Surveyor: 32335
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/24/19 through 6/26/19. Avantara Arlington was found not in compliance with the following requirements: F550, F556, F584, F610, F667, F658, F697, F761, and F880.

§483.10(a) Resident Rights.
The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.

§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen.
F 550

Continued from page 1

or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.

This REQUIREMENT is not met as evidenced by:

Surveyor: 32335

Based on observation, interview, record review, and policy review, the provider failed to ensure staff assisted four of four randomly observed residents (5, 12, 15, and 30) without moving from one resident to another or from one table to another during two of two meal observations.

Findings include:

1. Review of resident 5's 5/15/19 Minimum Data Set (MDS) assessment revealed:
   *His Brief Interview for Mental Status (BIMS) score was eight indicating his cognition was moderately impaired.
   *He required extensive assistance from one staff person for eating.

Review of resident 12's 6/3/19 MDS assessment revealed:
   *His BIMS score was fifteen indicating his cognition was not impaired.
   *He required supervision from one staff person for eating.

F550

1. The wheeled stool will be positioned in locations next to residents that need assistance, including residents 5, 12, 15, and 30, to minimize having to move the stools to other residents. When a resident in another location needs assistance, an assisting employee will walk over to the resident and sit on the wheeled stool next to the resident, or as needed push a wheeled stool next to the resident.

2. The administrator and director of nursing will educate employees that assist residents with eating on July 25, 2019, regarding the positioning of chairs and the expectation to stand up and push the wheeled stool when going to a different location to help a different resident.

**Addendum: Of the eight residents currently seated at the assisted tables, three of them need set-up help or cueing (residents 12 and 15) and three need physical assistance with eating (residents 5 and 30). There are sufficient employees to position one next to two each of these six residents. Resident 12 only needs set-up assistance but periodically will make a request during the meal for an additional food item. In keeping with a homelike environment, one of the assisting employees will respond to resident 12's request in a timely manner and then resume assisting the resident previously being assisted. PW 7/31/2019
Continued From page 2

Review of resident 15’s 5/13/19 MDS assessment revealed:
* Her BIMS score was seven indicating her cognition was severely impaired.
* She required supervision from one staff person for eating.

Review of resident 30’s 5/28/19 MDS assessment revealed:
* She was unable to be interviewed.
* She required extensive assistance from one staff person for eating.

Observation on 6/24/19 from 5:29 p.m. through 6:06 p.m. in the dining room revealed:
* An unidentified certified nursing assistant (CNA) had been assisting resident 15 with cutting up her food.
* She had been sitting on a chair with wheels.
* She wheeled behind residents 5 and 12 to get to a fourth resident sitting at that table.
* She then wheeled back over to resident 15.

Observation on 6/25/19 from 8:42 a.m. through 8:52 a.m. in the dining room revealed:
* CNA A was assisting residents 5 and 12 at one table, and then wheeled over to a different table to assist resident 30.
* During the above timeframe she had moved between those residents and/or the two tables six times.

Interview on 6/25/19 at 9:10 a.m. with CNA A revealed:
* She was assisting residents 5 and 30 with eating.
* Those two residents were sitting at different tables.
* She was cueing resident 12 who sat at the same
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Avantara Arlington  
**Street Address, City, State, Zip Code:** 120 Care Center Road, Post Office Box 260, Arlington, SD 57212

<table>
<thead>
<tr>
<th>Deficiency</th>
<th>Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 550</td>
<td>06/25/2019</td>
</tr>
</tbody>
</table>

#### Summary Statement of Deficiencies

**ID** F 550  
**Prefix**  
**Tag** Table as resident 5.

- Observation on 6/25/19 from 11:20 a.m. through 12:07 p.m. in the dining room revealed:  
  - Resident 30 was at the table with her beverages in front of her.  
  - There were no staff sitting with her.  
  - At 11:54 a.m., an unidentified CNA sat down with residents 5 and 12 to assist them with eating.  
  - At 11:58 a.m., CNA A sat down on the chair next to resident 30, and then wheeled over to resident 15 to assist her with eating.  
  - At 11:59 a.m., CNA A got up and left the dining room.  
  - At 12:00 noon, the unidentified CNA assisting residents 5 and 12 wheeled over to a drawer and got a clothing protector for resident 12.

- Interview on 8/26/19 at 2:08 p.m. with the director of nursing revealed the CNAs assisting the above residents should not have been moving between tables or wheeling between residents.

- Review of the provider's May 2017 Promoting/Maintaining Resident Dignity policy revealed:  
  - **“All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights.**  
  - **During interactions with residents, staff must report, document and act upon information regarding resident preferences.**  
  - **When interacting with a resident, pay attention to the resident as an individual.”**

#### F 558

- Reasonable Accommodations Needs/Preferences  
- CFR(s): 483.10(e)(3)  
- §483.10(e)(3) The right to reside and receive
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 558</td>
<td>Continued From page 4 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 32335 Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident (13) had the call light within her reach during three of three observations. Findings include:</td>
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<tr>
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<td>1. Review of resident 13's medical record revealed:</td>
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<td>*She was admitted on 12/27/18.</td>
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<td>*Her diagnoses included:</td>
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<td>- Morbid (severe) obesity due to excess calories.</td>
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<td>- Cerebral infarction, unspecified.</td>
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<td>- Type 2 diabetes mellitus without complications.</td>
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<td>- Abnormal posture.</td>
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<td>- Unspecified osteoarthritis, unspecified site.</td>
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<td></td>
<td>- Muscle wasting and atrophy, not elsewhere classified, multiple sites.</td>
</tr>
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<td></td>
<td>- Major depressive disorder, recurrent, unspecified.</td>
</tr>
<tr>
<td></td>
<td>- Major depressive disorder, single episode, severe without psychotic features.</td>
</tr>
<tr>
<td></td>
<td>- Bipolar disorder, current episode depressed, severe, with psychotic features.</td>
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<tr>
<td></td>
<td>- Vascular dementia without behavioral disturbance.</td>
</tr>
<tr>
<td></td>
<td>- Other cervical disc degeneration, unspecified cervical region.</td>
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<tr>
<td></td>
<td>- Functional dyspepsia.</td>
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<tr>
<td></td>
<td>Review of resident 13's 3/26/19 Minimum Data Set (MDS) assessment revealed:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 558</td>
<td>F558 1. The call light for resident 13 is positioned in the best location so that the resident can reach it with her functioning hand. This is care planned. All other residents have call lights positioned in the best locations for the best accessibility to use them.</td>
</tr>
<tr>
<td></td>
<td>2. An education meeting for employees from all departments will occur on 7/25/2019. The director of nursing (DON) will provide training about positioning call lights for all residents in the best locations for the residents' ability to access them, keeping in mind physical conditions that require adaptations.</td>
</tr>
<tr>
<td></td>
<td>3. Four designated leadership employees will be assigned to conduct audits one day a week for three months using the Continuous Survey Readiness Rounding form of resident use areas to identify concerns with positioning of call lights. The rounding forms will be given to the administrator or designee each assigned day for a review of identified concerns. The administrator will present the concerns to the leadership employees during the weekday morning stand-up report meetings for problem-solving and resolution. A summary of the concerns and trends will be presented by the administrator to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting for three months. At the end of three months of reporting the rounding trends to the QAPI committee, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of weekly rounding, reporting, problem-solving, and resolution during stand-up meetings to ensure the system changes remain sustainable.</td>
</tr>
</tbody>
</table>

| COMPLETION DATE | 8/15/2019 |
F 558 Continued From page 5

*Her Brief Interview for Mental Status (BIMS) score was four indicating her cognition was severely impaired.

*She required extensive assistance of two staff members for bed mobility, dressing, and personal hygiene.

*She was totally dependent on two staff members for transferring and toilet use.

Observation and interview on 6/24/19 at 3:51 p.m. with resident 13 revealed:

*The call light had been wrapped around the side rail to her right.

*She was unable to use her right arm.

*She stated she was cold, pointed to the air conditioner, and said they could turn it down.

*When asked her if she wanted to have a certified nursing assistant (CNA) turn off the air conditioner she stated yes.

*When asked her if she could turn on the call light she stated she could not see it.

*The location of the call light was pointed out to her.

*She attempted to reach the call light with her left arm but could not reach it.

*She was unable to use her right arm due to a past stroke.

*This surveyor turned on the call light for her due to her not being able to reach it.

Observation on 6/25/19 at 4:09 p.m. of resident 13 revealed she was laying in her bed on her back sleeping. The call light had been on the bed by her right arm under the blanket. That position had been further away and harder to reach then when the call light was wrapped around the side rail as above.

Observation on 6/26/19 at 8:30 a.m. of resident
### AVANTARA ARLINGTON

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:** 435050
- **(X2) MULTIPLE CONSTRUCTION**
  - A. BUILDING: 
  - B. WING: 
- **(X3) DATE SURVEY COMPLETED:** 06/26/2019

**NAME OF PROVIDER OR SUPPLIER:** AVANTARA ARLINGTON

**STREET ADDRESS, CITY, STATE, ZIP CODE:**
120 CARE CENTER ROAD
ARLINGTON, SD 57212

#### SUMMARY STATEMENT OF DEFICIENCIES

Each deficiency must be preceded by full regulatory or LSC identifying information.

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tbody>
<tr>
<td>F 558</td>
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Continued From page 6

13 revealed she was laying in bed with a breakfast tray on the bedside table. She was laying down in bed. The call light was placed on her right side beside her arm on the bed. It had not been within her reach.

Observation and interview on 6/26/19 at 8:33 a.m. with CNA A in resident 13's room revealed:

- She asked the resident to try and reach the call light that was on her right side clipped to the bed sheet.
- She was not able to reach it.
- She moved the call light and clipped it to the blanket in front of her where she could then reach it.

Interview on 6/26/19 at 9:01 a.m. with the director of nursing regarding resident 13 and the above observations revealed:

- The call light should have been in reach for the resident to use.
- They did not have a policy on this, as it was standard practice to have the call light within reach of the resident.

**F 584 SS=E**

Safe/Clean/Comfortable/Homelike Environment

CFR(s): 483.10(i)(1)-(7)

- §483.10(i) Safe Environment.
  
The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely.

The facility must provide:
- §483.10(i)(1) A safe, clean, comfortable, and
### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CJA Identification Number:**

435050

**Building:**

A.

**Wing:**

B.

**Name of Provider or Supplier:**

AVANTARA ARLINGTON

**Street Address, City, State, Zip Code:**

120 CARE CENTER ROAD POST OFFICE BOX 280

ARLINGTON, SD  57212

**Date Survey Completed:**

06/28/2019

<table>
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<tr>
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<th>TAG</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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</thead>
<tbody>
<tr>
<td>F584</td>
<td>Continued From page 7</td>
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<td>homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.</td>
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<td>8/15/2019</td>
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<td>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</td>
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<td>§483.10(i)(3) Clean bed and bath linens that are in good condition;</td>
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<td>§483.10(i)(4) Private closet space in each resident room, as specified in §483.80 (e)(2)(iv);</td>
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<td>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;</td>
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<td>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and</td>
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<td>§483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation and interview, revealed the provider failed to maintain a clean, homelike, and sanitary environment for: *Five of eight shared residents' bathrooms (100/102, 200/202, 201/203, 204/206, and</td>
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**F584** 1. Caulk will be replaced, as needed, around all toilets in the facility, including the toilets in the residents' bathrooms identified during the survey. This will be completed by the correction date.

All ceiling vents throughout the building were cleaned and repaired as needed on 5/25/2019, including the locations identified during the survey.

The identified wooden shelving and cupboards in the beauty shop identified during the survey and all other furnishings and/or shelving used for storage of resident supply items with uncleanable surfaces will be treated with Kilz and then sanded and/or painted to ensure items are stored on cleanable surfaces, by the correction date.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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</thead>
<tbody>
<tr>
<td>435050</td>
<td>A. BUILDING</td>
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<tr>
<td></td>
<td>B. WING</td>
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</tbody>
</table>

| (X3) DATE SURVEY COMPLETED                        | 06/26/2019 |

**NAME OF PROVIDER OR SUPPLIER**  
AVANTARA ARLINGTON

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
120 CARE CENTER ROAD, POST OFFICE BOX 280  
ARLINGTON, SD 57212

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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</thead>
</table>
| F 584              | Continued From page 8  
208/210.  
*Five of nine private residents' bathrooms (105, 107, 114, 207, and 211).  
*One of one clean linen room had clean linen stored on uncleanable shelves.  
*One of one beauty shop had clean towels and supplies stored on uncleanable shelves.  
Findings include:  
1. Observation on 6/25/19 at 8:40 a.m. revealed in the clean linen room:  
*The shelves holding clean linen had missing paint on the top and front edges that exposed the raw wood.  
*There were also gouges in the wood.  
*That made those surfaces uncleanable.  
2. Observation on 6/25/19 at 10:00 a.m. of the beauty shop revealed:  
*Towels and residents' hair care supplies were stored in the cabinet.  
*The surfaces of the shelves had what appeared to be a dark water stain on them.  
*The cabinet doors under the sink were chipped down to the bare wood.  
3. Observation on 6/25/19 at 4:40 p.m. of the following residents' bathrooms revealed  
*Residents' bathrooms 105, 107, 114, 201/203, and 207 had ceiling vents that had a moderate amount of built-up lint covering the blades of the vents.  
*Residents' bathrooms 100/102, 105, 114, 200/202, 201/203, 204/206, 208/210, and 211 revealed:  
-The caulking around the toilets was either missing, pulled away from the toilet, or stained a black, yellow, or gray color.  
The floors had vinyl flooring that was coming up | F 584 | 2. When uncleanable surfaces are identified on furnishings or shelving, they will be tagged out from use until the surfaces are repaired, or they will be thrown away in the event they cannot be made cleanable. A request to purchase new cleanable furnishings or shelving will be submitted for approval by the correction date for any uncleanable furnishings and shelving, including wooden shelving in the resident supply storage rooms, wooden cupboards in the beauty shop, and flooring in the resident bathrooms and resident rooms.  
The maintenance director will replace caulking around resident toilets anytime caulking is identified as uncleanable, peeling up, or missing around the base of the toilet, and will be replaced after a plumbing issue involves removing a resident's toilet to access the sewer lines. Dusting and testing of the ceiling vents and checking the condition of caulking around toilets will be completed monthly by the maintenance director. These tasks will be added to the TELS preventive maintenance plan with a monthly reminder and dates recorded when completed. The maintenance director will be educated on the facility policy and procedures related to maintaining cleanable surfaces.  
3. Four designated leadership employees will be assigned to conduct audits one day a week for three months using the Continuous Survey Readiness. Rounding form of resident use areas to identify concerns with clean, homelike, and sanitary environment, including identification of uncleanable surfaces and soiled ceiling vents. The rounding forms will be given to the administrator or designee each assigned day for a review of identified concerns. The administrator will present the concerns to the leadership employees during the weekday morning stand-up report meetings for problem-solving and resolution. A summary of the concerns and trends will be presented by the administrator to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting for three months. |  

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 584</td>
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<td>Continued From page 9</td>
<td>F 584</td>
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<td></td>
<td>At the end of three months of reporting the rounding trends to the QAPI committee, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of weekly rounding, reporting, problem-solving, and resolution during stand-up meetings to ensure the system changes remain sustainable.</td>
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<td>F 610</td>
<td></td>
<td></td>
<td>or had pieces missing.</td>
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<td></td>
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<td>-The wood baseboards had gouges in the wood making them uncleanable.</td>
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<td>4. Interview on 6/26/19 at 9:30 a.m. with the maintenance director revealed he:</td>
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<td>*Agreed the shelves in the clean linen room were uncleanable due to the missing paint and bare wood.</td>
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<td></td>
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<td>*Was aware of the condition of the residents' bathrooms.</td>
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<td>*Stated it was due to the old plumbing and the lack of resources to fix those areas.</td>
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<td>*Stated there were no policies or procedures related to ensuring all surfaces were cleanable.</td>
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<td>Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)</td>
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§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.

§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

§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:
<table>
<thead>
<tr>
<th>F 610</th>
<th>Continued From page 10</th>
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</table>
| Surveyor: 32335  
Based on interview, record review, and policy review, the provider failed to ensure one of one incident had been reported and thoroughly investigated for one of one sampled resident (13) who had fallen out of bed while a staff member was present. Findings include:  
1. Review of resident 13’s medical record revealed:  
   * She was admitted on 12/27/18.  
   * Her diagnoses included:  
     - Morbid (severe) obesity due to excess calories.  
     - Cerebral infarction, unspecified.  
     - Type 2 diabetes mellitus without complications.  
     - Abnormal posture.  
     - Unspecified osteoarthritis, unspecified site.  
     - Muscle wasting and atrophy, not elsewhere classified, multiple sites.  
     - Major depressive disorder, recurrent, unspecified.  
     - Major depressive disorder, single episode, severe without psychotic features.  
     - Bipolar disorder, current episode depressed, severe, with psychotic features.  
     - Vascular dementia without behavioral disturbance.  
     - Other cervical disc degeneration, unspecified cervical region.  
     - Functional dyspepsia.  
   * She had fallen out of bed on 3/21/19 while a staff member had been assisting her.  
Review of resident 13’s 3/28/10 Minimum Data Set (MDS) assessment revealed:  
   * Her Brief Interview for Mental Status (BIMS) score was four indicating her cognition was severely impaired.  
   * She required extensive assistance of two staff |

| F 610 | F810  
1. The employee that was involved in the incident with resident 13 is no longer employed with the facility. Other residents who need assistance with bed mobility could also be affected by the failure to fully investigate incident circumstances that may involve abuse or neglect.  
2. An education meeting for employees from all departments will occur on 7/25/2019. The administrator and the director of nursing (DON) will provide training on the state requirements and facility policy and procedures regarding incident reporting and investigation. The DON, social service manager (SSM), and administrator (or designee) will collaborate on each incident to assess the need for reporting, plan the incident investigation including who should be interviewed and how those interviews will be conducted, and determine whether abuse or neglect contributed to the incident. We will report incidents per state guidelines and regulations and facility policy.  
3. The administrator, the facility compliance officer, or designee will audit incident documentation for compliance with investigation requirements and procedures for each incident the same week it occurs. When an incident is not thoroughly competed or timely, the administrator will notify the regional clinical manager and regional director of operations. The compliance officer will report a summary of the audit findings to the Quality Assurance and Performance Improvement (QAPI) committee during the monthly meeting. After reporting the audit findings to the QAPI committee for three months, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of monthly audits to ensure the system changes remain sustainable. | 8/15/2019 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X4) ID  
PREFIX TAG  
SUMMARY STATEMENT OF DEFICIENCIES 
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F610  Continued From page 11  
members for bed mobility, dressing, and personal hygiene.  
*She was totally dependent on two staff members for transferring and toilet use.  
*She had one fall with no injury since admission or the prior assessment.

Review of resident 13's 3/21/19 incident and investigation report revealed:  
"Nurse was in hallway and heard resident scream. [Certified nursing assistant (CNA) name] came out of room and stated that resident fell out of bed while trying to clean and change brief.  
"Transferred to bed with total lift and three assist. Waited for her to calm down before taking vitals.  
"Resident is unable to ambulate on her own. And is mainly bed bound."  
*The summary of the investigation was:  
"CNA was turning her over to her side to do peri-care, and [resident name] got off center in the bed, and rolled out of bed.  
[Resident name] has a diagnosis of obesity.  
- Her current weight is 290# [pounds].  
- She has a bariatric bed and w/c [wheelchair], and is transferred with the dependent lift.  
- There is a partial bed rail that she uses to assist with turning.  
[Resident name] feeds herself, but is extensive assist to dependent with other ADLs [activities of daily living].  
- She is incontinent of bowel and bladder.  
- She receives antipsychotic, antidepressant, and cardiac medications that could increase her fall risk.  
- The psychiatrist was at the facility on 3/26/19 and visited with her.  
- No medication changes were made.  
- She does get tearful at times and will become upset.

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING  
B. WING  

(X3) DATE SURVEY COMPLETED  
06/26/2019  

NAME OF PROVIDER OR SUPPLIER  
AVANTARA ARLINGTON  

STREET ADDRESS, CITY, STATE, ZIP CODE  
120 CARE CENTER ROAD  
POST OFFICE BOX 280  
ARLINGTON, SD  57212  

(ID) PREFIX TAG  
PROVIDER'S PLAN OF CORRECTION 
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  

(X5) COMPLETION DATE  

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<th>X2 Multiple Construction A. Building</th>
<th>X3 Date Survey Completed 06/26/2019</th>
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<td>Name of Provider or Supplier</td>
<td>Street Address, City, State, Zip Code</td>
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</tr>
<tr>
<td>Avantara Arlington</td>
<td>120 Care Center Road Post Office Box 280</td>
<td>Arlington, SD 57212</td>
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<th>ID</th>
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<th>Providers Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<td>F 610</td>
<td>Continued From page 12</td>
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- [Resident name] has a diagnosis of DM [diabetes mellitus], but does not receive any diabetic medications.
- Her fingerstick blood sugars this month have ranged from 111-215.
- [Resident name] receives scheduled pain medications of Tramadol, Duragesic, and Hydrocodone/Acet [acetaminophen] with good pain control.
- She also receives a muscle relaxant @ [at] HS [bedtime].
- New interventions: [Resident name] needs to be positioned far enough back to allow sufficient room on the bed when she is turned to her side.
- Identification of abuse or neglect identified? No.
- There had been no documentation regarding interviews with the resident or the CNA in the room at the time of the fall, the level of assistance required not being followed, or training provided to the staff regarding bariatric residents.

Interview on 6/26/19 at 8:33 a.m. with CNA A regarding resident 13 revealed:
- Two staff members were supposed to be in the room when getting her up or changing her.
- Sometimes she would change her by herself at night.

Interview on 6/26/19 at 3:00 p.m. with the director of nursing and the MDS assessment coordinator revealed:
- They had not reported the incident to the SD DOH, because there was no injury.
- They had not investigated into why only one staff person was in the room assisting her, because sometimes the resident did not need two people to change her.
- Stated they only coded she was extensive assistance of two staff members on the MDS,
Continued From page 13
because three out of the seven days of the
lookback period the CNAs had coded it that way.
-They stated she did not always need two people
to assist her, because sometimes she could use
the bed rail to pull herself over.
*It was unclear on how the CNAs would have
known when to use two staff members versus
just one staff member.
*The care area assessment for ADLs had not
triggered on her admission MDS.
*They had not addressed why the CNA had not
noticed the position of the resident before she
started to assist her.

Interview on 6/26/19 at 4:45 p.m. with the
administrator revealed they had not provided
training on working with bariatric residents.

Review of the provider’s November 2017 Abuse,
Neglect, and Exploitation policy revealed:
**Neglect means failure of the facility, its
employees, or service providers to provide goods
and services to a resident that are necessary to
avoid physical harm, pain, mental anguish, or
emotional distress.”
**Investigation of Alleged Abuse, Neglect and
Exploitation. - When suspicion of abuse, neglect
or exploitation, or reports of abuse, neglect or
exploitation occur, an investigation is immediately
warranted. Once the resident is cared for and
initial reporting had occurred, an investigation
should be conducted. Components of an
investigation may include:
-Interview the involved resident, if possible, and
document all responses. If resident is cognitively
impaired, interview the resident several times to
compare responses.
-If there is no discernible response from the
resident, or if the resident's response is
F 610 Continued From page 14

incongruent with that of a reasonable person, interview the resident's family, responsible parties, or other individuals involved in the resident's life to gather how he/she believes the resident would react to the incident.

-Interview all witnesses separately. Include roommates, residents in adjoining rooms, staff members in the area, and visitors in the area. Obtain witness statements, according to appropriate policies. All statements should be signed and dated by the person making the statement.

-Document the entire investigation chronologically."

F 657 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.
(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
### Statement of Deficiencies and Plan of Correction

#### X1: Provider/Supplier/CJA Identification Number
**Identification Number:** 435050

#### X2: Multiple Construction
- **Building:**
- **Wing:**

#### X3: Date Survey Completed
**Date:** 06/26/2019

#### X4: ID Prefix Tag
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| F 657         | Continued From page 15 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: Surveyor: 26632 Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to ensure 3 of 13 sampled resident's (13, 14, and 23) care plans had been reviewed and revised to reflect their current status. Findings include: 1. Observation and interview on 6/25/19 at 8:55 a.m. with certified nurses assistants (CNA) E and F of resident 14 revealed: *He was incontinent of a loose bowel movement (BM).* *When he was laid down after meals he was often incontinent of a BM.* *He was unable to tell staff when he needed to have a BM.* Interview on 6/25/19 at 12:32 p.m. with resident 14's wife revealed he had loose BMs since his admission on 3/22/17. He was unable to tell staff when he had a loose BM. Interview on 6/26/19 at 2:00 p.m. with director of nursing revealed: *Resident 14 had loose BMs since prior to his admission.* *He had been tested for clostridium difficile (C. Diff) prior to admission.* *He had been tested two more times for C. Diff F657 | **Provider's Plan of Correction** (Each corrective action should be cross-referenced to the appropriate deficiency) 1. The care plans for residents 13, 14 and 23 were revised to address their needs. The care plans for all other residents will be reviewed during the scheduled quarterly assessment window, completed by end of September 2019. 2. An education meeting for the interdisciplinary team and nurses will occur on 7/25/2019. The director of nursing (DON) or designee will provide training on the requirement and the process for revising the care plans on an ongoing basis to reflect changes in the residents' status and needs. 3. Every week for six weeks, the DON or designee will select a sample of three residents to include residents that had clinical alerts, high priority progress notes, or order changes in the previous 72 hours. The DON will assign a nurse to audit the care plans for the three sampled residents to determine if the care plans address the 72 hour concerns or changes and verify the care plans reflect the current status of the residents. If there are discrepancies, the nurse will note those on the audit form. The DON will work with the nurse to update the care plan accordingly. The DON will report the audit findings to the Quality Assurance and Performance Improvement (QAPI) committee during the monthly meeting. At the end of six weeks of audits and reporting the findings to the QAPI committee, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of audits to ensure the system changes remain sustainable.
F 657  Continued from page 16 since his admission.
*All C. Diff tests were negative.

Interview on 6/26/19 at 2:20 p.m. with the Minimum Data Set assessment coordinator regarding resident 14 revealed:
*His frequent, loose BMs had been addressed with the physician, and interventions had been attempted.
*Those interventions included Imodium and a change in nutritional supplement he received.
*She did agree the care plan should have addressed the loose BMs.

Review of resident 14's last revised 6/23/19 care plan revealed no problems, goals, or interventions were present regarding his loose BMs.

2. Observation and interview on 6/24/19 at 4:04 p.m. with resident 23 revealed:
*He was sitting in his chair with braces on his lower legs and his shoes on his feet.
*He had developed a pressure ulcer to his left great toe from his shoe rubbing against that toe.
*The left shoe had been adjusted on 3/19/19 and on 4/1/19.

Observation on 6/25/19 at 11:40 a.m. revealed:
*After the dressing change to his left great toe LPN B assisted resident 23 to put his braces and shoes back on.
*She then offered to bring his lunch to his room.
*He was left sitting in his recliner with braces on his lower legs and his shoes on his feet.

Interview on 6/28/19 at 2:20 p.m. with the MDS coordinator regarding resident 23 revealed:
*He attended many activities throughout the day.
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<tr>
<td>F 657</td>
<td>Continued From page 17 and did not like to remove his braces and shoes each time he sat in his recliner. *His care plan should have been updated to include when he actually was to remove his braces and shoes. Review of resident 23's last revised 6/23/19 care plan revealed an intervention to remove the brace when he was in bed or in his chair. Review of resident 23's medical record revealed: *He had been admitted on 12/5/18. *His diagnoses included: - Other abnormalities of gait - Shortness of breath - Unsteadiness on feet - Gastroesophageal reflux disease without esophagitis - Pain in right ankle and joints of right foot - Muscle weakness (generalized) - Pain in right hip - Occlusion and stenosis of bilateral carotid arteries - Difficulty walking, not elsewhere classified - Dyspnea, unspecified - Hyperkalemia - Dry eye syndrome of bilateral lacrimal glands - Keratoconus, unspecified, unspecified eye - Essential (primary) hypertension - Unspecified asthma, uncomplicated - Pure hypercholesterolemia, unspecified - Hyperlipidemia, unspecified - Unspecified osteoarthritis, unspecified site - Unspecified contact dermatitis, unspecified cause *He had a pressure ulcer to his left great toe. *His left shoe had been adjusted on 3/19/19 and on 4/1/19. *A 4/22/19 interdisciplinary team progress note</td>
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<td>F 657</td>
<td>Continued From page 18 revealed they were to encourage him to have his left shoe/brace off when he was in the recliner or in bed.</td>
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Surveyor: 32335
3. Review of resident 13’s medical record revealed:
  *She was admitted on 12/27/18.
  *Her diagnoses included:
    -Morbid (severe) obesity due to excess calories.
    -Cerebral infarction, unspecified.
    -Type 2 diabetes mellitus without complications.
    -Abnormal posture.
    -Unspecified osteoarthritis, unspecified site.
    -Muscle wasting and atrophy, not elsewhere classified, multiple sites.
    -Major depressive disorder, recurrent, unspecified.
    -Major depressive disorder, single episode, severe without psychotic features.
    -Bipolar disorder, current episode depressed, severe, with psychotic features.
    -Vascular dementia without behavioral disturbance.
    -Other cervical disc degeneration, unspecified cervical region.
    -Functional dyspepsia.

Review of resident 13’s 3/28/19 Minimum Data Set (MDS) assessment revealed:
  *Her Brief Interview for Mental Status (BIMS) score was four indicating her cognition was severely impaired.
  *She required extensive assistance of two staff members for bed mobility, dressing, and personal hygiene.
  *She was totally dependent on two staff members for transferring and toilet use.
Interview on 6/24/19 at 5:57 p.m. with the dietary manager revealed resident 13 usually got a room tray for breakfast and supper. She normally came out for the noon meal.

Observation on 6/24/19 at 6:05 p.m. of resident 13 in her room revealed:
* She had gotten a room tray, and it had been placed on the bedside table.
* She was laying on her back at approximately a 180 degree angle.
* The head of the bed had been raised slightly, and she had two pillows behind her head.
* She had eaten the fruit lying in that position.

Observation on 6/25/19 at 9:08 a.m. of resident 13 revealed:
* She was laying in bed at approximately 180 degree angle with the head of the bed raised slightly.
* The breakfast tray was on the bedside table in front of her.
* She had eaten half a banana and had drank half of the cup of milk.

Observation and interview on 6/26/19 at 9:01 a.m. with the director of nursing (DON) regarding resident 13 revealed:
* She was laying in bed at approximately 180 degree angle with the head of the bed raised slightly.
* The resident had a breakfast tray in front of her.
* The DON stated she had tried to put her up yesterday when she brought her lunch tray, but she yelled out and did not want to be moved.
* The DON attempted to move the head of the bed up, but she yelled out.
* The DON stated she was particular and liked it.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>F 657</td>
<td>Continued From page 20</td>
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<td>her way. <em>It had not been care planned that she laid down in bed while eating.</em> <em>They had not notified the physician.</em> <em>They had not attempted to have her sit in her wheelchair for meals she took in her room.</em> <em>They had not provided her with education on the potential consequences of lying down while eating.</em></td>
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<td>4.</td>
<td>Review of the provider’s 12/17/18</td>
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<td>Resident-Centered Care Planning policy revealed: *<em>Each resident will have a resident-centered comprehensive care plan developed and implemented to meet his preferences and goal, and address the resident’s medical, physical, mental and psychosocial needs.</em> **Care plans will include resident-specific, measurable objectives and time frames in order to evaluate the resident’s progress toward his goal.”</td>
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<tr>
<td>F 658</td>
<td>Services Provided Meet Professional Standards</td>
<td>CFR(s): 483.21(b)(3)(i)</td>
<td>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (l) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and policy review, the provider failed to ensure professional standards of practice had been followed for medication administration for one of one sampled resident’s (14) nebulizer breathing treatment by</td>
<td></td>
<td>8/15/2019</td>
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<tr>
<td>F588</td>
<td>1.</td>
<td>Resident 14 was reassessed for the ability to self-administer the nebulizer treatment on 6/27/2019. The director of nursing (DON) educated RN D on 7/19/2019 on the need to encourage the resident to continue with the treatment as long as the resident is willing to do so. **Addendum: All other residents with orders for nebulizer breathing treatments have been reviewed for effectiveness and completion of nebulizer medication. PW 7/31/2019</td>
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<td>2.</td>
<td>The DON will educate nurses on 7/25/2019 regarding the proper administration of nebulizer treatments.</td>
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### Continued From page 21

one of one registered nurse (RN) (D). Findings include:

1. Observation and interview on 6/25/19 at 10:55 a.m. and again at 11:00 a.m. revealed RN D:
   *Poured three milliliter (ml) of albuterol liquid into the nebulizer cup from the unit dose container.
   *Listened to the resident's lung sounds and checked his oxygen saturation.
   *Placed the nebulizer mask on him and turned on the nebulizer machine.
   *Left the room to administer medication to another resident.
   *Returned at 11:00 a.m. RN D stated the resident had removed the nebulizer mask; "When he takes it off he's done."
   *Observation of the nebulizer cup revealed albuterol liquid was still in the cup.
   *The albuterol liquid was measured, and two ml was left in the nebulizer cup.
   *She did not offer or encourage him until she was asked questions about the above.
   *She asked him if he would finish the nebulizer treatment.
   *He agreed, and RN D placed the nebulizer mask back on him.

Interview on 6/26/19 at 2:00 p.m. with the director of nursing revealed:
*Resident 14 frequently would take off his nebulizer mask during the treatment.
*He would not let them place the nebulizer mask back on to finish the treatment.
*She agreed he should have been encouraged to complete the treatment.

Review of the provider's December 2017 Oral Inhalation Administration policy included:
*"Pour the medication into nebulizer cup."

### Provider's Plan of Correction

3. The DON or designee will observe one nurse provide medication administration for one resident with an order for nebulizer treatments, including resident 14. The observation will audit for the nurse's performance and the resident's ability to self-administer. The audits will occur weekly for three weeks, then every other week for three months. The DON will provide education if concerns with practice techniques are noted.

The results of the observation audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting by the DON. The committee will direct if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of auditing as needed to ensure the system changes remain sustainable.
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| F 658 | Continued From page 22
"Assemble the nebulizer equipment and attach it to the nebulizer compressor."
"Turn on the nebulizer and check the outflow part for visible mist."
"Instruct the resident to take a deep breath, pause briefly and then exhale normally. Repeat pattern throughout treatment."
"Tap the nebulizer cup occasionally to ensure release of droplets from the sides of the cup."
"Administer therapy until medication is gone (mist has stopped) or until the designated time of treatment has been reached." | F 658 | | | | |
| F 697 | Pain Management | SS=D | 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:
Surveyor: 32335
Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (19) who had complained of pain was accessed and offered interventions. Findings include:
1. Review of resident 19's medical record revealed:
*He had been admitted on 9/4/18.
*His diagnoses included:
- Constipation.
- Hyperlipidemia.
- Hypothyroidism.
- Essential hypertension. | F 697 | | | 8/15/2019
**F 697** Continued From page 23

- Other specified cardiac arrhythmias.
- Unsteadiness on feet.
- Pain in right shoulder.
- Pain in left hip.
- Lower back pain.
  
  *His Brief Interview for Mental Status (BIMS) score was nine indicating his cognition was moderately impaired.

Observation and interview on 6/24/19 at 4:00 p.m. with resident 19 revealed:

*He was sitting in a wheelchair and wheeling himself into his room.
*He complained of right knee pain and winced when he touched it.
*Stated he had told staff about the pain.

Observation on 6/25/19 at 9:57 a.m. of resident 19 revealed:

*He had been taken outside to smoke by the activity assistant.
*While outside he told the activity assistant his right knee was achy and hurt.
*He grimaced when he tried to move his knee or touch it.
*When returning inside the activity director informed licensed practical nurse (LPN) B of his knees hurting.

Review of resident 19's nurses progress notes from 6/1/19 through 6/26/19 revealed there was no documentation regarding the pain he mentioned above.

Review of resident 19's pain assessments from 6/1/19 through 6/26/19 revealed there was not one completed on 6/25/19 when he had complained of pain.
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<tr>
<td>F 697</td>
<td>Continued From page 24 Review of resident 19's June 2019 medication administration record (MAR) revealed he had an order for scheduled acetaminophen three times per day. There were no other scheduled or as needed (PRN) pain medications listed. LPN B was not available to be interviewed on 6/26/19 as she was not at work. Interview on 6/26/19 at 3:08 p.m. with the director of nursing regarding resident 19 revealed: *She was not aware of him complaining of knee pain. *If the resident had complained of pain they could have given him a PRN medication. *When asked what they should have done if they did not have a PRN medication already ordered she did not answer. *She did not think a user-defined assessment or pain assessment would have been done. *If given a PRN medication they would have rated the pain level on the MAR. *They would not rate the pain level if they had not given a medication. Review of the provider's November 2017 Pain Management policy revealed: **&quot;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.&quot; **Assessment and evaluation by the appropriate members of the interdisciplinary team (e.g., nurses, practitioner, pharmacists, etc.) may include: -Asking the patient to rate the intensity of his/her pain using a numerical scale or a verbal or visual...</td>
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**SUMMARY STATEMENT OF DEFICIENCIES**

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| DESCRIPTOR THAT IS APPROPRIATE AND PREFERRED BY THE RESIDENT.  
- REVIEW OF THE RESIDENT'S DIAGNOSES OR CONDITIONS AND ANY ADDITIONAL FACTORS THAT MAY BE CAUSING OR CONTRIBUTING TO PAIN.  
- IDENTIFYING KEY CHARACTERISTICS OF THE PAIN.  
- OBTAINING DESCRIPTORS OF THE PAIN.  
§483.45(g) LABELING OF DRUGS AND BIOLOGICALS  
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  
§483.45(h) STORAGE OF DRUGS AND BIOLOGICALS  
§483.45(h)(1) IN ACCORDANCE WITH STATE AND FEDERAL LAWS, THE FACILITY MUST STORE ALL DRUGS AND BIOLOGICALS IN LOCKED COMPARTMENTS UNDER PROPER TEMPERATURE CONTROLS, AND PERMIT ONLY AUTHORIZED PERSONNEL TO HAVE ACCESS TO THE KEYS.  
§483.45(h)(2) THE FACILITY MUST PROVIDE SEPARATELY LOCKED, PERMANENTLY AFFIXED COMPARTMENTS FOR STORAGE OF CONTROLLED DRUGS LISTED IN SCHEDULE II OF THE COMPREHENSIVE DRUG ABUSE PREVENTION AND CONTROL ACT OF 1976 AND OTHER DRUGS SUBJECT TO ABUSE, EXCEPT WHEN THE FACILITY USES SINGLE UNIT PACKAGE DRUG DISTRIBUTION SYSTEMS IN WHICH THE QUANTITY STORED IS MINIMAL AND A MISSING DOSE CAN BE READILY DETECTED.  
This REQUIREMENT IS NOT MET AS EVIDENCED BY:  
Surveyor: 28632
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 761</td>
<td>Continued From page 26</td>
<td></td>
<td>Based on observation and interview, revealed the provider had failed to ensure eight of eight residents* (4, 6, 12, 14, 19, 24, 28, and 85) insulin FlexPens in use had been labeled by the pharmacy. Findings include:</td>
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<tr>
<td></td>
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<td></td>
<td>1. Observation and interview on 8/26/19 at 8:56 a.m. with registered nurse D revealed:</td>
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<td></td>
<td></td>
<td></td>
<td>*A Basaglar 100 units per milliliter (mt) insulin FlexPen with no pharmacy label on it.</td>
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<td>*Resident 14’s name had been handwritten and a piece of clear tape had been placed over the label on the FlexPen.</td>
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<td></td>
<td>*RN D revealed only the box the insulin FlexPen came in had a pharmacy label on it.</td>
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<td></td>
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<td></td>
<td>*Those insulin FlexPens were kept in the medication refrigerator until they were needed.</td>
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<td></td>
<td></td>
<td></td>
<td>*After they had been removed from the medication refrigerator for use they were left in the medication cart.</td>
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<td>Observation on 8/26/19 at 4:30 p.m. of the medication refrigerator revealed:</td>
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<td></td>
<td></td>
<td></td>
<td>*It contained boxes of Insulin FlexPens for residents 4, 6, 12, 14, 19, 24, 28, and 85...</td>
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<td></td>
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<td></td>
<td>*Those boxes of insulin FlexPens had the pharmacy label on them.</td>
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<td></td>
<td></td>
<td></td>
<td>*The individual insulin FlexPens did not have a pharmacy label on them.</td>
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<td></td>
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<td></td>
<td>Interview on 8/26/19 at 4:00 p.m. with the director of nursing confirmed the above findings. She had not been aware each of the insulin FlexPens should have been labeled separately.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID</th>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
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<tbody>
<tr>
<td>F 761</td>
<td></td>
<td></td>
<td>1. The FlexPens for residents 4, 6, 14, 19, 24, 28, and 85 have been used for those residents. All residents who are prescribed FlexPens were at risk for medication administration errors due to the pens not being labeled for each resident.</td>
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<td></td>
<td>**Addendum: In addition to the residents listed above, resident 12’s unlabeled FlexPen has been used up. All other residents who received their medications from the same pharmacy also had unlabeled FlexPens that have since been used up. PVW 7/31/2019</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>2. The pharmacy was notified of the need to label each individual insulin pen. The nurses will check for proper labeling of pens when the medication arrives at the facility.</td>
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</table>
| | | | 3. The director of nursing (DON) will designate a nurse once a week for four weeks to audit the flex pens for individual labeling. The nurse will return the audit to the DON. The DON will review the audit form for concerns and report the trends to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting. The committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrance of auditing as needed to ensure the system changes remain sustainable. 

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F 880
Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f)
§483.80 Infection Control
F 880 Continued From page 27

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 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
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<th>(X4) ID</th>
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<td>F 880</td>
<td>Continued From page 28 involved, and</td>
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(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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Surveyor: 26832

Based on observation and interview, the provider failed to ensure proper infection control practices had been followed for one of three observed dressing changes for one of three sampled residents (26) by licensed practical nurse (LPN) B. Findings include:

1. Observation and interview on 6/25/19 at 9:10 a.m. of LPN B during the dressing change for resident 26 revealed she:
   * Took the packages that contained Kerlix wrap and other dressing supplies out of the drawer of F880

   1. The director of nursing (DON) educated LPN B on 7/19/2019 regarding following proper infection control practices during treatment changes. Any resident receiving treatments could potentially be affected.

   ** Addendum: The wound for resident 26 was not negatively affected by the improper infection control practices observed on 6/25/19. PW 7/31/2019

   2. The DON or designee will educate nurses on 7/25/2019 on the proper handling of dressings and dressing change techniques that comply with infection control standards.
**Summary Statement of Deficiencies**

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<th>ID</th>
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<th>Statement</th>
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<tr>
<td>F 880</td>
<td>Continued From page 29</td>
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- Placed those supplies on top of the treatment cart without any barrier or sanitizing the surface. 
- Retrieved a scissors from the top drawer of the treatment cart and without sanitizing them proceeded to:
  - Cut a packaged dressing in half with those scissors and then layed the two halves on the cart. Put the scissors back in the treatment cart. 
  - Retrieved the same scissors, opened a roll of Kerlix gauze, took approximately half of the gauze cut, and cut it. She put one half back in the package, labeled it with the date, resident 26's initials, and then put it back in the treatment cart. 
  - The other half she put inside one of the halves of the previously cut dressing. 
  - Placed the scissors back in the treatment cart without sanitizing them. 
  - Took four 2 inch by 2 inch gauze pieces and put them in a plastic cup, removed a bottle of wound cleanser, and sprayed it in the plastic cup until damp.
  - Took all the dressing supplies into the resident's room and placed them on two paper towels on the bed. 
  - Cleansed the wound with the dampened gauze, placed the used gauze on the barrier paper towels, and that used gauze had been touching the Kerlix roll. 
  - Washed her hands several times and placed the used paper towels on the sink counter. 
  - The garbage can was beside the resident's recliner, and his wheelchair was in front of the garbage can. 
  - It was not accessible to her, and she had not tried to move it. 
  - She had several pairs of gloves she used that had been in her scrub top pocket. 
  - She also carried keys and pens in those...

---

**Provider's Plan of Correction**

3. The DON or designee will audit for competency of infection control practices by observing a different nurse each time complete a dressing change or other treatment twice weekly for three weeks, then once a week for three weeks. Education will be provided following each observation if concerns with practice techniques are noted. The results of the observation audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting. The committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of auditing as needed to ensure the system changes remain sustainable.  

**Addendum:** The dressing change for resident 26 will be observed as part of the audit process.

PW 7/31/2019
F 880  Continued From page 30
pockets.
*Explained her process of a dressing change
throughout the procedure.
*She stated it was her usual way of doing a
dressing change, and she was very particular
about her infection control practices.
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</table>
| E 000 | Initial Comments | | Surveyor: 32335  
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 6/24/19 through 6/26/19. Avantara Arlington was found in compliance. | E 000 | | | | |

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.) Exceptions to all disclosures stated above are disclosable 90 days following the date of survey whether or not a plan of correction is submitted. (See instructions.) The deviations, and plans of correction are disclosable 14 days following the date these documents are made available to the public, if it is determined that a plan of correction is requisite to continued program participation.
K 000 INITIAL COMMENTS

Surveyor: 27198
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/25/19. Avantara Arlington was found not in compliance with 42 CFR 483.70 (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 deficiency identified at K363 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 363 Corridor - Doors
SS=D CFR(s); NFPA 101
Corridor - Doors
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open...
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<tr>
<td>K 363</td>
<td>Continued From page 1 devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3. 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to ensure one randomly observed corridor door (employee breakroom) was equipped with functioning positive latching hardware. Findings include: 1. Observation at 3:15 p.m. on 6/25/19 revealed the corridor door to the employee breakroom was only held into the frame by the automatic door closer. Testing of the door by pulling it closed and flush with the frame revealed the door was equipped with positive latching hardware, but it was not operating correctly. Further observation at that same time revealed the other door’s striker had retraced into the door and would not come to allow it to latch into the frame. Interview with the maintenance supervisor at the time of the observation confirmed that finding.</td>
<td>K 363</td>
<td>K363 1. The latch on the door of the employee breakroom was repaired and latches properly now. All corridor doors are tested weekly for proper operation of the doors and latching mechanisms. 2. Testing off all corridor doors is part of the TELS data base as a monthly task. The maintenance director was educated on the “Steps” listed in TELS for completion of this task. The maintenance director and the administrator will conduct a monthly environmental tour and review TELS data to spot check task and step completion of the preventive maintenance program. 3. The administrator or designee will audit five corridor doors each week for one month and then monthly for two months. The administrator or designee will report any locations found to be nonfunctioning that day or by the next day to the maintenance director for timely resolution.</td>
<td>8/15/2019</td>
</tr>
<tr>
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<tr>
<td>K 363</td>
<td>Continued From page 2</td>
<td>He stated he was unaware of that condition.</td>
<td>The administrator will report trends from the audits to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting for three months. At the end of three months, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of auditing as needed to ensure the system changes remain sustainable.</td>
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</table>
Compliance/Noncompliance Statement

Surveyor: 27198
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 06/24/19 through 6/26/19. Avantara Arlington was found not in compliance with the following requirement(s): S157 and S173.

S 157
44:73:02:13 Ventilation

Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system.

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 27198
Based on observation, testing, interview, and record review, the provider failed to maintain exhaust ventilation in three randomly observed locations (toilet room for room 111, toilet room for room 114, and the beauty shop). Findings include:

1. Observation and testing at 11:40 a.m. on 6/25/19 revealed the exhaust ventilation for the toilet room for resident room 111 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding.

2. Observation and testing at 11:45 a.m. on 6/25/19 revealed the exhaust ventilation for the toilet room for resident room 114 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding.

S157
1. The exhaust ventilation in rooms 111, 114, and beauty shop are now functioning. Exhaust ventilation in all locations were tested and fixed as needed to ensure all exhaust ventilation were working properly.

2. Testing for the operation of exhaust ventilation is part of the TELS data base as a monthly task. The maintenance director was educated on the “Steps” listed in TELS for completion of this task. The maintenance director and the administrator will conduct a monthly environmental tour and review TELS data to spot check task and step completion of the preventive maintenance program.

**Addendum: The maintenance director functions as the facility’s life safety code (LSC) employee. PW 7/31/2019**
<table>
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<tbody>
<tr>
<td>S 157</td>
<td>Continued From page 1</td>
<td>S 157</td>
<td>3. The administrator or designee will audit five exhaust ventilation locations each week for one month, and then monthly for two months. The administrator or designee will report any locations found to be nonfunctioning that day or by the next day to the maintenance director for timely resolution. The administrator will report trends from the audits to the Quality Assurance and Performance Improvement (QAPI) committee members during the monthly QAPI meeting for three months. At the end of three months, the committee will decide if the system changes have had the desired improvements. The QAPI committee will direct the continuation or recurrence of auditing as needed to ensure the system changes remain sustainable.</td>
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<tr>
<td>S 173</td>
<td>44:73:02:18(6-10) Occupant Protection</td>
<td>S 173</td>
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<td>The facility shall take at least the following precautions:</td>
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<td>(8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp;</td>
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<td>(9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and</td>
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**S 173 Continued From page 2**

(10) The storage and transfiling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition.

This Administrative Rule of South Dakota is not met as evidenced by:
Surveyor: 26632
Based on observation and interview, the provider failed to maintain light shields or lens covers on ceiling lights in the laundry. Findings include:

1. Observation and interview on 8/26/19 at 9:45 a.m. with the maintenance director in the laundry room revealed:
   "The fluorescent light in the front entry did not have a lens cover, and the bulbs were not shatterproof. The two fluorescent lights in the room where the clothes were washed, dried, and folded did not have a lens cover, and the bulbs were not shatterproof. The maintenance director agreed those lights should have had either a lens cover or the bulbs should have been shatterproof. He stated the light fixtures were old, and he could not get lens covers that fit. He thought those bulbs were the shatterproof kind."

**S 000 Compliance/Noncompliance Statement**
Surveyor: 32335
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide

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<td>S 173</td>
<td>Continued From page 2 (10) The storage and transfiling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 26632 Based on observation and interview, the provider failed to maintain light shields or lens covers on ceiling lights in the laundry. Findings include: 1. Observation and interview on 8/26/19 at 9:45 a.m. with the maintenance director in the laundry room revealed: &quot;The fluorescent light in the front entry did not have a lens cover, and the bulbs were not shatterproof. The two fluorescent lights in the room where the clothes were washed, dried, and folded did not have a lens cover, and the bulbs were not shatterproof. The maintenance director agreed those lights should have had either a lens cover or the bulbs should have been shatterproof. He stated the light fixtures were old, and he could not get lens covers that fit. He thought those bulbs were the shatterproof kind.&quot;</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 10592

(X2) MULTIPLE CONSTRUCTION
A. BUILDING: 
B. WING 

(X3) DATE SURVEY COMPLETED: 06/26/2019

NAME OF PROVIDER OR SUPPLIER

AVANTARA ARLINGTON

STREET ADDRESS, CITY, STATE, ZIP CODE

120 CARE CENTER ROAD POST OFFICE BOX 280
ARLINGTON, SD 67212

(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 | Continued From page 3 training programs, was conducted from 6/24/19 through 6/26/19. Avantara Arlington was found in compliance. | S 000 |  |  |