| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435058 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 07/17/2025 |
|---|---|---|---|

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

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| F0000 | INITIAL COMMENTS<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 7/16/25 through 7/17/25. Areas surveyed included resident neglect and quality of care/treatment regarding safety and falls. Avantara Clark City was found to have past non-compliance at F689. | F0000 | | |
| F0689<br>SS = D | Free of Accident Hazards/Supervision/Devices<br><br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br><br>The facility must ensure that -<br><br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to provide adequate supervision and assistance to ensure the safety of one of one sampled resident (1) who fell while being transferred by certified nursing assistant (CNA) C who did not transfer the resident as directed in the resident's care plan and did not report the incident as a fall to the nurse for timely and appropriate assessment of the resident. This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the incident.<br><br>Findings include:<br><br>1. Review of provider's 7/1/25 SD DOH FRI for resident 1 revealed: | F0689 | "Past Noncompliance - no plan of correction required" | |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Rachel Morehouse | Administrator | 8/1/25 |

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| F0689 SS = D | Continued from page 1<br>* On 6/30/25 at 7:30 p.m. licensed practical nurse (LPN) E notified director of nursing (DON) D that certified nursing assistant (CNA) B stated resident 1 fell on 6/29/25.<br><br>*CNA B reported to LPN E that CNA C had been looking for assistance to transfer resident 1 on 6/29/25 around 5:30 p.m. up from the floor.<br><br>*There was no fall assessment completed.<br><br>*No neurological assessments were started.<br><br>*No family notification of the incident was documented in resident 1's chart.<br><br>*DON D notified administrator A on 6/30/25 to review fall sensor footage.<br><br>*Administrator A reviewed the footage on 6/30/25 at 8:10 p.m. while on the phone with DON D and saw that CNA C had completed a stand pivot transfer of resident 1 from her bed to her wheelchair. CNA C appeared to have:<br><br>-lost her balance and tipped resident 1 in her wheelchair, along with herself, over backwards.<br><br>-CNA C was seen in the footage going and getting CNA B to assist with getting resident 1 upright in her wheelchair.<br><br>-CNA C was seen going to get registered nurse (RN) F from the dining room.<br><br>*CNA C reported to RN F that she tipped resident 1's wheelchair back, but it was not a fall, and she did not hit her head.<br><br>-RN F went to resident 1's room, observed resident 1 in her wheelchair with no injuries, and instructed CNA C to bring resident 1 to the dining room to eat supper.<br><br>*After reviewing that information, DON D instructed LPN E on 6/30/25 to initiate fall follow-up, and to complete a head-to-toe assessment and neurological checks.<br><br>*Administrator A suspended CNA C pending an investigation.<br><br>*Upon completing assessment on resident:<br><br>-Neurological assessment (evaluation of nerve function, | F0689 | | |

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| F0689 SS = D | Continued from page 2<br>reflexes, coordination, motor skills, sensation, reflexes, and mental status) was within normal limits (WNL).<br><br>-Range of motion (measurement of movement around a joint or body part) was WNL.<br><br>-Resident 1 complained of pain in her left upper extremity from a previous fracture.<br><br>-Vital signs (measurement of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate) were WNL.<br><br>*On 7/1/25 witness statements were obtained from CNA B and RN F who had worked with CNA C on 6/29/25 and confirmed what administrator A saw on security camera footage.<br><br>*CNA C was interviewed regarding the incident with resident 1 and revealed:<br><br>-She was not aware the incident was considered a fall since resident 1 remained in her wheelchair.<br><br>-She confirmed that resident 1was to be transferred with the assistance of two staff members, and she did not wait for another staff member's assistance.<br><br>*CNA C's employment was then terminated immediately on 7/1/25.<br><br>*Resident 1's family, primary care provider, and orthopedic doctor were notified of the fall.<br><br>*All staff were educated on the fall management policy.<br><br>*CNAs demonstrated competencies with full mechanical lift (a mechanical lift and sling used to lift a person's full body) and sit-to-stand lift (a mechanical lift used to assist from a seated to standing position).<br><br>*A whole-house audit was of transfer assistance needs was completed of all resident care plans, Kardex, CNA assignment sheets, and current therapy orders.<br><br>*Transfer status and staff would be audited weekly for one month, then monthly for three months, and then quarterly for a year for continuance of care.<br><br>2. Review of resident 1's electronic medical record (EMR) revealed: | F0689 | | |

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| F0689 SS = D | Continued from page 3<br><br>*She admitted to facility on 5/26/22.<br><br>*Physical therapy's 4/28/25 recommendations were for her to be transferred with maximum staff assistance (staff member provides the majority of the support) with the use of a mechanical lift and two staff members' assistance, and to use a sit-to-stand or total mechanical lift if she was too lethargic (tired).<br><br>*Occupational therapy's 4/29/25 recommendations were for a mechanical sit-to-stand lift with two staff members assistance when able, or a total mechanical lift with two staff members' assistance if she was unsafe in the sit-to-stand.<br><br>*Her care plan indicated transfers with total mechanical lift initiated 6/7/22.<br><br>*Review of fall risk assessments completed on 2/28/25 and 6/1/25 identified resident 1 as having a high risk for falling.<br><br>3. Interview on 7/16/25 at 2:47 p.m. with CNA B revealed:<br><br>*On 6/29/25 at approximately 5:30 p.m. CNA C was in the west hallway, motioning for her to come to resident 1's room.<br><br>*Upon entering resident 1's room, CNA B observed resident 1 in her wheelchair tipped over and lying on the floor.<br><br>*CNA C had told her she had lowered resident 1 to the floor, and that she did not fall.<br><br>*CNA B told CNA C to notify the nurse because she thought what happened was a fall.<br><br>*CNA C was already trying to sit the wheelchair up, so CNA B assisted resident 1 into an upright position.<br><br>*CNA B left the room to notify RN F, but CNA C passed her in the hallway, and went to RN F.<br><br>*She assumed CNA C told RN F of the fall as RN F went to resident 1's room.<br><br>*On 6/30/25, she asked LPN E if she was aware of resident 1's fall from the previous day.<br><br>*She wrote a statement about the events involving | F0689 | | |

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| F0689 SS = D | Continued from page 4<br>resident 1 on 6/29/25.<br><br>*She was aware resident 1 needed the assistance of two staff members and the use of a mechanical lift for transferring.<br><br>*She had received education on the fall policy after the incident, and a disciplinary "teaching moment" for failing to report a fall to the nurse.<br><br>*She completed competencies on the safe use of the total mechanical lift and sit-to-stand lift following the incident.<br><br>Interview on 7/17/25 at 9:25 a.m. with administrator A revealed:<br><br>*She considered the 6/29/25 incident with resident 1 as a fall.<br><br>*The fall policy should have been followed.<br><br>*Resident 1's incident occurred because the staff did not follow her care plan and need to be transferred with a total mechanical lift and two staff.<br><br>Education was provided to caregiver staff on the mechanical lift policy and the fall policy following the incident.<br><br>*Competencies for the mechanical lift were completed with the nursing staff following the incident.<br><br>Audits were being completed weekly, and adjustments like sling size and needed lift evaluations completed, and care plans being updated with the needed information was being made to ensure similar incidents do not happen again.<br><br>*A quality assurance and performance improvement (QAPI) meeting was held on 7/1/25 regarding safe resident transfers, updating resident care plans, competencies being completed and transfer status updated to reflect safest option for the resident's transfers, and timely reporting of incidents to the nurse.<br><br>4. Review of the provider's revised February 2024 Fall management policy revealed:<br><br>*"It is the policy of the facility to identify and implement appropriate interventions to reduce the risk of falls or injuries while maximizing dignity and | F0689 | | |

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| F0689 SS = D | Continued from page 5<br>independence."<br><br>-"A fall is the unintentional change in position coming to rest on the ground, floor or onto the next lower surface."<br><br>-"An intercepted fall occurs when the resident would have fallen if he or she had not caught him/herself or had not been intercepted by another person-this is still considered a fall."<br><br>The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 7/17/25 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing staff regarding mechanical lift policy and fall policy, mechanical lift competencies were completed for caregiver staff, and audits were being completed and will be ongoing. Interviews with nursing staff revealed they understood the education provided regarding those topics. Observation of mechanical lift transfers in residents' rooms were conducted and confirmed staff understood how to use lifts and transfer residents safely. A QAPI meeting was held on 7/1/25 to implement a plan and will continue to be a part of their QAPI process for review and further advise staff as needed.<br><br>Based on the above information, non-compliance at F689 occurred on 6/29/25, and based on the provider's 6/30/25 implemented corrective actions for the deficient practice confirmed on 7/17/25, the non-compliance is considered past non-compliance. | F0689 | | |