STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 10/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH STREET RAPID CITY, SD 57701

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 10/7/24. Areas surveyed were elopement and negligence in resident safety. Avantara North was found to have past non-compliance at F600 and F609.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, and policy review, the provider failed to ensure the safety for: *One of one sampled resident (1) who staff assisted out of the building in the early afternoon hours, left the facility grounds without staff knowledge, was returned to the facility by an unknown individual, was not appropriately assessed for potential harm, and his physician was not notified timely of the incident.	F 600	Past noncompliance: no plan of correction required.	

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

Celina Block | *Administrator* | *10/17/2024*

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.

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*One of one sampled resident (2) whose care plan was not followed by staff who were to provide her supervision while she was in her wheelchair with a safety belt around her lap. This citation is considered past non-compliance based on review of the corrective actions the provider implemented following the incidents. Findings include:

1. Review of the provider's submitted SD DOH FRI regarding resident 1 revealed:
*On 9/28/24 at an 1:30 p.m. the resident 1 was assisted out the front door by registered nurse (RN) D.
-RN D got busy and was not able to monitor resident 1 while he was outside.
*RN D heard the doorbell, and upon answering it, an unknown woman was observed with resident 1.
-The woman asked if he "lived here".
-She stated she found him "approximately 125 yards from the facility."
--His "face slightly flushed but returned to baseline with thickened fluids."
-A full skin assessment, neuros, or vital signs were obtained upon his return to the facility.
-An order for a Wanderguard (a wearable door alarming device) was obtained from his physician and the Wanderguard was placed on resident 1's wheelchair.
*Interventions included:
-Resident 1's identifying information was added to elopement binder.
-Care staff were to supervise him when he was outside.
-His care plan was updated with the new interventions.
-The daily care sheet (a document that nursing staff references to identify individual care needs)

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was updated with the new interventions.
-Provider reviewed all the residents for their current elopement risk.

Review of resident 1's medical record revealed:
*His 7/12/24 Brief Interview for Mental Status (BIMS) score was 0, which indicated he had severe cognitive impairment.
*His diagnoses included: Alzheimer's disease, anxiety disorder, cerebral infarction (stroke), Aphasia (affects communication), history of falling, and hemiplegia (paralysis) affecting dominant right side.

The provider implemented actions to ensure the deficient practice does not reoccur by having:
*Followed their quality assurance process, and provided education all nursing care staff including:
-Review of the provider's 2/20/24 Elopement Risk Evaluation policy.
-Definition of an elopement.
-Immediate notification of nurse manager or administrator when an elopement occurs.
-Properly assessing a resident after an elopement.
-Resident 1 was "not to be outside unless there is always a staff member with his [him] to ensure his safety."
*Re-assessed all residents for their elopement risk.
*Held an Ad Hoc Quality Assurance Process Improvement meeting.
*Initiated new interventions for resident 1 that included:
-Obtained a physician's order that indicated he must not be left "outside unattended or unsupervised do [due] to elopement risk."
-Obtained and placed a Wanderguard on his

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wheelchair.
*Implemented corrective actions for the nurse including:
-Education on their abuse and neglect policy.
-Reporting of incidents.
*Observations and staff interviews on 10/7/24 revealed the staff understood the education that had been provided and the revised processes.

Based on the above information, non compliance at F600 occurred on 9/28/24, and based on the provider's implemented corrective actions on 9/29/24 for the deficient practice it was confirmed on 10/7/24 that the non compliance is considered past non compliance.

2. Review of the provider's submitted SD DOH FRI regarding resident 2 revealed:
*On 7/12/24 at 7:00 p.m. resident 2 was in her wheelchair at the nurses' station, unattended.
-CNA F found resident 2 on the floor and alerted the nurse.
--The nurse assessed her, and no injuries were identified.
--Resident 2 was assisted back into her wheelchair.
*The report identified CNA G as having been involved in the incident.
*CNA G reported she was told by an unidentified CNA that resident 2 was known to unbuckle her seat belt when staff were not looking but did not know that resident 2 would put herself on the floor.

Review of resident 2's medical record revealed:
*Her 6/29/24 BIMS score was 9,which indicated she had severe cognitive impairment.
*Her diagnoses included: epilepsy, unspecified psychosis, glaucoma, intellectual disabilities,

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anoxic brain damage, anxiety, restlessness, agitation, vascular dementia, and encephalopathy.
*Her 7/12/24 care plan included the following:
*A focus area that indicated, "[Resident 2] is at risk for falls ... [resident 2] will release her w/c [wheelchair] belt and slide/throw herself out of the w/c if upset or not being attended to quick enough."
-Interventions for this focus area included:
--On 11/29/21 "is not to be left alone in her wheel chair [wheelchair]. [Resident 2] is to be in line of sight of staff while in w/c."
--Revised on 10/19/23 "Nursing monitors while up in w/c and should not be left out of line of sight of staff."

The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 10/7/24 after record review revealed:
*LPN H provided immediate education on 7/12/24 to all CNAs on duty at the time of the incident regarding resident 2's need for continuous observation while in her wheelchair.
*The facility had followed their quality assurance process, and education was provided to all nursing care staff on 7/18/24 regarding:
-The provider's Abuse and Neglect policy.
-Ensuring resident 2's person-centered care plan was followed.

*Observations and staff interviews on 10/7/24 revealed the staff understood the education that had been provided.

Based on the above information, non compliance at F600 occurred on 7/12/24, and based on the provider's implemented corrective actions on 7/18/24 for the deficient practice it was confirmed

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F 600	Continued From page 5 on 10/7/24 that the non compliance is considered past non complianc	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, policy review, the	F 609	Past noncompliance: no plan of correction required.	

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provider failed to ensure their policy related neglect reporting had been followed regarding an incident of elopement for one of one sampled resident (1). This citation is considered past non-compliance based on a review of the provider's corrective actions immediately following the managements knowledge of the elopement. Findings include:

1. Review of provider's SD DOH FRI for resident 1 revealed:
*On 9/28/24 at approximately 1:30 p.m. registered nurse (RN) D assisted resident 1 outside.
*RN D was busy and was not able to monitor resident 1 while he was outside.
*Review of the footage from provider's cameras revealed that at 2:47 p.m. resident 1 was no longer in view of the facility cameras.
*At 3:43 p.m. RN D heard the doorbell, answered it, and a woman was observed with resident 1.
-The woman asked if he "lived here".
-The woman "said she found him on the sidewalk on the other side of neighboring apartments, approximately 125 yards from the facility."
-Time of submission from the provider to SD DOH for the initial FRI report was on 9/29/24 at 6:00 p.m.
*The SD DOH initial FRI was not submitted within 24 hours of resident 1's elopement.

Interview on 10/7/24 at 4:13 p.m. with RN D revealed:
*She had not provided notification to any management staff of resident 1's elopement on 9/28/24.
*On 9/29/24 she notified Minimum Data Set Nurse/Care Plan Coordinator/RN (MDS/CPC/RN) C, who was the manager on duty that day, of

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resident 1's elopement.
*RN D confirmed she should have notified the director of nursing "right away".
*She stated, "I didn't do it right."

Interview on 10/7/24 at 4:30 p.m. with MDS/CPC/RN C revealed:
*Resident 1's 9/28/24 elopement was reported to her by RN D on 9/29/24 at approximately 9:00 a.m.
-MDS/CPC/RN C notified director of nursing (DON) B and administrator A immediately.
-MDS/CPC/RN C initiated the investigation.
*She stated the time frame for an elopement to be reported to the SD DOH was within two hours if there had been an injury and within 24 hours if there was no injury.
-She stated the report to the SD DOH should have been completed "as soon as possible".

Interview on 10/7/24 at 5:40 p.m. with DON B revealed:
*She was made aware of resident 1's elopement on 9/29/24.
*She submitted the FRI to the SD DOH on 9/29/24 at 6:00 p.m.
-The delay in reporting of the FRI was due to the information to be submitted needed to be reviewed by the Regional Nurse Consultant.
-She submitted the FRI when she received notice that it was "okay" to submit.

Review of the provider's Abuse and Neglect policy revealed:
*"Notify the appropriate/designated organization/authority that an investigation is being initiated immediately following intervention for the resident's safety."
*"All allegations and/or suspicions of abuse must

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be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee."

Review of the provider's 2/20/24 Elopement policy revealed:
*"Upon return of the resident to the facility, the Director of Nursing or charge nurse should:"
-"Report to the DOH (SD DOH) per state requirements.

The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 10/7/24 after record review revealed:
*The facility had followed their quality assurance process, and education was provided to all nursing care staff.
-The nursing staff had been educated on their abuse and neglect policy, what an elopement was, and to immediately notify an elopement to a nursing manager or the administrator.
*Corrective actions for RN D had included: education on their abuse and neglect policy, what an elopement was, and the process of reporting resident elopements to management immediately.

Based on the above information, non-compliance at F609 occurred on 9/28/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 10/7/24, the non-compliance is considered past non-compliance.
Based on the above information, non compliance at F609 occurred on 9/28/24, and based on the provider's implemented corrective actions on 9/29/24 for the deficient practice it was confirmed on 10/7/24 that the non compliance is considered past non compliance.

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