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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435059	A. BUILDING _____ B. WING _____	C 01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA LAKE NORDEN	803 PARK STREET LAKE NORDEN, SD 57248

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/17/23 through 1/19/23. Avantara Lake Norden was found not in compliance with the following requirement: F686. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/17/23 through 1/19/23. Areas surveyed included quality of life, resident rights, and physical environment. Avantara Lake Norden was found in compliance.	F 000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitues with Federal Medicare and Medicaid .	
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to put appropriate interventions in place for one of two sampled resident (289) to prevent a pressure ulcer from developing. Findings include:	F 686	1. Heel lift/protector boot was placed on resident 289 left heel on November 21, 2022. All residents have the potential to be at risk. 2. The administrator, DON and inter-disciplinary team in collaboration with the Medical Director have reviewed the skin management policies and procedures about completing an appropriate skin assessement and implementation of appropriate approaches to ensure best possible situations to avoid development of alteration in skin integrity/pressure injury. Education was provided to all licensed and unlicensed staff responsible for the provision of care to use available tools and resources, assess and document skin integrity, alterations in skin integrity, and appropriate implementation of approaches to alleviate risk by the DON on1/25/23. Applicable staff not in attendance will be trained prior to their next shift worked.	2/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 02/09/2023

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

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F 686	Continued From page 1 1. Observation and interview on 1/18/23 at 11:49 a.m. revealed resident 289: *Was sitting in a recliner in his room with his legs elevated and a heel boot on his left foot. *Stated he had a wound on his heel. *Reported displeasure that it had developed since he moved into the nursing home. 2. Observation on 1/18/23 at 3:49 p.m. of registered nurse (RN) F changing the dressing on resident 289's heel revealed: *She described it to the resident as a "nickel size compared to a quarter" and then stated to this surveyor that it could not be staged (rated based on how deep the wound was) because of the eschar (dead tissue covering the wound). Review of the nursing admission documentation on 11/16/22 in the electronic medical record (EMR) for resident 289 revealed: *A nursing-admission/readmission UDA (user defined assessment) at 11:44 a.m. by RN E noted a skin alteration to his left "trochanter (hip)" and a score of six (meaning high risk) on the Braden Scale [a standardized tool to assess pressure ulcer risk] based in part on: -No sensory impairment that would limit his "ability to feel or voice pain or discomfort." -"Spends majority of each shift in bed or chair." -"Requires minimum assistance" to move causing a "potential problem" with friction to the skin when repositioning in bed or in the chair. *An admission summary progress note (PN) at 6:46 p.m. by RN E noted he was admitted after a recent fall with a left hip fracture that required surgical repair. *A late entry PN at 8:58 p.m. by director of nursing (DON) B reported an admission bed bath	F 686	3. The DON or designee will audit all residents determined to be at risk for altered skin integrity for appropriate implementation of interventions, assessing, documenting and that those interventions are reflected on those care plans weekly x 4 weeks, then monthly for at least 2 months. The DON or designee will present audit findings to QAPI committee monthly for review and recommendations for at least 3 months.	

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F 686	Continued From page 2 was completed. There was no notation regarding skin condition in that note. Further review of the EMR revealed: *A skin alteration evaluation on 11/18/22 at 8:10 p.m. by RN F noted resident 289's left heel had redness. No measurements of the redness were noted on that evaluation. *A change of condition PN on 11/21/22 at 11:56 a.m. by DON B reported: -A certified nursing assistant (CNA) informed her that resident 289's left heel was "breaking down." -DON B observed resident 289 "sitting in his recliner, with both legs elevated. Heels do not touch recliner." -Resident 289 reported he had "pin point [sic] pain to his feet all the time." -The heel had "intact skin with a localized area of persistent non blanch able [sic] deep red area measuring 10cm (centimeters) x (by) 5cm with increased warmth surrounding a maroon/purple centered wound bed and area of fluid filled blister that is clear that measures 8.1cm x 3.6cm. Will suspend heel with off loading [sic] boot." *A skin evaluation on 11/21/22 at 1:53 p.m. by licensed practical nurse (LPN) D noted: -The Braden Scale score was 17, which was still considered high risk. -"Resident has alteration in skin integrity." -The pressure ulcer section was blank. -The "Additional Skin/Treatment Note" stated, "See skin alteration evaluation assessment. No other skin conditions noted at this time." *An admission summary PN on 11/21/22 at 6:14 p.m. by DON B noted resident 289 "resists all movement made to left leg. Although he refused to allow off loading [sic] heel boots before due to discomfort, he states he will give it another try." *A skin alteration evaluation on 11/22/22 at 8:10	F 686		

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F 686	Continued From page 3	F 686		

p.m. by RN F noted the left heel pressure ulcer with an onset date of 11/21/22 using the same description as noted in the 11/21/22 PN by DON B.

Review of resident 289's care plan revealed:
*A focus for fluctuating blood sugars with increased risk for skin breakdown was initiated on 11/19/22 but there were no interventions to address the left heel redness discovered on 11/18/22.
*A focus for the left heel pressure ulcer was initiated on 11/28/22 with interventions initiated on:
-11/28/22 to "alert nurse of skin breakdown or potential for skin breakdown noted while completing ADL's (activities of daily living)"
-12/14/22 for "heel boots as he will allow, encourage not to wear left shoe."

Interview on 1/19/23 at 12:51 p.m. with Resident Assessment Instrument/Minimum Data Set (RAI/MDS) assessment coordinator C to clarify the timing of the skin evaluation and skin alteration evaluation related to resident 289's pressure ulcer revealed she would attempt to provide a timeline of the development of it and documented interventions to prevent it.

Follow-up interview on 1/19/23 at 3:52 p.m. with RAI/MDS coordinator C revealed "we cannot find any documented interventions" between the skin alteration evaluations on 11/18/22 noting the left heel redness and on 11/22/22 noting the unstageable left heel pressure ulcer.

Review of the "Skin Program" policy with a revision date of April 2021 revealed:
*A baseline assessment of the resident's skin

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F 686	Continued From page 4 status would have been completed upon admission by completing the Nursing Admission assessment, which includes a "physical exam of the resident's skin." *"Nursing personnel will utilize the results of the physical exam and the Pressure Injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident." *"A comprehensive wound assessment will be completed when a pressure injury is identified." *When a pressure injury is identified, "a Skin Evaluation UDA should be completed." *"Following identification of a skin issue, the Skin Alteration Evaluation UDA will be completed weekly until resolved." *"Nursing personnel will develop a plan of care with interventions consistent with resident and family preferences, goals and abilities, to create an environment to the resident adherence to the pressure injury prevention/treatment plan. "Routine skin checks will be completed weekly and recorded on the Skin Evaluation UDA." "Nursing personnel who will be providing care for the resident will receive pressure injury training, to include checking potential pressure areas and recognize pressure injuries in 'at-risk' residents, (skin-reddening that does not disappear after pressure removed) and instructed to notify the nurse when this is observed."	F 686		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/17/23 through 1/19/23. Avantara Lake Norden was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 02/09/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/18/23. Avantara Lake Norden was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K522 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitues with Federal Medicare and Medicaid requirement.	
K 211 SS=C	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide unlocked egress doors as required at one of seven exit door locations (south wing north exit door). Findings include: 1. Observation on 1/18/23 at 12:13 p.m. revealed the dining room west exit door was equipped with a magnetic lock that prevented egress. Signage mounted on the door indicated the magnetically locked door was functioning as a delayed egress door. Testing of the door by applying force in the	K 211	1. United Technology was called on January 19, 2023. An electronic TAB monitor was placed on door to alert staff if the door was opened. Door was repaired February 3, 2023. All residents could potentially be at risk. 2. Maintenace Director or designee will complete daily checks on magnetic lock doors. 3. Audits will be completed by the Administrator or designee to ensure door releases daily for two weeks, weekly for four weeks, then monthly for three months. The Administrator or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.	2/14/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Margaret Grimm	Administrator	02/09/2023

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K 211	Continued From page 1 direction of the path of egress revealed it would not initiate the process to unlock the magnet and release the door. Interview at the time of the observation with the regional project manager confirmed those conditions. He stated he was unaware that door was not operating correctly. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 211		
K 522 SS=C	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also: * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include:	K 522	1. Warnke Electric arrived on January 27, 2023. Once a part is found it will be ordered to repair the fan. All residents could potentially be at risk. 2. Upon arrival of the part the damper will be fixed. Until then we will manually open the vent when the dryer is operating. 3. Audits will be completed to ensure the damper opens when the dryer(s) are operating by the Housekeeping Director or designee daily for two weeks, then weekly for four weeks ,then monthly for three months. The Houskeeping Director or designee will bring the results of these audits to the monhtly QAPI meetings for further review and recommendations.	2/14/2023

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K 522	Continued From page 2 1. Observation of the commercial gas-fired dryers (2) in the laundry room on 1/18/23 at 11:58 a.m. revealed the following: a. There was a dedicated combustion (fresh) air opening provided for the operation of the two natural gas-fired commercial clothes dryers. b. The opening had an electrically driven automatic damper covering the opening c. Testing of the automatic damper by running both dryers revealed it would not open to allow outside air to enter. Interview with the regional project director at the time of the observations confirmed those findings. The deficiency affected one of several requirements for fuel fired devices.	K 522		
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to hold fire drills at least quarterly for each shift. Findings include:	K 712	1. Fire drills will be completed at least quarterly on each shift. All residents could potentially be at risk. 2. Maintenance Director or designee will arrange fire drill to be held at expected and unexpected times under varying conditions, at least quarterly on each shift. 3. Audits will be completed by Administrator or designee weekly for four weeks, then monthly for three months. to ensure fire drills are completed at least quarterly on each shift. The Administrator or designee will bring the results of these audits to the montly QAPI meetings for further review and recommendations.	2/14/2023

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K 712	Continued From page 3 1. Record review on 1/18/23 at 12:32 p.m. revealed the provider only had documentation for three fire drills being conducted in 2022. Interview with the regional project manager that same day at 2:47 p.m. confirmed that finding. He stated it was apparent that the maintenance staff for the building was not conducting quarterly fire drills for each shift as required. The deficiency affected 100% of the building occupants.	K 712		

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/17/23 through 1/19/23. Avantara Lake Norden was found not in compliance with the following requirement: S166.	S 000	DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitues with Federal Medicare and Medicaid requirement	
S 166	44:73:02:18(1-2) Occupant Protection The facility shall take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents; (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and record review the provider had not implemented a preventative maintenance program as required. 1. Interview on 1/18/23 at 1:41 p.m. with the regional project manager revealed the director of maintenance for the building was not completing regularly scheduled preventative maintenance.	S 166		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm — TITLE: Administrator — (X6) DATE: 02/09/2023

South Dakota Department of Health

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S 166	Continued From page 1 He stated the parent company had a preventative maintenance program they trained each building's maintenance staff on. He further stated it was apparent, a preventative maintenance program had not been implemented for the building. Record review at that same time confirmed that finding.	S 166	1. Binders with the preventative maintenance program initiated on February 2, 2023. All residents could potentially be at risk. 2. Maintenance Director will complete task daily, weekly, monthly, or as directed in the preventative maintenance program.	2/14/2023
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/17/23 through 1/19/23. Avantara Lake Norden was found in compliance.	S 000	3. Audits to ensue preventative maintenace is being completed will be completed by Administrator or designee twice a week for two weeks, weekly for four weeks, monthly for three months. The Administrator or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations.	