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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/12/24 through 3/13/24. Areas surveyed included resident abuse and neglect, weight loss, pain management, and resident safety. Avantara Norton was found not in compliance with the following requirements: F658, F689, and F697.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure medications were administered at the time they were prepared and by the individual who prepared the medications for one of one sampled resident (4). Findings include: 1. Observation and interview on 3/12/24 at 11:30 a.m. through 11:50 a.m. with resident 4 revealed: *There was a medication cup full of multiple pills on her bedside table. There were no staff in the resident's room at that time. *When the resident was asked what medications were in the medication cup, she stated that those were the pills that the nurse had given her. She was unable to tell me what medications were in the medication cup. *When asked if she was in pain, she stated she	F 658	1. Resident 4's medications will not be left at bedside. 2. All residents are at risk of being affected by failure to ensure medications were administered at the time they are prepared and by the individual who prepared them. Residents are receiving their medications per policy. 3.DON or designee will provide education to all nurses and medication aides on 6 rights of medication administration and Self Administration of Medication Administration policy by 4/8/2024. Staff who do not receive education by 4/8/24 will receive education prior to next shift worked. 4. DON or designee will complete a medication administration to ensure there are no medications left at bedside and staff are following the six rights of medication administration. The audit will be 5 times weekly for 4 weeks and then monthly for three months. Audits will be reviewed, and revised as needed based on results, at monthly QAPI meeting.	04/08/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Nickel	LNHA	4/2/2024

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

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 1 was always in pain. When asked to rate her pain she was unable to do so and seemed agitated. 2. Interview on 3/12/24 at 11:55 a.m. with certified nursing assistant/medication technician (CNA/MT) H regarding the medications that were left on resident 4's bedside table revealed: *She stated that those medications were her morning medications scheduled for 8:00 a.m. and stated that the resident had gotten up late that day. *She stated that she had not set up resident 4's morning medications and that the travel agency registered nurse (RN) G was the one who had set up the medications and placed them in the resident's room. *When asked CNA/MT H if that was a common practice to leave resident's medications in the room without administering them, she stated no. *She was not sure how long those medications had been sitting in resident 4's room. 3. Interview on 3/12/24 at 12:21 a.m. with travel agency RN G revealed: *She was not aware that she had left medications in resident 4's room and thought the resident had taken her medications while she was in the room. *RN G then showed me that she administered the medications by showing me resident 4's Medication Administration Record (MAR) and explained that the medications that were in green were given. *When she was asked what medications were in the resident's room, she stated that she did not know because she thought the resident had taken them. *When asked if she could come to the residents' room to confirm what the medications were she stated that she would not be able to confirm what	F 658		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 2	F 658		

those medications were.
*When asked RN G confirmed that resident 4 did not have a physician's order to self-administer her own medications and it was not common practice to leave medications unattended in the resident's rooms.
*RN G went to resident 4's room and asked resident 4 if she took her medications that morning.
*When resident 4 stated that she was in pain, RN G stated she would have to wait an hour because she had just taken her pain medication that was in the medication cup that was sitting in the resident's room on the bedside table.
*CNA/MT H administered the medications to resident 4 that were sitting on the bedside table (after she had confirmed she had not set up resident 4's medications).

4. Review of resident 4's MAR revealed that resident 4's morning medications scheduled for 8:00 a.m. included the following:
*Duloxetine 60 milligram (mg) one time a day.
*Ferrous sulfate 325 mg tablet one time a day.
*Losartan potassium 50 mg tablet one time a day.
*Magnesium oxide 400 mg tablet one time a day.
*Multivitamin tablet one time a day.
*Omeprazole 20 mg tablet one time a day.
*Thiamine HCl 100 mg tablet one time a day.
*Phospha 250 mg neutral tablet one time a day.
*Gabapentin 300 mg capsule three times a day.
*Lactose 3000 unit tablet three times a day.
*Tramadol 50 mg tablet three times a day.

5. Review of resident 4's 12/26/2023 care plan revealed:
*Resident 4 was at risk for altered thought processes.
*She had a Brief Interview for Mental Status

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 3 (BIMS) score of 9 which suggested moderate cognitive impairment. *There was a diagnosis of dementia. *The resident would often refuse to take her medications, would pick out certain pills, and then refuse to take them. 6. Interview on 3/13/24 at 10:30 a.m. with director of nursing (DON) B revealed: *The expectation was that the resident's medications would have been administered at the time they were set up. *Medications were not to be left unattended in the resident's rooms. 7. Review of the provider's undated Medication Administration Policy revealed: *Medications were to have been administered by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. *When medications were administered by mobile cart and taken to the resident's location (room, dining room, etc.) medications were administered at the time they were prepared. *Medications were not to have been pre-poured or pre-setup in advance of the medications pass or for more than one resident at a time. *Medications were to have been administered without unnecessary interruptions. *The person who prepared the medication dose for administration was the person who administered the dose. *Individuals who administered the medications dose records the administration in the resident's MAR directly after the medications were given. *The residents MAR was initialized by the person administering the medications.	F 658		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 4 8. Review of the provider's January 2020 Self-Administration of Medications Policy revealed: *Nursing was to have gotten an order from the clinician for self-administration of medications. *Documentation of the ability to self-administer medications would have appeared on the resident's plan of care. *Residents would not have been permitted to self-administer narcotics.	F 658		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint online report, observation, interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident (2) had staff supervision in place to prevent a hot liquid burn. *Two of two sampled residents (2, and 3) had hot liquid safety evaluations completed, were documented accurately, and interventions in place to prevent potential burns from hot liquids. Findings include: 1. Review of the 3/5/24 SD DOH facility reported incident regarding resident 2 revealed: *On 3/4/24 at approximately 10:30 a.m. resident 2	F 689	1. Resident 2 and 3 Assessed for Hot Liquid Safety, care plans reviewed and revised to reflect hot liquid interventions. 2. All residents are at risk for hot liquid safety. 3. DON or designee will provide education for all licensed and unlicensed staff about their role and responsibility to ensure the resident safety with hot liquid consumption. Coffee/ hot water machines placed in kitchen/ kitchenettes and made only accessible for residents with staff assistance on 3/12/2024. Appropriate hot liquid cups readily available at each machine 3/12/2024. Hot Liquid Assessments completed on all residents 3/12/2024. Care plans reviewed and revised for residents identified as at risk for hot liquids 3/12/2024. Wheelchair Cup Holders ordered for residents at risk for hot liquids order 3/19/24. 4. DON or designee will complete hot liquid safety audit 5 times weekly for 4 weeks. Audits will be reviewed and revised monthly in QAPI.	04/08/2024

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 was in her wheelchair in the central dining room. *She placed hot water from a coffee/water dispenser into a personal plastic cup to make tea. *When the cup was filled with water, she pressed the lid onto the cup and placed the cup between her thighs on top of the wheelchair seat. *Resident 2 then used her arms to wheel herself out of the dining room and into the hallway toward her room. *When she entered the hallway, resident 2 yelled which caught the attention of a nearby nurse. *The plastic cup that held the hot liquid melted and spilled the hot water onto her inner thighs. *Resident 2 was quickly taken to her room by the responding nurse and cold compresses were applied to the areas. *The nurse completed a skin assessment that revealed a reddened skin area of 1.2 centimeters (cm) in width x 6.2 cm in length. *Physician's orders were obtained for treatment of the burn. Observation on 3/12/24 at 10:40 a.m. during the initial walk-through tour revealed: *Automatic coffee/ hot water dispensers in the following areas: -The central dining room. -The rehabilitative dining area. -Across the hallway from the nurse's station, but that coffee/hot water dispenser had been out of service. Interview on 3/12/24 at 11:45 a.m. with activities director D who was assisting with the central dining room meal service revealed: *The central dining room doors remained open all day. *Activities were conducted in that dining area such as bingo, or other scheduled activities for	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 the residents to participate in. *Staff, visitors, and residents were free to come in and out of the central dining room for beverages if they chose. *The residents were able to get beverages independently. Interview on 3/12/24 at 11:50 a.m. with dietary manager F revealed: *Coffee and hot water were available for residents, visitors, and staff. *The doors of the central dining room stayed open because the room was used throughout the day. *Residents were in and out of the dining room for activities or leisure. *She confirmed residents could get hot water or coffee independently. *Insulated coffee cups were stored on a table nearby and were available if someone wanted a beverage. Review of resident 2's electronic medical record (EMR) revealed: *She was admitted on 1/15/24. *Her Brief Interview for Mental Status (BIMS) score of 12 indicated she had mild cognitive impairment. *Hospice services had began on 1/18/24. *Her diagnoses included the following: -Anemia. -History of amnesia. -Cirrhosis of the liver. -Osteoarthritis. -Congestive heart failure. -Atherosclerotic heart disease. -Chronic kidney disease. -Atrial fibrillation. -Anxiety disorder.	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 *The physician was contacted on 3/4/24 and an order was received to continue monitoring the burn area. Apply cold/ice pack as needed. *An additional physician's order was received on 3/5/24 for Sulfadiazine cream to burn twice daily with an applied thickness of 1/16 inch. *Wound assessments and physician-ordered wound treatment was reviewed and completed by nursing staff. *The wound was healing. Review of resident 2's 1/15/24 admission Hot Liquids Safety Evaluation revealed: *The total score of the evaluation was four, that indicated she was at risk for injury related to handling hot liquids, and individualized interventions were to have been put in place. *Section B: "Made decisions regarding tasks of daily life" was documented with a score of one, and marked "modified independence". *Section G: "Demonstrates ability to handle eating equipment (cup, glass, utensils)" was documented with a score of three, and marked "no". *Section III: "Determination -I. --A was blank: "A Score of 3 or > (greater) list interventions put in place, in comments section below." --B was documented: "Resident is not considered to be at risk related to hot liquids at this time". -II. The additional comments section was blank. Review of resident 2's 3/5/24 Hot Liquids Safety Evaluation revealed: *The form was documented with a score of four. *However, the evaluation was still documented: "Resident is not considered to be at risk related to hot liquids at this time".	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 *A note was added in the comments section, "Resident used a cup for hot water that was not appropriate for hot water and it melted." Review of resident 2's 1/15/24 care plan revealed: *Interventions: [Resident name] has a burn to her inner right thigh from hot liquid. [Resident name] was educated on the importance of proper container use, use of a lid, and to ask for help pouring and transporting hot liquids. Initiated: 3/8/24. *Those interventions were not added to her care plan until after the resident was burned with hot water on 3/4/24. *If nursing staff had completed the admission Hot Liquids Safety Evaluation correctly, resident 2 should have had staff assistance when she had hot liquids from the time of her admission and the need for staff assistance would have been added to her care plan at her admission. Interview on 3/13/24 at 9:45 a.m. with resident 2 in her room revealed: *She was seated in her wheelchair next to her bed. *When asked about the incident that had resulted in her burn, she said she used a plastic cup that she thought would work for hot drinks. *She was in the central dining area after breakfast. *She went to the coffee/hot water dispenser while in her wheelchair to make a cup of hot tea. *She put hot water into her plastic cup, placed the cup between her legs, and wheeled out of the central dining room into the hall and toward her room. *Shortly after she got to the hall, she felt a hot sensation against the skin of her legs, yelled, and	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 threw the cup from between her legs and onto the floor. *A nurse came over and helped her to her room and placed a cold cloth on the area. *The plastic cup had melted from the hot water. *The nurses would check the area twice a day, put a cream on it, and cover it with a bandage. *The wound was healing. *She had gotten hot beverages independently since her admission and that was the first time she had been burned. *After the burn incident, a nurse asked her to request staff assistance when she wanted hot beverages and she agreed to that. *The cup that she used when she had gotten burned was thrown away after the incident. 2. Observation on 3/12/24 at 12:23 p.m. in the central dining room with resident 3 revealed: *She left her spot at the dining room table, and wheeled her wheelchair next to the coffee/hot water dispenser. *She placed an insulated cup under the coffee spout, filled the cup with coffee, placed a lid on top of the cup, set the cup to her right between the side of the wheelchair and her right thigh and then wheeled back to her room. *Staff were present in the central dining room assisting other residents with their meals, but none of the staff approached and offered assistance to resident 3 with the hot coffee. Review of resident 3's EMR record revealed: *She was admitted on 12/19/22. *Her BIMS score of 14 indicated her cognition was intact. *Her diagnoses included the following: -Cerebral Palsy -Adrenal gland disorder	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 -Cancer of the left lower lung and bronchus -Anemia -Charcot's joint, left ankle and foot -Unsteadiness Review of resident 3's Hot Liquids Safety Evaluation revealed: *She had not had an evaluation completed in the last quarter *Her last evaluation was completed on 2/25/23 with a score of 4. *That score indicated she would require interventions regarding hot liquids and staff assistance. Review of resident 3's revised 3/5/24 care plan revealed: *There were no interventions related to the resident's handling hot liquids or the need for staff assistance. Interview on 3/12/24 at 4:45 p.m. with administrator A regarding residents 2 and 3 revealed: *Hot Liquids Safety Evaluations were to have been completed on admission, quarterly, and with a significant change of condition. *The Minimum Data Set (MDS) coordinator was primarily responsible for completing the Hot Liquids Safety Evaluations when the MDS assessments were done. *The floor nurses would complete the Hot Liquids Safety Evaluations when needed. *She confirmed that resident 2 and 3's evaluation forms had been documented incorrectly. *If a resident had scored higher than a three on the evaluation, the resident should have had staff supervision which would include the staff getting the hot beverage and delivering it to the resident	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 in their room or the dining area. *Education on how to complete the evaluations would be prioritized to ensure the forms were completed accurately. *She agreed resident 2 should have had staff assistance according to their Hot Liquids Safety Evaluation scoring. *Resident 3 should have had a hot liquid evaluation completed the past quarter. *On prior evaluations resident 3 had scored a three or higher and should have had staff supervision with hot liquids. *The nurses had difficulty with completing the evaluations due to other duties on the floor. *They had issues filling the MDS coordinator position and had not had someone in that position consistently. -The current MDS coordinator was new to the position and had started at the beginning of 2024. Review of the provider's revised 3/23/23 Hot Liquid Safety policy revealed: *"Hot Liquid Safety Evaluation will be completed on admission, re-admission, quarterly, with significant change, and as needed. *The Hot Liquid Safety Evaluation includes the following: -Vision -Decision Making Ability -Altered Level of Consciousness -Psychomotor Retardation -Upper Extremity Impairment -Upper Extremity Tremors -Ability to handle eating utensils -Diagnoses *Procedure: 1. Complete the [facility corporate name] Hot Liquids Safety Evaluation (West) to determine if the resident scores 3 or greater.	F 689		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 2. If resident scores 3 or greater proceed to care plan and implement individualized interventions for safe handling of hot liquids."	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health (SD DOH) complaint online report, record review, interview, and policy review, the provider failed to follow physician orders to provide pain medication before scheduled wound care was completed for one of one sampled resident (1). Findings include: 1. Review of the South Dakota Department of Health facility complaint online report revealed: *A family member of resident 1 had concerns regarding the resident receiving his pain medication, specifically his oxycodone that was prescribed for pain. *That family member reported that resident 1 was frequently in pain, would cry out in pain, and noticed a substantial decline in his health. *On 2/10/24 the resident requested to go to the emergency room (ER) due to complaints of his pain and rated his pain a 10 out of 10 scale rating (A pain scale with 10 being the worst pain you could experience) according to the records provided. The resident was admitted to the hospital for acute encephalopathy and cellulitis of	F 697	1. Resident 1 no longer at facility. 2. All residents are at risk of being affected by not adhering to pain management policy, including evaluating efficacy of pain management, and developing and implementing approaches to pain management. Pain assessments will be completed on all residents and pre-procedural medications reviewed for identified individuals. 3. DON or Designee will provide education to all nurse on pain management policy, including updating care plans, evaluation of efficacy of pain management, medicating resident before and after therapy or treatment, notification of provider for inadequate pain relief, observation of non-verbal signs of pain, providing pain medications as ordered, using non-pharmacological interventions by 4/8/2024. Staff who do not receive education by 4/8/24 will receive education prior to the next shift worked.	04/08/2024

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 13 the right lower extremity. He was later discharged into hospice care on 2/13/24 and passed away on 2/16/24. 2. Review of resident 1's electronic medical record (EMR)revealed: *The resident's diagnoses included Type 2 diabetes, chronic kidney disease, atherosclerotic heart disease, depression, and a history of Hailey-Hailey disease (a genetic disorder that caused blisters and erosions on the skin). *There were multiple days in January 2024 where there was no pain rating obtained by staff or only one pain rating documented for resident 1. * A Wound Care progress note dated 1/10/24 indicated that the resident had an unstageable pressure ulcer (An ulcer that has full-thickness skin and muscle tissue loss and covered in dead tissue making it difficult to stage) measuring 4 centimeters (cm) in length x 3 cm in width with no measurable depth with an area of 12 square (sq) cm. The resident reported pain 10/10 on the pain scale. *Resident 1's Medication Administration Record (MAR) indicated that he only had acetaminophen for pain as needed for pain twice daily. That was not administered on 1/10/24 when resident complained of the above 10/10 pain. *Wound nurse/licensed practical nurse (LPN) C had sent a fax on 1/10/24 to the resident's medical provider that stated, "CNP [certified nurse practitioner] wound provider recommends lidocaine 4% gel or stronger oral pain medication for dressing changes based on 10/10 [pain scale] rating with recent dressing changes. Would you approve lidocaine and recommend an oral pain medication?" *The medical provider's order was received and noted on 1/12/24 for lidocaine gel, would	F 697	4.DON or designee will complete Pain Management audit to ensure efficacy of pain management, medicating resident before and after therapy or treatment, notification of provider for inadequate pain relief, observation of non-verbal signs of pain, providing pain medications as ordered, and using non-pharmacological interventions 5 times weekly for 4 weeks and then monthly for 3 months. Audits will be reviewed, and revised as needed based on results, at monthly QAPI meeting.	

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 14 schedule Tylenol at that time. Administer tramadol 25 milligram (mg) thirty minutes before the dressing change, no more than once daily. *Review of the resident 1's January MAR revealed: -A physician order dated of 1/12/2024 for tramadol 25 mg tablet by mouth for thirty minutes before the scheduled dressing change. -A physician order for acetaminophen 500 mg tablet by mouth as needed for mild pain was only administered four times in the month of January (Dressing changes to resident 1's right heel was scheduled daily). *Review of resident 1's January Treatment Administration Record (TAR) revealed that the resident received wound care to the right heal on 1/12/24 through 1/21/24. *According to the January MAR the resident only received the tramadol 25 mg in four out of the ten dressing changes scheduled from 1/12/24 through 1/21/24. *According to the January MAR lidocaine gel was not documented as being administered from 1/12/24 through its discontinued date on 1/23/24. *Wound nurse/LPN C had sent a fax on 1/22/24 to the resident's medical provider stating "Resident c/o [complains of] 10/10 pain with dressing changes with new order of tramadol 25 mg. Would it be possible to increase? Wound care CNP would like to debride site but still too painful with this medication and lidocaine." *An order was received and noted on 1/23/24 to increase tramadol to 50 mg PO (by mouth) daily PRN [as needed] with dressing changes. *Resident 1's January TAR revealed that resident 1 received wound care daily from 1/24/24 through 1/31/24. *Resident's January MAR revealed that resident had only received tramadol 50 mg before the	F 697		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 15 scheduled wound care twice out of eight dressing changes. *On 2/1/2024 the resident was prescribed oxycodone 5 mg tablet by mouth every 6 hours as needed for pain. That medication was to have been given thirty minutes before the residents scheduled dressing changes. *The February TAR indicated that the resident received wound care from 2/2/24 through 2/8/24. *Resident 1's February MAR indicated that the resident had not received the oxycodone 5 mg tablet before his scheduled dressing change on 2/3/24, 2/7/24, and 2/8/24. *A nursing progress note dated 2/4/24 at 9:55 a.m. stated, "Yelling out of room wanting for staff [requesting staff assistance], not using call light. Non-pharmacological interventions: reorientation to situation. Pharmacological intervention: NA" *There was no documentation found that the resident's pain had been assessed or that the physician-ordered pain medication was offered or administered at that date and time. *A nursing progress note dated 2/7/24 at 4:26 p.m. stated that resident refused wound care (That was confirmed to have been due to his pain through an interview with wound nurse LPN C on 2/13/24 at 4:30 p.m.) *A nursing progress note dated 2/8/24 at 1:48 p.m. stated "Resident attention seeking, moaning, and yelling from room all day long and stopped when wife and daughter came to visit resident. As soon as [the] family [had left,] resident started to moan and yell from [his] room despite all needs being met. Despite medication being given on time ...". No non-pharmacological or pharmacological interventions were noted. *Review of the February 2024 MAR indicated that on 2/8/24 the resident received his scheduled morning dose of acetaminophen 1000 mg, but	F 697		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 16 the physician ordered oxycodone 5 mg had not been administered. *A progress note dated 2/8/24 from the resident's primary care provider CNP stated "Resident continues to complain of right heel pain. Review of the [February 2024] MAR shows Oxy IR [oxycodone immediate release] has not been utilized to fullest extent. Resident had only received four doses [of the Oxy IR] since the initiation of that medication ordered on 2/1/24. He had been receiving scheduled acetaminophen twice daily. He had one additional PRN [as needed] dose of acetaminophen that could have been utilized. He had received no PRN doses of acetaminophen since [the physician's order] change on 2/1/24. His pain does not appear to be well managed with PRN dosing." *The resident's pain was only assessed once on multiple days in January 2024 other days there was no assessment of his pain documented. *Resident 1's care plan dated 12/26/23 revealed that the pain interventions included the following: -Evaluate the efficacy of pain management. -Medicate before therapy and treatment. -Notify the physician if there was inadequate pain relief. -Observe for non-verbal signs of pain. -Provide analgesics as ordered. -Utilize non-pharmacological interventions. 3. Interview on 3/12/24 at 1:45 p.m. with LPN/wound nurse C revealed: *When asked about the resident's pain medication before the resident's scheduled dressing change. She stated that he would often refuse medications and his scheduled dressing changes due to his complaints of pain. *She was only able to provide documentation for one day where resident 1 had refused his	F 697		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 17 dressing change. When asked specifically about the lidocaine gel she stated that the wound care CNP normally would apply it for the resident's wound debridement and that was why it was never documented on the MAR. 4. Interview on 3/12/24 at 3:10 p.m. with long term care (LTC) unit manager E revealed the resident's pain was supposed to have been assessed every shift. 5. Interview on 3/13/24 at 10:30 a.m. with LPN/wound nurse C and director of nursing (DON) B revealed: *They were not able to locate any documentation for the dates requested that the physician ordered pain medication was administered before the scheduled dressing changes and documented in the MAR for resident 1. *They both agreed that if it was not documented they would not be able to prove that the resident received his pain medication before his dressing change. *When asked how it was determined that medication was ineffective when the dosage increases were requested, they were not able to answer that question. *DON B expected that the resident would have been assessed for pain and administered his pain medication before his scheduled wound care. 6. Review of provider's March 2023 Pain Management Policy revealed: *The process for managing pain included assessing for potential pain, recognizing the presence of pain, identifying characteristics of pain, addressing the causes of the pain, developing and implementing interventions for	F 697		

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 03/13/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 18 pain (including pharmacological and non-pharmacological interventions), monitoring effectiveness of the interventions, and modifying interventions as necessary. *Comprehensive pain assessments were to have been completed upon admission, with the quarterly review, whenever there was a significant change in condition, and when there was onset of new pain. *Pain was to have been assessed at least twice daily during the day and the night shifts.	F 697		