 35%, Reduced Physical Function 98%. --"Special Treatment and Conditions:" number of residents with behavioral health needs - 17 --"Assistance with Activities of Daily Living:" number of resident needing assist of 1-2 staff plus dependent for "transfer" 73 + 6 = 79, "toilet use" 79 + 3 = 82. -"1.6. We strive to maintain a respectful and	F 726		

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F 726	Continued From page 127 neighborly environment for our staff and residents. in response to this diversity, we strive to maintain activities, traditions, meals, and an environment that is reflective of many cultures...We strive to ensure residents have a choice in their activities of daily living. Our dietary staff regularly solicit input from the resident council regarding menu and food preparation." -"1.7. Other pertinent facts we consider when determining staffing and resource needs are our resident's sleep preferences, bathing schedules, dietary needs, weekend activities, community outings and religious preferences." *"Part 2: Services and Care We offer Based on our Residents' Needs" -"Activities of daily living: bathing, showers...eating, support with needs related to hearing/vision/sensory impairment, supporting resident independence..." -"Mobility and fall/fall with injury prevention: transfers, ambulation, restorative nursing..." -"Skin integrity: pressure ulcer prevention and care, skin care, wound care...with repositioning, w/c [wheelchair] cushions and pressure relieving mattresses." -"Mental health and behavior: manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individual with depression, trauma/PTSD [post traumatic stress disorder]..." -"Nutrition: individualized dietary requirements, liberal diets, specialized diets...culture or ethnic dietary needs..." -"Provide person centered/directed care: --"Build relationship with resident/get to know him/her; engage resident in conversation."	F 726		

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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 726	Continued From page 128 --"Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process." --"Make sure staff caring for this resident have this information." --"Provide culturally competent care: learn about resident preferences and practices regarding culture and religion, stay open to requests and preferences and work to support those as appropriate." --"Identify hazards and risks for residents." *"Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies" -"3.1. The following is a list of staff/services that are typically provided for our residents. Some of these services are covered by multiple staff members..." --Nursing Services: Director of Nursing (DON), Assistant Director of Nursing, Registered Nurses (RN), Licensed Practical Nurses (LPN), Certified Nursing Assistants (CNA), Certified Medication Assistant, CCN [??] Nurse, Treatment Nurse --Food and Nutrition Services: Dietary Director, Dietary Aide, Cook, Registered Dietitian --Hospitality aide -"3.2. Staffing plan" --Licensed nurses: "DON (1 FTE [full-time equivalent])...RN or LPN charge nurse: Minimum of 2-4 [two to four] for each shift based [on] resident needs and current census. Nurses are scheduled for 12, 8, or 4 hour shifts always with no less than 2 licensed nurses on duty per shift." --Direct care staff: "The typical staffing level for each shift is as follows..." CNAs and restorative aides: "Day = 9-10 scheduled, Night = 5-6 scheduled. Nurse aides and Restorative Aides are scheduled for 12-, 8-, or 4-hour shifts.	F 726		

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F 726	Continued From page 129 Qualified Medication Aides (QMA) are scheduled to support the nurses and CNAs. QMAs are scheduled 12,8,or 4- hour shifts. QMA are scheduled 1-3 per day depending on resident needs and current census. --Dietary: "The minimum staffing consists on one cook and one dietary aide per meal. Based upon the licensed occupancy, the Dietary Manager may serve as a member of the line staff to meet this requirement." -"3.3. Avantara Norton nursing schedule is reviewed by nursing leadership on a weekly/daily basis to ensure adequate staffing and consistent assignments. Avantara Norton utilizes a consistent staffing model to coordinate staffing assignments for the facility." -"3.4. All employees complete training and competencies on the following upon hire:" --"Company policies regarding effective communication for direct care staff...problem resolution procedure...cell phones and cameras." --"Environmental Services: *hazard communication...Preventing Slips; Trips and Falls..." --"Clinical Services: ...*elopement,...caring for visually...impaired; caring for depression / delirium and dementia; *dietary and hydration needs of residents; resident rights; *person-centered care/management for persons with dementia, depression, delirium, and trauma," Interview on 10/31/23 at 3:38 p.m. with CNA X regarding her orientation for working at the facility revealed: *She had not received any orientation at the facility prior to working. *She had not completed any competency for the full-body lift use. *She stated this is her fourth time working here.	F 726		

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F 726	Continued From page 130 *She does not know where in the chart to find the resident care plans. *Rounding sheets had been provided and used as a patient care guide. Interview on 11/9/23 at 8:33 a.m. with human resource director GG regarding orientation of agency staff revealed she and staffing coordinator WW coordinated the agency staff orientation. Interview on 11/9/23 at 9:12 a.m. with staffing coordinator WW revealed: *She had been staffing coordinator since August/September 2022. *She assembled an orientation packet with an agency orientation checklist on top along with the user's EHR log-in credentials and would leave the packet at the center nurses station. *The charge nurse was responsible to have the agency staff complete the orientation packet before starting their shift. *She would then sign the orientation packet as completed and gave the packet to human resource director GG. *When asked about LPN LL's agency orientation checklist, she could not locate her agency orientation checklist. Interview on 11/9/23 at 9:56 a.m. with staffing coordinator WW confirmed that LPN LL had not completed an agency orientation checklist.	F 726		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a	F 756	Root Cause Analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plans Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are:	12/07/2023

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F 756	Continued From page 131 licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure the consultant pharmacist(s) communicated their	F 756	5 Whys 1. No process owner 2. Nurse manager turnover 3. Pharmacy consultants change over. 4. Late reviews from consulting pharmacy 5. Lack of follow through on recommendations by facility. 1. Resident 12 GDR, thyroid and lipid lab tests recommendation reviewed by physician. Resident 3 MMR has been reviewed by Physician. Resident 3's care plan and order reviewed and revised for use of Risperdal off label for dementia with behavioral disturbance. Resident 32, 33 MRR reviewed by physician. All pharmacy recommendations reviewed with medical director for the last 3 months on 11/15/2023. DON printing recommendations and dispersing to nurse unit managers for follow up, DON will maintain copy in binder for pending recommendations to ensure timely completion. All residents are at risk for not having drug regimen reviewed. 2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate communication facilitated by the facility between pharmacist and physician about medications and regimen review. Pharmacist consultant manager to educate consulting pharmacist on timeliness of the completion of the reports and/or	

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F 756	Continued From page 132 recommendations to the residents physicians. Findings include: 1. Interview on 11/8/23 at 11:35 a.m. with licensed practical nurse (LPN) unit manager J revealed she: *Had only been in her current position since June 2023. *Received the pharmacists recommendations from director of nursing (DON) B each month. *Would send the consultant pharmacist recommendations to the residents physicians and wait for the response, *Was not sure if the consultant pharmacist also sent the recommendations to the residents physicians. *Did not have responses to the consultant pharmacists recommendations for resident 12: -Those recommendations included: --A 3/13/23 request for a gradual dose reduction of a psychoactive medication. --A 7/14/23 request for thyroid laboratory tests. --A 9/10/23 request for lipid (blood test that measures the amount of certain fat molecules) due to medication use. Interview on 11/8/23 at 3:46 p.m. with DON B and Regional Nurse Consultant (RNC) HH revealed: *The consultant pharmacist sent to DON B and administrator A a report which included: -Recommendations for residents physicians. -Recommendations for nursing personnel. *DON B and the unit managers would then send any recommendations to the residents physicians. *The consultant pharmacist did not communicate of the recommendations to the residents physicians. *They were unaware the consultant pharmacist	F 756	recommendations and whom to send them to. The DON will educate Nurse Unit Managers on Pharmacy recommendation process. Education will occur no later than December 7, 2023. 3. The DON or designee will audit 5 random residents weekly x 4, then monthly x2 on the completion of medication regimen review and/or follow through with recommendations. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 756	Continued From page 133 should have sent the recommendations to the residents physicians and the provider would then follow-up on those recommendations. Review of the provider's revised December 2019 Consultant Pharmacist Reports policy revealed: *The consultant pharmacist reviewed the medication regime of each resident at least monthly. *"The findings are phoned, faxed, or e-mailed within (24 hours) to the director of nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's [active record]." *The prescriber (physician) is notified if needed. *"At least monthly, the consultant pharmacist reports any irregularities to the attending physician, medical director and director of nursing, at a minimum." 2. Interviews and observations on 10/31/23 at 4:15 p.m., 11/2 at 9:45 a.m. and at 3:40 p.m. with resident 3 revealed she: *Was in her room seated in a recliner chair watching television. *Was not able to carry on an extensive conversation during each visit, but responded to questions that indicated she had no concerns. Review of the Order Summary for Resident 3 revealed: *On 5/24/23, "Anti-anxiety Behavior Tracking-record number of episodes for agitation every shift for monitoring." *On 8/8/93, RisperDAL Oral Tablet 0.5 MG (Risperidone) Give 0.5 mg by mouth three times a day for anxiety	F 756		

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F 756	Continued From page 134 *On 9/17/23, "LORazepam Oral Tablet 2 MG (Lorazepam) Give 0.5 mg by mouth every 2 hours as needed for anxiety or restlessness related to ANXIETY DISORDER, UNSPECIFIED (F41.9)" Review of the Medication Administration Records for October - November 2023 revealed the LORazepam had not been administered. Review of a Psychotropic Drug Evaluation 1.3 dated 6/28/23 revealed a "Change in Medication" that included: *LORazepam Concentrate 2 MG/ML [milligrams/milliliter], an anti-anxiety, last administered on 6/25/23, consent was obtained and the care plan was updated/current. *RisperDAL Oral Tablet (Risperidone), an antipsychotic, last administered on 6/28/23, consent was obtained and the care plan was updated/current. *Conclusion/Narrative Summary: "resident end of life care" Review of the Medication Regimen Review (MRR) UDAs [user defined assessments] for resident 3 revealed: "See report for any noted irregularities and/or recommendations" was checked on the MRRs dated 6/16/23, 8/18/23, and 10/13/23. Request for those MRR reports revealed: *On 6/16/23, the Pharmacist Recommendations to MD form had reported, "unfortunately a diagnosis of anxiety for risperidone will not suffice for survey." The physician responded on 7/13/23 with a note, "This is being used off label for dementia with behavior disturbance. *On 8/18/23, the Pharmacist Recommendation to Nursing noted, "Resident is on hospice, but was	F 756		

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F 756	Continued From page 135 noted residents [sic] blood pressures [BPs] have been elevated; possibly due to anxiety? Is provider aware of elevated BPs?" No physician response was provided. *On 10/13/23, the Recommendation Summary Reoprt [sic] (DON/Medical Director Copy) noted, "Resident has an order for XXX with no stop dated indicated." Review of the care plan for resident 3 revealed: *Focus: "at risk for altered thought process related to dx [diagnosis] of dementia," initiated 2/16/23. -Intervention: "Give medications as ordered," initiated 2/20/23, had not been changed in light of medication changes. *Focus: "on Hospice related to a diagnosis of Severe Protein Calorie Malnutrition," initiated 8/25/23. *Focus: "taking psychotropic medication Risperdal and Lorazepam to help manage and alleviate Agitation and aggressive behavior., Anxiety," initiated 6/13/23, revised 7/29/23. *Goal: "[resident 3] will comply with the physician orders for taking psychoactive medication through hospice care," initiated 6/13/23. Review of the 10/22/23 quarterly MDS assessment for resident 3 revealed: *Her Brief Interview for Mental Status (BIMS) was scored at 03, which indicated she had severe cognitive impairment. *No behaviors, mood indicators, or reports of pain were coded on the MDS. Interview on 11/8/23 at 4:12 p.m. with DON B and RNC HH revealed DON B: *Was not aware the order for RisperDAL had not been updated based on the physician's response	F 756		

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F 756	Continued From page 136 on 7/13/23 to the 6/16/23 MRR report. *Will update the care plan regarding the use of Risperdal and Lorazepam. *Will follow-up on the physician's response for 8/18/23 MR report. *Will follow-up with the pharmacist about the "xxx" in the 10/31/23 report that was emailed to him "just today from the pharmacist." *Was not aware the Lorazepam has not been administered. *Understood that anti-anxiety medications cannot continue as an "as needed" order beyond a 14 day time frame without being re-ordered. 3. Review of the Medication Regimen Review (MRR) UDAs for resident 32 revealed: "See report for any noted irregularities and/or recommendations" was checked on the MRR dated 3/13/23. On 11/9/23 at 1:14 p.m., DON B provided a blank "Recommendations Summary (Medical Director copy). He stated, "If there was an irregularity, there isn't information to follow through. 4. Review of the Medication Regimen Review (MRR) UDAs for resident 33 revealed: "See report for any noted irregularities and/or recommendations" was checked on the MRR dated 5/13/23. Request for the MRR reports revealed, on 5/13/23, the Recommendations Summary (Medical Director copy) reported: *"Resident received sertraline 25 mg qd [every day] for depression." *"I was unable to find documentation of an	F 756		

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

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F 756	Continued From page 137 attempt or documentation of a GDR [gradual dose reduction] for this resident since admission. If no reduction attempted at this time, please document rationale for keeping current dosage." Interview on 11/9/23 at 1:20 p.m. with DON B and RNC HH revealed the MRR recommendation had not be followed through on with the physician.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758	Root Cause Analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plans Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Whys 1. No process owner 2. Nurse manager turnover 3. Pharmacy consultants change over. 4. Late reviews from consulting pharmacy 5. Lack of follow through on recommendations by facility. 1. Resident 12, 3, 33 had GDR review completed. Resident 3's medications have been reviewed by physician. Resident 3's care plan and order reviewed and revised for use of Risperdal off label for dementia with behavioral disturbance completed. Resident 33 MMR reviewed by physician. DON printing recommendations and dispersing a copy to nurse unit managers for follow up with provider(s), while DON will maintain copy in binder for pending recommendations to ensure timely completion. All residents are at risk for unnecessary psychotropic meds/PRN usage.	12/07/2023

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F 758	Continued From page 138 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure three of three (3, 12, and 33) sampled residents reviewed for unnecessary psychotropic (mood stabilizer) medications had a gradual dose reduction (GDR). Findings include: 1. Review of resident 12's consultant pharmacist monthly documentation revealed: *The consultant report indicated a recommendation had been made on 4/1/23. *The recommendations were not located in his electronic medical record. Interview on 11/8/23 at 11:35 a.m. with licensed practical nurse (LPN) unit manager J revealed she: *Was not aware of the consultant pharmacists	F 758	2. Administrator, DON, and interdisciplinary team in collaboration with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Appropriate communication facilitated by the facility between pharmacist and physician about medications and regimen review. Pharmacist consultant manager to educate consulting pharmacist on timeliness of the completion of the reports and/or recommendations and whom to send them to. The DON will educate Nurse Unit Managers on Pharmacy recommendation process. Education will occur no later than December 7, 2023. 3. The DON or designee will audit 5 random residents weekly x 4, then monthly x2 on the completion of medication regimen review and/or follow through with recommendations. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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F 758	Continued From page 139 recommendation to resident 12's physician for a gradual dose reduction of his psychoactive medications. *Received the pharmacists recommendations from director of nursing (DON) B each month. *Would send the consultant pharmacist recommendations to the residents physicians and wait for the response. Review of the consultant pharmacists 4/1/23 recommendations summary received from LPN/unit manager J on 11/8/23 at 2:30 p.m. revealed: *The recommendations summary included: -A review of the current medications he was taking. -A recommendation to his physician for a GDR of his Seroquel XR (mood stabilizer)100 milligrams (mg) every day and his escitalopram (anti-depressant) 20 mg every day. Interview on 11/8/23 at 3:46 p.m. with DON B and Regional Nurse Consultant (RNC) HH revealed: *DON B had found the recommendation in the provider's copies of the consultant pharmacists recommendations. *Confirmed the recommendation had not been sent to the provider. *The consultant pharmacist sent to DON B and administrator A a report which included: -Recommendations for residents physicians. -Recommendations for nursing personnel. *DON B and the unit managers would then send any recommendations to the residents physicians. *The consultant pharmacist did not communicate of the recommendations to the residents physicians.	F 758		

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F 758	Continued From page 140 Review of the provider's revised 3/23/23 Psychotropic Medications policy revealed: *GDR guidelines consisted of tapering the resident's daily dose to determine if the resident's symptoms would be controlled by a lower dose or to determine if the dose could be eliminated. *Residents who received any psychotropic medications, unless clinically contraindicated, would undergo a GDR. *If the psychotropic was initiated within the last year the GDR would be attempted in two separate quarters with at least one month between attempts. *If more than one year since the medication was initiated, attempt a GDR annually, unless contraindicated. 2. Interviews and observations on 10/31/23 at 4:15 p.m., 11/2 at 9:45 a.m. and at 3:40 p.m. with resident 3 revealed she: *Was in her room seated in a recliner chair watching television. *Was not able to carry on an extensive conversation during each visit, but responded to questions that indicated she had no concerns. Review of the Order Summary for Resident 3 revealed: *On 5/24/23, "Anti-anxiety Behavior Tracking-record number of episodes for agitation every shift for monitoring." *On 8/8/93, RisperDAL Oral Tablet 0.5 MG (Risperidone) Give 0.5 mg by mouth three times a day for anxiety *On 9/17/23, "LORazepam Oral Tablet 2 MG (Lorazepam) Give 0.5 mg by mouth every 2 hours as needed for anxiety or restlessness related to ANXIETY DISORDER, UNSPECIFIED (F41.9)"	F 758		

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

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F 758	Continued From page 141 Review of the Medication Administration Records for October - November 2023 revealed the LORazepam had not been administered. Review of a Psychotropic Drug Evaluation 1.3 dated 6/28/23 revealed a "Change in Medication" that included: *LORazepam Concentrate 2 MG/ML [milligrams/milliliter], an anti-anxiety, last administered on 6/25/23, consent was obtained and the care plan was updated/current. *RisperDAL Oral Tablet (Risperidone), an antipsychotic, last administered on 6/28/23, consent was obtained and the care plan was updated/current. *Conclusion/Narrative Summary: "resident end of life care" Review of the Medication Regimen Review (MRR) UDAs [user defined assessments] for resident 3 revealed: "See report for any noted irregularities and/or recommendations" was checked on the MRRs dated 6/16/23, 8/18/23, and 10/13/23. Request for those MRR reports revealed: *On 6/16/23, the Pharmacist Recommendations to MD form had reported, "unfortunately a diagnosis of anxiety for risperidone will not suffice for survey." The physician responded on 7/13/23 with a note, "This is being used off label for dementia with behavior disturbance. *On 8/18/23, the Pharmacist Recommendation to Nursing noted, "Resident is on hospice, but was noted residents [sic] blood pressures [BPs] have been elevated; possibly due to anxiety? Is provider aware of elevated BPs?" No physician response was provided. *On 10/13/23, the Recommendation Summary	F 758		

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F 758	Continued From page 142 Reoprt [sic] (DON/Medical Director Copy) noted, "Resident has an order for XXX with no stop dated indicated." Review of the care plan for resident 3 revealed: *Focus: "at risk for altered thought process related to dx [diagnosis] of dementia," initiated 2/16/23. -Intervention: "Give medications as ordered," initiated 2/20/23, had not been changed in light of medication changes. *Focus: "on Hospice related to a diagnosis of Severe Protein Calorie Malnutrition," initiated 8/25/23. *Focus: "taking psychotropic medication Risperdal and Lorazepam to help manage and alleviate Agitation and aggressive behavior., Anxiety," initiated 6/13/23, revised 7/29/23. *Goal: "[resident 3] will comply with the physician orders for taking psychoactive medication through hospice care," initiated 6/13/23. Review of the 10/22/23 quarterly MDS assessment for resident 3 revealed: *Her Brief Interview for Mental Status (BIMS) was scored at 03, which indicated she had severe cognitive impairment. *No behaviors, mood indicators, or reports of pain were coded on the MDS. Interview on 11/8/23 at 4:12 p.m. with DON B and DNP/RNC HH revealed DON B: *Was not aware the order for RisperDAL had not been updated based on the physician's response on 7/13/23 to the 6/16/23 MRR report. *Will update the care plan regarding the use of Risperdal and Lorazepam. *Will follow-up on the physician's response for 8/18/23 MR report.	F 758		

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F 758	Continued From page 143 *Will follow-up with the pharmacist about the "xxx" in the 10/31/23 report that was emailed to him "just today from the pharmacist." *Was not aware the Lorazepam has not been administered. *Understood that anti-anxiety medications cannot continue as an "as needed" order beyond a 14 day time frame without being re-ordered. 3. Review of the Medication Regimen Review (MRR) UDAs for resident 33 revealed: "See report for any noted irregularities and/or recommendations" was checked on the MRR dated 5/13/23.. Request for the MRR reports revealed, on 5/13/23, the Recommendations Summary (Medical Director copy) reported: *"Resident received sertraline 25 mg qd [every day] for depression." *"I was unable to find documentation of an attempt or documentation of a GDR [gradual dose reduction] for this resident since admission. If no reduction attempted at this time, please document rationale for keeping current dosage." Interview on 11/9/23 at 1:20 p.m. with DON B and DNP/RNC HH revealed the MRR recommendation had not be followed through on with the physician.	F 758		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments,	F 802	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are:	12/07/2023

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F 802	Continued From page 144 individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on interview, observation, review of weekly schedule for dietary, Grievance and Satisfaction Forms, Resident Council Minutes, a Resident Council Department Response Form, minutes of Kitchen Crew Meetings, provider policy, and the Facility Assessment, the provider failed to have sufficient dietary personnel to ensure timely delivery of meal room trays and snacks for twenty residents (5, 7, 11, 12, 19, 23, 28, 36, 38, 46, 53, 58, 62, 67, 71, 73, 74, 81, and two discharged residents) who reported ongoing grievances regarding timely meal and snack services. (Refer to F 809.) Findings include: 1. Interview on 10/31/23 at 10:42 a.m. with dietary manager (DM) N revealed: *The lunch meal service started at 11:15 a.m. on the Warren unit, then the Center unit, then the East unit. *The supper meal service following the same rotation and started at 5:15 p.m.	F 802	5 Whys 1. Influx of room trays need to encourage to come out to dining room. 2. Condiments not readily available for room tray service 3. Alternate menu items not always available as items are not available on truck. 4. Serving rooms trays out of center dining room versus out of each dining rooms. 5. Stocking remote kitchens prior to meals 6. Lack of follow up on Grievances and Resident council grievances. 7. Accountability of staff on all shifts 1. Residents 5, 7, 11, 12, 19, 23, 28, 36, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81 are receiving timely meals and snack services as identified through audits. No correction can be made for the 2 unidentified discharged residents. All residents are at risk of receiving untimely meals and not being offered snacks. All residents will be asked their menu preferences daily for the next day's menu. Condiments will be placed on tray carts for room trays. Room trays will be served out of each respective dining room. If resident is unavailable the room tray will be held until resident is available. Manager on Duty schedule modified and implemented to cover into the evening hours to ensure HS snacks are passed. All resident grievances reviewed for last 30 days to ensure thorough investigation and resolution per Grievance policy. Reviewed and revised Dining room services policy.	

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F 802	Continued From page 145 Observation and interview on 10/31/23 of the lunch meal service from 11:15 a.m. through 12:30 p.m. revealed: *At 11:15 a.m., in the Warren dining room, cook C dished food onto plates and a dietary aide (DA) RR served beverages and plated food. *At 11:38 a.m., licensed practical nurse (LPN)/unit manager (UM) M served room trays to a resident room on the Warren unit. *At 11:43 a.m., cook SS prepared a requested alternate grilled cheese sandwich in the Center kitchen. *At 12:00 p.m., -Cook CC was preparing to dish food onto plates in the East dining room and DA RR was serving beverages. -DA TT discovered there were no cups in the East dining room to serve coffee to a resident who had just requested some. He left to retrieve some from the Center kitchen. -At that time, DM N discovered the coffee machine had just started a cleaning cycle. DM N reported there was "no way to schedule" the cleaning cycle. She directed someone to retrieve a pot of coffee from the Center kitchen. *At 12:08 p.m., DA FF served the cup of coffee to the resident who had requested it at 12:00 p.m. *At 12:10 p.m., DA RR served the first plated food to a resident. *At 12:15 p.m., DA RR delivered plated food to a table with two residents. Restorative aide UU commented she had been offering beverages to the residents for about 20 minutes while waiting for their food. *At 12:23 p.m., cook SS "just started" setting up room trays for Center unit, and East room trays would be done next. *At 12:30 p.m., DM N reported she usually staffed "one morning cook and one evening cook," and	F 802	2. The Administrator, DON, and interdisciplinary team with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Resident choice and mitigating resident grievances. The dining room services policy was reviewed and revised. The Administrator or Designee will provide education to all staff on grievance policy and procedure before December 7, 2023. The DON or designee will provide education to nursing and dietary staff on room tray process before December 7, 2023. Education will include that residents will be served out each respective dining room and trays not delivered when resident is not available. Managers educated on new MOD expectations by Administrator before December 7, 2023. Those staff not present for education sessions will be educated prior to their first shift worked. 3. Administrator or Designee will audit meal timeliness 10 times a week at random mealtimes. Administrator or Designee will audit HS snack pass offering 3 times a week. Audits will be completed by Administrator or designee weekly x4 weeks, monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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"they work together over the noon meal." She also explained "several people [were] in training today."

Review of the weekly schedule for dietary between 10/29/23 to 11/4/23 revealed:
*One a.m. cook and one p.m. cook were scheduled on Sunday through Friday, and their schedules overlapped the noon meal.
*Only one cook was scheduled on Saturday.
*One cook that was in training was scheduled on Monday, two cooks were in training on Tuesday - Thursday, and one cook was in training on Friday.
*Three dietary aides were scheduled on Sunday and on Wednesday through Friday.
*Five dietary aides were scheduled on Monday.
*Four dietary aides were scheduled on Tuesday.
*One dietary aide in training was scheduled Monday through Friday.

Review of Grievance and Satisfaction Forms for the past six months revealed the individual resident grievances related to meals and snacks as follows (refer to F 561, finding 4):
*On 5/4/23, a resident, who was discharged at the time of the survey, reported she "waited an hour for her lunch tray which never came. She then asked for a PB&J [peanut butter and jelly sandwich] and asked for it again an hour later. At that time she was told she could have a snack because it was not a meal time."
*On 6/21/23, a resident who was discharged at the time of the survey reported she "only had 6-7 [six to seven] hot meals since she has been here."
*On 6/21/23, resident 53 reported "snack pass cart is out...have asked about it and the [they] ignore him about it. happened 6/20 night. was on the phone ignoring him. third time this has

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F 802	Continued From page 147 happened." *On 8/13/23, resident 36 who was discharged at the time of the survey, reported he was "angry that breakfast was over hour late." *On 8/18/23 at 9:20 a.m., resident 74 reported, "8 pm [p.m.] asked where supper was. Staff said they didn't [did not] know. 10 minutes later staff brought yogurt and said that was their supper. Currently [resident] does not have breakfast yet either." Interview on 11/6/23 at 10:10 a.m. during a resident group interview with sixteen residents (5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who attended resident council meetings revealed there was consensus on the following concerns (refer to F 565): *Room trays with meal items were not delivered timely to the resident rooms. *Some residents had gone without a breakfast or evening meal when they chose to eat in their rooms. *Staff had not taken the time to offer condiments or help residents with setting up the meal trays when it was served in the residents' rooms. *Preferred beverages were not always served at the same time as the meal tray. *Snack carts were delivered to the nurses' stations, but snacks were not distributed. *Residents would have to go to the cart to get a snack. Review of the handwritten Resident Council Minutes for the past six months revealed concerns regarding meal service and snacks had been reported: *On 6/14/23: -Food: "Not getting what is listed. Undercooked sometimes. Not tasty. Cold.	F 802		

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F 802	Continued From page 148 -Snacks: "Feels staff ignor [ignore] snacks - not getting." *On 7/12/23: -Food: "Fried chicken [served] undercooked. Feels like seeing more fish." -Snacks: "Some [residents] state [they are] getting (East) [snacks], some [residents] state [they are] not getting." *On 8/9/23: -Food: "Chicken slimy, still feels like to [too] much fish." -Snacks: Under "Resolved" column - "Yes" *On 9/13/23: -Food: "New concerns: Condiments - do not get - East/T-wing" and "Center. Temp getting better, still not warm enough sometimes." *On 10/11/23: -Activities: "snacks [-] if activity coordinator C not here dont [do not] always get done." -Food: "Run out of condiments. Still too much fish. Pork chops overcooked. Veggies mushy." -Kitchen: "Late w/meals [with meals] - room trays, food overcooked, cold food sometimes, nurses aides not willing to warm up food." -Nursing: "Nurses & [and] aides [CNAs] still issues with saying come back and dont [do not]. "Snacks at night late. Issues with water pass during day." Review of a Resident Council Department Response Form regarding the concerns reported during the Resident Council meeting on 6/14/23 noted above revealed: *Dietary Manager (DM) N will "be staying later on days to watch." *"Some menu items will be changing." *"We will start serving warren out of warren center out of center & east out of east."	F 802		

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F 802	Continued From page 149 Review of minutes for Kitchen Crew Meetings revealed concerns as follows: *On 8/29/23: temperature of the food was not right related to the supper's slow delivery process, and condiments were missing on the trays. *In September: residents were still not getting condiments. *In October: the food was not hot enough. Observation and interview on 11/6/23 between 6:00 p.m. and 6:30 p.m. revealed: *Cook CC started dishing plates in the Center kitchen for the meal room trays at 6:00 p.m. after completing meal service in the dining room for Warren, Center, and East. *Dietary Manager (DM) N said, "This is the normal time for room trays." *At 6:05 p.m., one wheeled cart of room trays was taken out of the kitchen to Center resident rooms. *At 6:19 p.m., the first cart of room trays was taken of the kitchen out to East resident rooms. *At 6:22 p.m., room trays were observed being served to resident rooms on East. *At 6:28 p.m., another cart with room trays for resident rooms arrived on East. DM N reported there was "one more [cart] to come" to East. Interview on 11/8/23 at 9:01 a.m. with DM N revealed: *A couple of months ago they started using plate warmers to address concerns related to temperature palatability. *She had educated staff about proper cooking methods to ensure palatable results related to not being undercooked or overcooked. *When questioned about residents' concerns regarding timeliness of room meal tray delivery,	F 802		

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she explained the operational process for serving three dining rooms and then room trays.
*She confirmed the posted mealtimes were correct: breakfast started at 7:15 a.m., lunch started at 11:15 a.m., supper started at 5:15 p.m.
*The dining rooms were served consistently in the order of Warren, Center, and then East.
*The delivery of the room trays always followed after serving the dining rooms.
*The order of room tray delivery was rotated so that one unit was not always the last one to receive room trays.
*When residents voiced concerns, she educated them on the process and encouraged them to come to the dining room.
*There was a manager on duty (MOD) during each meal to ensure room trays were delivered to the rooms timely.
*She did not know if the concerns about timeliness of meal delivery were related to the timing of the carts with room trays getting to the units or the room trays getting to the resident rooms.

Interview on 11/8/23 at 2:23 p.m. with LPN/UM manager Y revealed:
*"A lot of people have room trays."
*Dietary staff alert the nursing staff when the trays arrive.
*The MOD was responsible to ensure room trays and the snacks were distributed in the evening and on the weekend.
*Room trays were to have been delivered within 10-15 minutes after being delivered to the unit.
*Activity coordinator C delivered the snacks from the carts on the weekdays.
*The evening snack cart came out from the kitchen between 7:30 p.m. and 8:00 p.m..
*The snack cart "stays available for only two

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F 802	Continued From page 151 hours" since there were perishable food items on the cart. Interview on 11/8/23 at 5:11 p.m. with DM N revealed she: *Confirmed more dietary staff would be beneficial to address the resident concerns of timeliness. *Wondered if the dietary staff would be able to serve room trays since they were not certified nursing assistants. Interview on 11/9/23 at 10:40 a.m. and review of "Weekend MOD [manager on duty] Checklist" with administrator A revealed (refer to F 726): *The MOD was expected to be in the building for three to four hours on the weekend, and should include being present for at least one meal. *The MOD checklist listed "general duties" to be addressed included: -Any customer complaints -Meals served timely (7:15 a.m., 11:15 a.m., 5:15 p.m.) -Snack pass (2:00 p.m. and 8:00 p.m.) Review of the provider policy, "Dining Room Service," copyright 2018, Crandall Corporate Dietitians, revealed: *"Policy: Residents should be encouraged to receive dining room service whenever possible, be served with dignity and promptly assisted." *"Procedure:" -"1. Restaurant style service is encouraged." - "2. Resident trays or meals are distributed by nursing or dietary or other designated staff. Order of service should be rotated." -"7. Hotel style room service should be the goal for room trays. Room trays should be served in approximately 20 minutes or in a prompt manner in order to assure palatability."	F 802		

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	435039	A. BUILDING _____ B. WING _____	C 11/09/2023

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 802	Continued From page 152 Review of the Facility Assessment, last updated on 7/13/23 and last reviewed by the QAPI (quality assurance and performance improvement) committee on 8/16/23, revealed (refer to F 726): *Purpose: "The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies" *Guidelines for Conducting the Assessment: "4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions." *"Part 1: Our Resident Profile:" -"1.1. Licensed number of residents: 110 total with possibility of 110 maximum." -"1.2. Average daily census: 90 residents, of which approximately 15% [percent] are short-term." -"1.6. We strive to maintain a respectful and neighborly environment for our staff and residents. In response to this diversity, we strive to maintain activities, traditions, meals, and an environment that is reflective of many cultures...We strive to ensure residents have a choice in their activities of daily living. Our dietary staff regularly solicit input from the resident council regarding menu and food preparation." -"1.7. Other pertinent facts we consider when determining staffing and resource needs are our resident's...dietary needs..." *"Part 2: Services and Care We offer Based on our Residents' Needs" -"Nutrition: individualized dietary requirements, liberal diets, specialized diets...culture or ethnic dietary needs..."	F 802		

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F 802	Continued From page 153 -"Provide person centered/directed care: --"Build relationship with resident/get to know him/her; engage resident in conversation." --"Find out what resident's preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process." --"Make sure staff caring for this resident have this information." --"Provide culturally competent care: learn about resident preferences and practices regarding culture and religion, stay open to requests and preferences and work to support those as appropriate." *"Part 3: Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies" -"3.1. The following is a list of staff/services that are typically provided for our residents. Some of these services are covered by multiple staff members..." --Food and Nutrition Services: Dietary Director, Dietary Aide, Cook, Registered Dietitian --Hospitality aide -"3.2. Staffing plan" --Dietary: "The facility provides enough support personnel to safely and effectively carry out the function of the food and nutrition service. The minimum staffing consists on one cook and one dietary aide per meal. Based upon the licensed occupancy, the Dietary Manager may serve as a member of the line staff to meet this requirement."	F 802		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the	F 809	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this	12/07/2023

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F 809	Continued From page 154 facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, review of Resident Council Minutes, Grievance and Satisfaction Forms, Kitchen Crew Meetings minutes, manager on duty documents, and policy review, the provider failed to ensure timely delivery of meal room trays and snacks for nineteen residents (5, 7, 12, 19, 23, 28, 36, 38, 46, 53, 58, 62, 67, 71, 73, 74, 81, and two discharged residents) who reported ongoing grievances regarding timely meal and snack service. Findings include: 1. Interview on 11/6/23 at 10:10 a.m. during a resident group meeting with sixteen residents (5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81) who attended resident council meetings revealed there was consensus that: *Room trays with meal items were not delivered timely to the resident rooms.	F 809	deficiency are: 5 Why's 1. Influx of room trays, can encourage to come out to dining room. 2. Serving rooms trays out of center dining room versus out of each dining rooms. 3. Stocking remote kitchen prior to meals 4. Lack of follow up on Grievances and Resident council grievances. 5. Accountability of staff on all shifts 1. Residents 5, 7, 12, 19, 23, 28, 38, 46, 53, 58, 62, 67, 71, 73, 74, and 81 are receiving timely delivery of meals and are being offered snacks as identified through audits. No corrections could be made for the 2 unidentified discharged residents. All residents are at risk for not receiving meals on time and snacks not being offered. Resident room trays will be served out of each respective dining room. If resident is unavailable room tray will be held until resident is available. Manager on Duty schedule modified and implemented to cover into the night shift to ensure HS snacks are offered. All resident grievances reviewed for last 30 days for thorough investigation and resolution per Grievance policy. Reviewed and revised Dining room services policy. 2. The Administrator, DON, and interdisciplinary team with the governing board, medical director, pharmacy consultant, registered dietician, and any consulting agencies utilized to review, revise, create as necessary policies and procedures that support: Resident choice and mitigating resident grievances.	

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

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F 809	Continued From page 155 *Some residents had gone without a breakfast or evening meal when they chose to eat in their rooms. *Snack carts were delivered to the nurses' stations, but snacks were not distributed. Residents would have to go to the cart to get a snack. Refer to F565. Review of the handwritten Resident Council Minutes for six months revealed concerns regarding snacks had been reported on 6/14/23, 7/12/23, 9/13/23, and 10/11/23. Review of Grievance and Satisfaction Forms for six months revealed individual resident grievances related to snacks as follows (refer to F 561, finding 4): *On 5/4/23, a resident, who was discharged at the time of the survey, reported she "waited an hour for her lunch tray which never came. She then asked for a PB&J [peanut butter and jelly sandwich] and asked for it again an hour later. At that time she was told she could have a snack because it was not a meal time." *On 6/21/23, a resident who was discharged at the time of the survey reported she "only had 6-7 [six to seven] hot meals since she has been here." *On 6/21/23, resident 53 reported "snack pass cart is out...have asked about it and the [they] ignore him about it. happened 6/20 night. was on the phone ignoring him. third time this has happened." *On 8/13/23, resident 36 who was discharged at the time of the survey, reported he was "angry that breakfast was over hour late." *On 8/18/23 at 9:20 a.m., resident 74 reported, "8 pm [p.m.] asked where supper was. Staff said	F 809	The dining room services policy was reviewed and revised. The Administrator or Designee will provide education to all staff on grievance policy and procedure before December 7, 2023. The DON or designee will provide education to nursing and dietary staff on room tray process before December 7, 2023. Education will include that residents will be served out each respective dining room and trays not delivered when resident is not available. Managers educated on new MOD expectations by Administrator before December 7, 2023. Those staff not present for education sessions will be educated prior to their first shift worked. 3. Administrator or Designee will audit meal timeliness 10 times a week at random mealtimes. Administrator or Designee will audit HS snack pass offering 3 times a week. Audits will be completed by Administrator or designee weekly x4 weeks, monthly x 2 months. The Administrator will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits	

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F 809	Continued From page 156 they didn't [did not] know. 10 minutes later staff brought yogurt and said that was their supper. Currently [resident] does not have breakfast yet either." Review of minutes for Kitchen Crew Meetings revealed concerns as follows: *On 8/29/23: temperature of food not right related to supper's slow delivery process, and condiments were missing on the trays. *In September: still not getting condiments. *In October: food not hot enough. Interview on 11/8/23 at 9:01 a.m. with dietary manager N revealed: *When questioned about residents' concerns regarding timeliness of meal room tray delivery, she explained the operational process for serving three dining rooms and then room trays. -She confirmed the posted meal times were correct: Breakfast starts at 7:15 a.m., Lunch starts at 11:15 a.m., supper starts at 5:15 p.m. -The dining rooms were served consistently in the order of Warren, Center, and then East. -The delivery of the room trays always followed after serving the dining rooms. -The order of room tray delivery was rotated so that one unit was not always the last one to receive room trays. *There was a manager on duty to ensure room trays and snacks were delivered to the rooms timely. *She did not know if the concerns about timeliness of meal delivery were related to the timing of the carts with room trays getting to the units or the room trays getting to the resident rooms. Interview on 11/8/23 at 2:23 p.m. with licensed	F 809		

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F 809	Continued From page 157 practical nurse/unit manager Y revealed: *"A lot of people have room trays." *Dietary staff alert the nursing staff when the trays arrive. *The MOD is responsible to ensure trays and snacks are distributed in the evening and on the weekend. *Room trays are to be delivered within 10-15 minutes after being delivered to the unit. *The timing for the carts with room trays to arrive from the kitchen varied day to day. *It had helped that cook CC announced when meal service was started for each unit. *She had changed the time for the East residents to be in the dining room for meals since the East unit was the third location for food delivery. Interview on 11/9/23 at 10:40 a.m. with administrator A and review of "Weekend MOD [manager on duty] Checklist," revealed (refer to F 726): *The MOD is expected to be in the building for three to four hours on the weekend, and should include being present for at least one meal. *The MOD checklist listed "general duties" to be addressed included: -Any customer complaints -Meals served timely (7:15 a.m., 11:15 a.m., 5:15 p.m.) -Snack pass (2:00 p.m., 8:00 p.m.) Review of the provider policy, "Dining Room Service," copyright 2018, Crandall Corporate Dietitians, revealed: *"Policy: Residents should be encouraged to receive dining room service whenever possible, be served with dignity and promptly assisted." *"Procedure:" -"1. Restaurant style service is encouraged."	F 809		

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F 809	Continued From page 158 - "2. Resident trays or meals are distributed by nursing or dietary or other designated staff. Order of service should be rotated." -"7. Hotel style room service should be the goal for room trays. Room trays should be served in approximately 20 minutes or in a prompt manner in order to assure palatability."	F 809		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, complaint reviews, and policy review, the provider failed to ensure the facility was operated and administered by administrator A and director of nursing (DON) B, in a manner that ensured the safety and overall well-being of all 95 residents in the facility. Findings include: 1. Observations, interviews, record reviews, and policy reviews throughout the survey revealed administrator A and DON B had not ensured the safe management and overall well-being of all the residents who lived in the facility. This was evidenced by: *There was a widespread system breakdown to ensure the facility was free from accident hazards from the use of mechanical lifts, residents with elopement risks had been identified and interventions had been put in place for prevention.	F 835	Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Why's 1. Clinical Leadership turnover/vacancy 2. Agency Utilization 3. Lack of communication 4. Lack of staff education/competencies 5. Grievance process breakdown 1. A Licensed Nursing Home Administrator was placed as a Temporary Manager effective 11/27/23. The Temporary Manager will assist the Administrator and Director of Nursing in facility management and overall well-being of residents that reside in facility. A Huddle Policy was developed and implemented on 11/8/2023 to increase and promote communication. The facility is transitioning short-term per diem agency staff to contracted long term agency staff as able for continuity of care for all residents. All resident grievances for the past 30 days were reviewed to ensure thorough investigation and resolution per Grievance policy.	12/07/2023

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F 835	Continued From page 159 *Lack of staff education, monitoring, and communication to prevent facility acquired pressure injuries. *Concerns regarding the lack of communication available to staff to ensure appropriate care of the residents had been provided. *Responsiveness to residents choices for dietary concerns. *Responsiveness to residents concerns with staffing and call light issues. Refer to F561, F565, F686, F689, F725, F726, F802, and F809.	F 835	2. Education provided to Wound Nurse on 11/28/2023 and 11/29/2023 by Wound Care Certified Nurse from Gentell, our wound care partner. Education to Wound Nurse included pressure injury prevention, assessment of chronic wounds, residents at risk for pressure, best practices for pressure injury care plans, Moisture Associated Skin Damage, partial and full thickness wounds, wound identification, documentation, and pressure injury staging. The DON or designee will educate all nursing staff on ensuring interventions are being followed and timely completion of skin evaluations and skin alteration assessments. Education will occur no later than December 7, 2023 and those not in attendance at the education session will be educated prior to first shift worked. Competencies on mechanical lifts for all nursing staff began on 10/31/2023 and continue with any new nursing staff prior to first shift. All staff education on Elopements and door safety began on November 7th, 2023 and continues with any new hire. The Administrator or designee will educate all managers on new Manager on Duty expectations by December 7th, 2023. Education provided by Administrator or Designee to all facility staff licensed and unlicensed about their roles and responsibilities to ensure quality of care and quality of life in the above identified areas for all resident care and services in the facility will be completed no later than	
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record reviews, and policy reviews, the governing body failed to ensure the facility was operated in a manner that ensured the safe management and overall well-being for all 95 residents in the	F 837		

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F 837	Continued From page 160 facility. Findings include: 1. During the survey, from 10/31/23 through 11/2/23 and 11/6/23 through 11/9/23, the provider had not been operated in a manner to ensure the residents had received quality care. Refer to F561, F565, F623, F625, F656, F657, F658, F686, F689, F692, F725, F726, F756, F758, F802, F809, F835, and F880.	F 837	December 7th, 2023. Those staff not present for education sessions will be educated prior to their first shift worked. 3. The Temporary Manager with Administrator and Director of Nursing will review the survey binder progress and review each grievance to ensure proper investigation and resolution weekly. This audit will continue weekly x 4 weeks and then monthly x 2 months. The Temporary Manager will attend QAPI meetings monthly for 3 months with discussion for continued need at that time.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880	F837 Governing Body Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. The "5 Whys" related to this deficiency are: 5 Whys 1. Clinical Leadership turnover/vacancy 2. Agency Utilization 3. Lack of communication 4. Lack of staff education/competencies 5. Grievance process breakdown 1. All cited deficiencies have been corrected and will be audited. 2. A Licensed Nursing Home Administrator was placed as a Temporary Manager effective 11/27/23. The Vice President of Operations along with the Temporary Manager will assist the Administrator and Director of Nursing in facility management and overall well-being of residents that reside in facility. A member of the Governing Body will visit weekly in person	12/07/2023

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F 880	Continued From page 161 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 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	F 880	or via phone to check on progress and needs. 3. A visit report will be completed each week by a member of Governing Body. The visits will continue weekly x 4 weeks, and then monthly x 2 months. The Administrator or Designee will discuss results through monthly QAPI for further review of progress and discussion of continuation/discontinuation of audits. F880 Infection Control Root cause analysis was conducted with the Temporary Manager and reviewed with the Quality Improvement Advisor with the Great Plains Quality Innovation Network on 11/30/23. QIN recommended to Incorporate unofficial peer to peer observations of hand hygiene. The "5 Whys" related to this deficiency are: 5 Whys 1. Lack of agency orientation/competency 2. Lack of on-going education 3. Lack of supervisor oversight auditing 4. Agency utilization 5. IP/Nurse manager turnover/vacancies 1. There is no Resident 25 on the resident identifier list, therefore, corrections could not be made. Observations during the provision of personal care for Residents 9 and 7 occurred in the past and cannot be corrected. Appropriate hand hygiene and glove use is being followed during the provision of care for Residents 9 and 7. All residents who receive assistance for personal care are at risk.	12/07/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 162 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 infection control policies were adhered to with the following: *Appropriate hand hygiene and glove use by five of five certified nursing assistants (CNAs) X, U, I, K, and T during the provision of personal care for three of three sampled residents (9, 25, and 7). Findings include: 1. Observation on 10/31/23 at 11:29 a.m. with CNA X and CNA U getting resident 9 out of bed using a mechanical full-body lift revealed: *CNA X had removed her gloves without performing hand hygiene and applied a new pair of gloves. *Staff attempted to raise the resident out of the bed and the resident slide out and onto her bed the straps were crossed between her legs. *CNA X had removed her gloves. *CNA X applied a new pair of gloves and assisted with changing resident 9's incontinent brief. *CNA X performed peri-care and with her gloved hands: -Rolled resident over to her left side to remove the old incontinent brief. -Continued to perform peri-care and removed the old incontinent brief. -Placed a clean brief under the resident and helped roll her to her right side. -Removed her gloves and performed hand hygiene. -Assisted the resident with pulling her pants up. *Put on a clean pair of gloves without performing hand hygiene and assisted with positioning the	F 880	2. The Administrator, DON, and interdisciplinary team in collaboration with the governing board and the medical director reviewed and revised the hand hygiene policy. The DON or Designee will provide hand hygiene and glove use education to staff that complete resident personal care. Education will occur no later than December 7th, 2023 and those staff not present for education sessions will be educated prior to their first shift worked. 3. The DON or Designee will audit the provision of peri care and hand hygiene on 5 random residents weekly. This audit will be completed weekly x 4 weeks, monthly x2 months. The DON will discuss audits in monthly QAPI for further review of progress and discussion of continuation/ discontinuation of audits.	

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	435039	A. BUILDING _____ B. WING _____	C 11/09/2023

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F 880	Continued From page 163 green sling under the resident. *Removed her gloves without performing hand hygiene. Interview on 10/31/23 at 11:30 a.m. with CNA X regarding the above observation revealed: *She had not realized that she had not changed her gloves after performing peri-care and removing the soiled brief. *Agreed that she should have changed her gloves and performed hand hygiene after performing the resident's peri-care. 2. Observation on 11/2/23 at 9:21 a.m. with CNA I and registered nurse (RN) L changing resident 25's incontinent brief revealed: *RN L performed hand hygiene and applied a new pair of gloves. *Resident 25 was transferred from her wheelchair to bed using the mechanical full-body lift with a large, divided leg sling. *CNA I retrieved a new pair of gloves and put them without performing hand hygiene and with those same gloved hands she: -Assisted with changing the resident's soiled incontinent brief. -Used wipes to perform peri-care and then assisted the resident to roll to her right side. -Removed her old incontinent brief and slid a new brief under the resident. -Reached into the resident's bedside table and retrieved some cream. -Applied the cream to the resident's buttock and then assisted resident to roll to her left side. -Secured the new brief and then helped pull the resident's pants up. -Retrieved the mechanical lift to move it closer to the resident. -Attached the sling to the full-body lift.	F 880		

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F 880	Continued From page 164 *She removed her gloves without performing hand hygiene and assisted with lifting the resident out of her bed and back into her wheelchair. *CNA I removed the lift from the room *RN L removed his gloves and grabbed the resident's glasses and then performed hand hygiene. Interview with CNA I following the above observation revealed: *She stated that she had removed a pair of gloves from her pocket and changed her gloves after performing peri care on the resident. *She had not performed any hand hygiene after the removal of her gloves. 3. Observation on 11/6/23 9:01 a.m. of CNA K and CNA T transferring resident 7 back to bed with the full-body lift revealed: *They both used their gloved hands and the mechanical full-body lift to transfer him back to bed. *CNA K performed peri-care and rolled the resident over to his left side and with those same gloved hands she: -Continued to perform peri-care and removed his old incontinent brief, and applied ointment to his buttock. -Assisted with applying the new incontinent brief and rolling the resident to his right side. -Pulled his pants back up. -Placed the resident's shoes on his feet. *Removed her gloves and assisted with transferring the resident with the full-body lift. *CNA T had removed her gloves and then performed hand hygiene. Interview with CNA K following the above observation revealed:	F 880		

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

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F 880	Continued From page 165 *She had not realized that she had not changed her gloves and performed hand hygiene after going from a unclean surface to a clean job. *Agreed that she should have changed her gloves and performed hand hygiene more often during the above observation. Interview on 11/9/23 at 11:19 a.m. with director of nursing (DON) B infection control, licensed practical nurse (LPN) J infection control, and regional nurse consultant HH regarding the above observation of resident cares revealed: *They agreed that the CNA's should have changed their gloves and performed hand hygiene after removing the soiled brief. *Agreed that if CNA I had kept gloves in her pocket those gloves would not have been clean to use for resident care. Review of the provider's January 2023 revised Hand Hygiene policy revealed: *"If hands are not visible soiled, use an alcohol based hand rub for the following situations: "-Before putting on and after removing gloves. "-Glove changes and hand hygiene before and after moving from a contaminated body site during resident care, (e.g., after cleaning perineal area and prior to proceeding to another area of the body or dressing the resident)."	F 880		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 10/31/23 through 11/2/23 and from 11/6/23 through 11/9/23. Avantara Norton was found in compliance.	E 000		

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

Ashley Nickel | LNHA | 12/01/2023

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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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/02/2023**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted 10/31/23 and 11/2/23. Avantara Norton 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 K321, K345, K353, K712, and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	1. Door Closure placed on T-wing supply, medical records room doors, east medical storage room, east gym wheelchair storage room doors by 12/07/2023. 2. Administrator or Designee educated maintenance director on placement of closures 12/01/2023. 3. Audits will be completed weekly x 4 weeks, monthly x2 months. Will review audit findings in QAPI monthly.	12/07/2023

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

Ashley Nickel | LNHA | 12/01/2023

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K 321	Continued From page 1 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain four separate hazardous areas (east T-wing supply room, east T-wing medical records room, east medical storage room, and east gym wheelchair storage room) as required. Findings include: 1. Observation on 10/31/23 at 11:05 a.m. revealed the east T-wing supply room was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. 2. Observation on 10/31/23 at 11:15 a.m. revealed the east T-wing medical records room was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. 3. Observation on 10/31/23 at 11:40 a.m. revealed the east medical storage room was over 100 square feet and had large amounts of combustibles stored in it. The door was not equipped with a closer. 4. Observation on 10/31/23 at 11:55 a.m. revealed the east gym wheelchair storage room was over 100 square feet and had combustibles	K 321		

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K 321	Continued From page 2 stored in it. The door was not equipped with a closer. Interview with the maintenance director at the time of each observation revealed he concurred and agreed with the observations. The deficiencies affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		
K 345 SS=E	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain the fire alarm system as required (batteries were not replaced following notice by contractor they had failed, and two inoperable pull stations were not repaired) for calendar year 2023. Findings include: 1. Record review on 10/31/23 at 3:00 p.m. revealed the contractor providing maintenance to the fire alarm system reported on 10/24/23 failed emergency power supply (batteries) were failed in all three fire alarm systems. Interview with the maintenance director and regional maintenance director on 11/2/23 at 10 a.m. confirmed that	K 345	1. Batteries were replaced in 3 failed fire alarm system on 11/09/2023. 2 Manual fire alarm pull stations were repaired/replaced 11/09/2023. 2. Administrator or designee educated on maintenance on Fire Safety on 12/01/2023. 3. Administrator or designee will audit fire pull stations, and fire alarm system to be completed monthly x 4 months. Audit findings will be reviewed in QAPI meeting.	12/07/2023

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K 345	Continued From page 3 finding. 2. Record review on 10/31/23 at 3:00 p.m. revealed the fire drill performed on 10/25/23 found two non-operable manual fire alarm pull stations. During the interview with the maintenance director and regional maintenance director on 11/2/23 at 10:15 a.m. the maintenance director explained that he had called the contractor and was told the pull stations were out of service currently. Failure to maintain the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants.	K 345		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353	1. Consulted Western States on hydraulic plates, they will be sending hydraulic design information sign that reads, "Pipe Schedule System", these will be in place by 12/7/23. Sprinkler obstructions repaired and main drain test will be completed by 12/7/23. Maintenance to maintain sprinkler system with weekly system checks. 2. Administrator or designee educated maintenance director on sprinkler system maintenance on 12/01/2023. 3. Administrator or designee to complete weekly audits of sprinkler maintenance. Audits findings will be reviewed in QAPI meeting.	12/07/2023

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K 353	Continued From page 4 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (missing hydraulic name plates and system obstructions). Findings include: 1. Record review on 10/31/23 at 3:30 p.m. revealed the annual fire sprinkler inspection report dated 8/24/23 stated the hydraulic name plate on all three systems was missing. 2. Record review on 10/31/23 at 3:30 p.m. revealed the annual fire sprinkler inspection report dated 8/24/23 stated obstructions in two of three locations did not allow the main drain test to be performed. Since obstructions are usually due to pipe degradation, this has the potential to have large consequences. Interview with maintenance director at the time of the record review confirmed those conditions. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected three of numerous requirements for the automatic sprinkler system.	K 353		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712	1. Fire drills will be completed monthly alternating shifts. 2. Administrator or designee educated Maintenance director on Fire Safety 12/01/2023.	12/07/2023

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K 712	Continued From page 5 conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to demonstrate quarterly fire drills had been conducted during one of the last four yearly quarters (August to October 2023) for two of the three working shifts (afternoon and night shift). Findings include: 1. Review of the fire drill records at 7:30 a.m. on 10/2/23 revealed missing records for one of the last four yearly quarters August to October 2023 for the second and third shifts. There were two fire drills conducted during that interval, and both were held during first shift. Fire drill records indicated drills had not been documented for every shift during each of the last four quarters. Interview with the administrator on 10/2/23 at 10:30 a.m. confirmed those conditions. She further stated the current maintenance director was new to the position and was in the process of trying to get that documentation in order. The deficiency affected one of numerous requirements for staff training regarding fire drills.	K 712	3. Administrator or designee will complete monthly fire drill audits x4 months. Audit findings will be reviewed in QAPI meeting.	
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918	1. All generators are being tested monthly and documented in TELS.	12/07/2023

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K 918	Continued From page 6 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document generator battery conductivity monthly (no documentation for 2022	K 918	2. Administrator or designee educated maintenance director on Electrical system testing on 12/01/2023. 3. Administrator or designee will complete monthly generator testing audit x 4 months. Audit findings will be reviewed in QAPI meeting.	

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K 918	Continued From page 7 and 2023). Findings include: 1. Record review on 10/31/23 at 4:00 p.m. revealed there was not documentation of the battery conductivity in the monthly maintenance logs for the generator for the calendar years 2022 and 2023. Interview with the maintenance director on 11/2/23 at 8:15 a.m. revealed the generator had a maintenance-free battery installed and it could not be tested for specific gravity. He stated he was unaware of the monthly battery conductivity documentation requirement. Further conversation with a regional maintenance manager on 11/2/23 at 9:30 a.m. revealed a plan to contract for all monthly generator maintenance. The facility was currently finishing installation of a new generator and switchgear. The deficiency affected 100% of the building occupants.	K 918		

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
	10682	A. BUILDING: _____ B. WING _____	11/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3900 S 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) 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 10/31/23 through 11/2/23 and 11/6/23 through 11/9/23. Avantara Norton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Ashley Nickel

TITLE

LNHA

(X6) DATE

12/01/2023