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
	435064	A. BUILDING _____ B. WING _____	09/28/2023

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

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 9/25/23 through 9/28/23. Avantara North was found not in compliance with the following requirements: F657, F693, and F812.	F 000		
F 657 SS=D	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 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	F 657	1.Resident 12, 48, and 49's facility comprehensive care plans have been updated and reflect the planned visit schedule according to the hospice plan of care. A house audit was completed to ensure all hospice residents care plans are current and collaborate with the hospice plan of care. Resident 21 was not updated as she expired prior to the completion of the POC. 2.All residents on hospice are at risk for adverse effects related to the facility care plans not collaborating with the hospice plan of care. 3.The Administrator, DON, Clinical Care Coordinator (CCC), and IDT in collaboration with the governing body and Medical Director reviewed the Hospice Services policy. The hopsice provider will ensure a schedule is provided in each residents medical chart and the CCC will monitor this process. The CCC or designee will educate the IDT and all professional nurses on the Hospice Services policy to ensure that all hospice residents care plans are updated to collaborate with their hospice plan of care, and that facility staff are aware of the calendar location for visits from hospice staff.	11/12/23

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

Celina Block | *Administrator* | 10/31/23

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 657	Continued From page 1 by: Based on observation, record review, interview, and hospice service review, the provider failed to develop a collaborative comprehensive care plan that defines hospice care for three of four sampled residents (12, 21, and 49) receiving hospice services. Findings include: 1. Observation on 9/26/23 at 12:45 p.m. of resident 12 in her room revealed she was laying in bed with her back to the door. Comparison review of resident 12's comprehensive care plan and revised 9/10/23 hospice care plan revealed: *She was admitted to hospice on 7/28/23 with diagnosis of protein calorie malnutrition. *While the comprehensive care plan reflected, the hospice aide visits were one to two days a week; no hospice aide visits were reflected on the hospice care plan. *While the hospice care plan reflected, the medical social worker was one visit every week; no medical social worker vists were reflected on the comprehensive care plan. 2. Observation on 9/26/23 at 8:30 a.m. of resident 21 in her room revealed she was resting with eyes closed and her oxygen was on per nasal cannula. Comparison review of resident 21's comprehensive care plan and revised 9/17/23 hospice care plan revealed: *She was admitted to hospice on 7/27/23 with diagnosis of acute on chronic respiratory failure. *While the hospice care plan reflected, medical scial worker visits were one visit every two weeks; no medical social worker visits were reflected on	F 657	Education will occur no later than October 26, 2023 and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The CCC or designee will audit all the hospice residents' to ensure their hospice plan of care is received and integrated with the facility care plan to collaborate with the hospice plan of care. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months. Results of the audits will be discussed by the CCC or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/12/23

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F 657	Continued From page 2 the comprehensive care plan. 3. Observation on 9/25/23 at 3:00 p.m. of resident 49 in his room revealed he was tossing a ball back and forth with guest service aide I. Comparison review of resident 49's comprehensive care plan and revised 9/20/23 hospice care plan revealed: *He was admitted to hospice on 11/7/22 with diagnosis of dysphagia causing pulmonary aspiration with swallowing. *While the comprehensive care plan reflected hospice aide visits were one day a week; hospice care plan reflected no visits. *While the comprehensive care plan reflected medical social worker once every three weeks; hospice care plan reflected one visit every two weeks. While the comprehensive care plan reflected skilled nursing visits every week; hospice care plan reflected two visits every week. 4. Interview on 9/27/23 at 2:45 p.m. with nurse supervisor D revealed: *She had no knowledge of when hospice staff planned to come to the facility or how many days a week each resident was seen by each hospice staff member. *Resident hospice binders had no up-to-date calendar with the times of upcoming visits. -No recent documentation from hospice staff on their visits. 5. Interview on 9/27/23 at 3:00 p.m. with director of nursing (DON) B revealed: *Hospice had its own schedule and the staff do not know what days of the week or what time the hospice staff would come visit the residents.	F 657		

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F 657	Continued From page 3 *We do not have hospice aides come visit because we have our own certified nurse aides (CNAs). *It should have been documented in the chart when the hospice staff had visited. 6. Interview on 9/27/23 at 3:30 with licensed practical nurse (LPN) K revealed: *She had no schedule for the residents hospice visits. *Hospice would stop at the nurse's station and give a verbal report to the staff. -Hospice nurse visits are not in the residents chart. *All hospice residents would have hospice aide visits. *Hospice aides would call before coming to the facility for their visits. *She would call the hospice phone number to talk to the nurse, if she would have a question or concern about a hospice resident. 7. Interview on 9/28/23 at 7:55 a.m. with CNA T revealed: *Hospice aide's give bed baths. *Hospice aides usually call before their visits and the bath aide will reschedule their regular bath around hospice aide visits. 8. Interview on 9/28/23 at 8:10 with DON and assistant administrator S revealed hospice visits should have been posted to communicate with staff. 9. Review of the provider's revised May 18, 2021 "Hospice Services" revealed: "3. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be	F 657		

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F 657	Continued From page 4 developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status."	F 657		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, nursing textbook review, and policy review, the provider failed to: *Appropriately check for PEG (percutaneous endoscopic gastrostomy) tube placement prior to administering a liquid medication and enteral	F 693	1.Nurse Q was immediately educated on the proper procedure for tube feeding and completed a competency after reviewing the Enteral Tube Feeding policy upon discovery during the annual recertification survey. 2.All residents requiring enteral tube feeding are at risk for adverse effects related to improper tube feeding procedures. 3.The Administrator, DON, ADON and the IDT in collaboration with the governing body and Medical Director reviewed the Enteral Tube Feeding policy. DON or designee will educate all nurses, to include Nurse Q, on the Enteral Tube Feeding policy to ensure the proper procedures are followed; including a clean surface for supplies is maintained, ensuring proper placement by obtaining the PH level and notify the MD if this is out of range, to date and time the supplies then refrigerate the remaining supply, and not use cola to unclog the feeding tube. If the tube becomes clogged nursing staff are to notify the physcian.	11/12/23

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F 693	Continued From page 5 nutrition formula for one of one sampled resident (28). *Follow the provider's policy when the pH of the stomach contents was out of range. *Follow the manufacturer's guidelines for refrigerating the cartons of enteral nutrition formula after opening. *Follow professional standards by using cola to unclog one of one resident's (28) PEG tube without obtaining a physician's order. Findings include: 1. Observation and interview on 9/27/23 at 12:43 p.m. with registered nurse (RN) Q in resident 28's room revealed: *She brought the resident's liquid medication and obtained the enteral feeding supplies from the tray on top of the resident's dresser. -On the tray, there were two opened cans of cola, two cartons of Jevity 1.2 (the enteral nutrition formula), a used orange de-clogger tool, a box of sponge gauze, a measuring bottle, a measuring pitcher, and a syringe. -The supplies were sitting on a white towel with visible brown stains on it. *She filled the water bottle with approximately 150 mL (milliliters) of tap water from the bathroom faucet. *She poured approximately 270 mL of Jevity 1.2 into the pitcher. -She used one entire carton of the formula, and a partial amount from the second carton. She replaced the cap onto the carton and marked it with the date. *Prior to administering the medication or enteral nutrition formula, RN Q explained that she needed to check the pH of the stomach contents. -She attached the syringe to the PEG tube. -With the plunger, she injected air into the PEG	F 693	Education will occur no later than October 26, 2023, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift. In addition, the DON or designee will complete an enteral tube feeding competency with all nurses no later than November 12, 2023. 4.The DON or designee will audit the tube feeding procedures for all residents requiring enteral tube feeding to ensure a clean surface for supplies is maintained, proper placement by obtaining the PH level and notify the MD if this is out of range is followed, leftover formula requiring refrigeration is dated with a timed prior to storing in the refrigeration, and cola is not used to unclog the feeding tube. Audits will be completed weekly for 4 weeks, bi-weekly for 2 months, and monthly for 2 months to ensure the proper procedure is being followed. The results of the audits will be discussed by the DON at the monthly QAPI meeting with the IDT team and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	11/12/23

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F 693	Continued From page 6 tube. -She then pulled the plunger back but did not get any stomach contents into the PEG tube or syringe. -She removed the plunger from the syringe and poured about 50 mL of water into the syringe and waited for the water to enter the stomach through the PEG tube. -After all the water entered the stomach, she used the plunger to inject air into the PEG tube. -She drew the plunger back and obtained residual stomach contents into the syringe. -She dripped some of the residuals onto a pH tester strip and reported that the pH was 1.0. --She did not stop the procedure to notify the resident's physician. *To administer the resident's liquid medication, RN Q poured more water into the syringe to flush the tube. *She then poured the liquid medication into the syringe. *Without flushing the tube with water after administering the medication, she poured the Jevity 1.2 formula into the syringe. -After filling the syringe twice more with formula, she flushed the tube with water. *After flushing the tube with water, she poured the rest of the formula into the syringe. *To finish off the tube feeding session, she poured the last of the water into the syringe to flush the tube. *She replaced the cap on the PEG tube. *She rinsed out the water bottle, formula pitcher, and syringe in the bathroom sink and placed the items on the towel to dry. *RN Q confirmed that after she opened the carton of enteral formula, she wrote the opened date on the carton and stored it on the dresser with the rest of the tube feeding supplies.	F 693		

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F 693	Continued From page 7 -She was not aware that the instructions on the carton indicated to "Refrigerate after opening." *She said, "Well it gets pretty cold in here. But if her room is hot that day then I will throw the rest of the formula away if I know it's been sitting out." Continued interview on 9/27/23 at 1:39 p.m. with RN Q about the tube feeding supplies revealed: *The night shift would replenish the tube feeding supplies each night. -They would put out a new tray, a clean towel, a water bottle, a formula pitcher, and a syringe. 2. Interview on 9/27/23 at 1:57 p.m. with director of nursing (DON) B about her expectations for proper tube feeding administration revealed: *She expected staff to set up the supplies prior to administering the tube feed. *She confirmed that RN Q should have followed the resident's physician's orders and the provider's policy for checking for PEG tube placement prior to administering water, medication, or formula into the tube. *She explained they used the cola to unclog the PEG tube. -She indicated that she had received an order from the resident's nurse practitioner to use the cola to unclog the tube. -They only used a "small amount" of cola. -Staff were supposed to change the cans of cola once per shift. *She expected staff to write the opened date on the Jevity 1.2 cartons and refrigerate them after opening. *The towels and equipment were changed daily. -Staff rinsed the equipment in between each procedure. *She explained that they recently had to change resident 28's PEG tube "quite often" because it	F 693		

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F 693	Continued From page 8 kept getting plugged. -They were unable to determine why the PEG tube kept getting plugged. Continued interview on 9/27/23 at 2:30 p.m. with DON B about the resident's PEG tube revealed: *She confirmed she could not locate any documentation for a physician's order to use cola to unclog the resident's PEG tube. -She explained that it was a verbal order from the resident's nurse practitioner. *The nursing staff had recently been through competency training on tube feeding administration, but RN Q had been hired after the competency training. 3. Review of resident 28's electronic medical record revealed: *She had physician's orders for the following: -"Enteral Feed Order three times a day 270 cc [mL] Jevity 1.2cal- via gravity. If PH greater than 5.5, alert MD [medical doctor] as tube may not be in place. If unable to withdraw contents for testing PH, Use a stethoscope, inject air listening over abdomen. After completed flush with 50 cc [mL] water." --That order was listed twice, indicating the resident was to receive 270 mL of formula six times per day. --Those physician's orders started on 9/2/23. -A verbal order of "Send [to] interventional radiology for PEG tube eval/ exchange if needed," which was ordered on 9/15/23. -There were no orders or instructions for the use of cola to unclog the PEG tube. -There were no orders for how staff were to unclog the PEG tube. *Her current care plan included the following interventions:	F 693		

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F 693	Continued From page 9	F 693		

-"Check GTube [gastric tube] placement prior to feeding to prevent aspiration pneumonia," that was initiated on 1/7/21.
-"Give GT tube [gastric tube] feeding and water flush as ordered," that was initiated on 1/7/21.
*There were no interventions documented on her care plan about how staff were to unclog the PEG tube.
*A nurse's progress note from 8/21/23 read, "I attempted to flush the g-tube prior to medication administration and there was resistance. I added warm water to the tube and let sit for 20 mins and attempted to flush it again with no luck. I used the feeding tube declogger tool, then added soda (Coke) to the tube and let sit for 30 minutes. Myself and another nurse [name redacted] attempted to flush again with no luck."
*Her PEG tube was replaced on 8/30/23 and again on 9/15/23 due to a complete blockage of the tube.
*A nurse's progress note from 9/16/23 read, "Went to give pt [patient] her morning feed with her meds and tried pouring water down the tube and it would not go. Attempted several times and even got another nurse to attempt with no luck. PT [Patient] will not swallow meds and meds were already crushed and mixed and it won't go down tube. On call Dr [doctor] called and talked with [nurse practitioner] and gave her the information. She states that [it is] not urgent to go in to get a tube change since she just got it done yesterday. We are to continue to give pt [patient] food tray and supplement with Ensure plus qid [four times a day]. Pt [Patient] did take a few sips of the [Ensure] but needs to be continually monitored and ask to continue to take sips. We are to do this through the weekend and then follow up on Monday."
*Throughout 9/16/23, resident 28 refused all oral

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F 693	Continued From page 10 meds and oral nutritional intake. -The nurse practitioner gave an order to send the resident to the emergency room for PEG tube placement. -Resident 28 refused to go to the emergency room, but had agreed to go the next morning. *There was a nursing progress note from 9/17/23 that read, "DON was able to get peg tube unplugged this AM [morning] with coke." *There was a nursing progress note from 9/20/23 that read., "Feeding tube slow to flush to no flushing. Attempted to aspirate unable to aspirate fluid. Stylus/ DE clogger put down tube twisted several times. Continued to not flush or aspirate. Poured 30cc [mL] of coke down tube. slowly drained down tube. Flushed with water with pressure. Again, added 30cc [mL] of coke plugged tube and let set for 20 min. Flushed coke through tube. Noted air escaping from tube. flushed water through tube with little force." 4. Review of the provider's 3/23/23 "Enteral Feeding (Tube Feeding)" policy revealed: *Procedure: -"4. Check for residual and placement by attaching a sixty (60) ml piston syringe to gastric tube and gently pulling back about 10 ml. If resistance is met as stomach contents are aspirated, stop procedure and notify MD." -"5. If no resistance, aspirate 5-10 ml of gastric contents. The appearance of gastric content that the tube is patent and in the stomach. Use pH strips to confirm that aspirate is at a pH of 1.5 to 5.5. If outside of these parameters, stop procedure and notify MD." -"6. If no gastric contents appear, the tube may be against the lining of the stomach or may be obstructed. Stop procedure and notify MD." *The policy had no instruction on what staff	F 693		

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F 693	Continued From page 11 should have done if the feeding tube became clogged during administration. *The policy had no instruction for the use of cola as a means of unclogging a feeding tube. 5. Review of the provider's undated "Medication / Tube Feeding (Observe)" competency checklist revealed: *"15. Check for residual and placement by attaching sixty (60) ml piston syringe to gastric tube and gently pulling back approximately 10 ml." *"16. If resistance is met as stomach contents are aspirated, stop procedure and notify MD [medical doctor]. If no resistance, aspirate 5-10 ml of gastric contents and check pH. The appearance of gastric content implies that the tube is patent and in the stomach. Use pH strips to confirm that aspirate is at a pH of 1.5 to 5.5. If outside of these parameters, stop procedure and notify MD. If no gastric content appears, the tube may be against the lining of the stomach or may be obstructed. Stop procedure and notify MD. After establishing that the tube is patent and in correct position, clamp tube." 6. Review of the carton of Jevity 1.2 enteral nutrition formula indicated there were instructions which read, "Once opened, reclose, refrigerate and use within 48 hours." 7. Review of the provider's 2021 copy of the tenth edition of "Fundamentals of Nursing" revealed: *Page 1125, Box 45.14, "Procedural Guidelines, Obtaining Gastrointestinal Aspirate for pH Measurement ..." -"1. Review agency policy and procedures for frequency of irrigation and frequency and method of checking tube placement. Do not insufflate air	F 693		

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	435064	A. BUILDING _____ B. WING _____	09/28/2023

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F 693	Continued From page 12 into tube to check placement." -"11. Verify tube placement." --"Clinical Decision: Listening for insufflated air instilled through tube to check tube tip position is unreliable ..." --"a. Check tube placement at following times ..." ---"(1) For patients receiving intermittent tube feedings, test placement immediately before each feeding (usually a period of at least 4 hours will have elapsed since previous feeding) and before medications." ---"(3) Wait to verify placement at least 1 hour after medication administration by tube or mouth." --"b. ...For intermittent feedings, remove plug at end of feeding tube. Draw up 30 mL of air into a 60-mL ENFit syringe. Place tip of syringe into end of gastric ...tube. Flush with air before attempting to aspirate fluid. Repositioning patient from side to side is helpful. In some cases more than one bolus of air is necessary." --"c. Draw back on syringe slowly and obtain 5 to 10 mL of gastric aspirate. Observe appearance of aspirate ..." -"12. If after repeated attempts it is not possible to aspirate fluid from tube that was confirmed by x-ray film to be in desired position and if (1) there are no risk factors for tube dislocation, (2) tube has remained in original taped position, (3) patient is not in respiratory distress, assume that tube is correctly placed. Continue with irrigation." -"13. Irrigate tube." --"Clinical Decision: Do not use cola or fruit juices for flushing tubing as these liquids can club tube."	F 693		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	1.The kitchen equipment that was identified during survey has been cleaned and sanitized. A full house audit was completed on expirations dates for all food items.	11/12/23

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F 812	Continued From page 13 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to: *Maintain the cleanliness of the following kitchen equipment: -The dishwasher. -The microwave. -The reach-in ice machine. -The tabletop in which the beverage machines were located. -The flattop grill and stove backsplash. -The ovens underneath the flattop grill and stove. -The utensil drawers that were located underneath the kitchen prep table. -The convection ovens. -The reach-in beverage cooler. *Dispose of expired and visibly spoiled foods from one of two reach-in coolers in the kitchen, one of one shared resident refrigerator, one of one dry storage room, and two of two emergency food supply cabinets.	F 812	All identified issues were corrected. All unpasteurized eggs have been discarded, and the department purchased pasteurized eggs. 2.All residents are at risk for adverse effects related to unsanitary equipment, expired food items, and not properly cooking unpasteurized eggs. 3.The Administrator, DON, ADON and the IDT in collaboration with the governing body and Medical Director reviewed policies for cleaning schedules, egg cookery and disposal of all expired food items and visibly spoiled foods. The Administrator or designee will educate all dietary staff to ensure the deep cleaning schedule is completed, discard expired food items timely, and only use pasteurized eggs.The deep cleaning schedule is daily with a new task for each position in the department.This process includes monitoring for expiration dates. Education will occur no later than October 26, 2023, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Administrator or designee will audit the kitchen environment to ensure it is clean and sanitary, food items are discarded timely, and unpasteurized eggs are not utilized. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months.	11/12/23

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F 812	Continued From page 14 *Properly cook unpasteurized eggs prior to serving to one of one sampled resident (34). Findings include: 1. Observation on 9/25/23 from 2:04 p.m. to 2:45 p.m. in the kitchen and dry storage room revealed: *The dishwasher had a layer of limescale buildup on the top and on the outside seams and edges of the machine. -There was a thick layer of grey slimy unidentified substance that was built up on the inside of the dishwasher doors. -Interview at that time with dietary aide U revealed that he cleaned the dishwasher each day by draining the dishwasher and rinsing out the food trap. He would delime the dishwasher once per week. *The reach-in ice machine had an orange-colored unidentified substance growing on the inside surfaces of the machine. *The microwave was dirty with burnt-on and crusty food particles. *There was a large black stain on the stainless-steel table where the beverage machines were kept. *The backsplash of the flattop grill and stove was caked with burnt-on black grease. There was a grease stain on the outside wall of the ovens too, that was located directly to the left of the stove. *The right oven located below the flattop grill had a large spill of an unidentified thick yellow substance. *The left oven located below the stovetop was covered in burnt-on black grease that was not able to have been opened without significant force. *The plastic utensil drawers located in the bottom shelf of a prep table had dust, food crumbs, and	F 812		

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F 812	Continued From page 15 other unknown crumbs amongst the clean utensils. *Both convection oven interiors were covered in a sticky layer of brown and black burnt-on grease, which had the potential to affect how the oven cooked foods and could have led to uneven cooking. *There were lists on the cork-board labeled "Deep Clean," however there were no assignments or checklists to document if a cleaning task had been completed. *The reach-in beverage cooler had crusty food crumbs and sticky liquid spills on the bottom surface of the cooler. *There was a bag of celery in the other reach-in cooler that had started to turn brown and felt mushy when picked up. -The producer's label on the bag indicated "Best if used by 9/11/23." -There was a handwritten note of "Opened 9/15" on the bag. *There was an opened case of five cucumbers. The cucumbers had started to shrivel and became mushy, and had an unknown white fuzzy-looking mold-like substance growing on them. -The delivery label indicated the cucumbers were delivered on 9/8/23. -There was a handwritten note of "Opened 9/17/23" on the box. *There was another unopened case of cucumbers with a delivery date of 9/18/23. -Upon looking in the case, those cucumbers had also started to shrivel and there was more of the unknown white fuzzy-looking mold-like substance on the cucumbers. *There was an unopened case of diced celery with a delivery date of 9/1/23. The manufacturer's "Best By" date was 9/11/23.	F 812		

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F 812	Continued From page 16 *There were thirteen cans of sweetened condensed milk in the dry storage room with the manufacturer's label indicating "Best used by 120321 [12/3/21]." Continued observation on 9/25/23 at 2:48 p.m. in the resident's dining room revealed there was a locked refrigerator for the resident's shared use. *There was a bottle of nondairy French vanilla coffee creamer in the door with a "Best By" date of "18 Dec 2021." -That bottle of coffee creamer was not labeled with any resident's name, nor was it labeled with an open date. *There was a plastic bag of resident 24's food in the lower left drawer of the refrigerator. -The bag contained a bottle of water, a package of two hard-boiled eggs, three cups of yogurt, and a Styrofoam container with an unlabeled and undated unknown food item. --The unknown food item in the Styrofoam container was covered with an unknown mold-like substance that was colored with spots of brown, green, black, and white. --All the food, except for the bottle of water, was either visibly spoiled or past the expiration date. 2. Observation on 9/26/23 at 8:30 a.m. in the main dining room revealed: *Staff served over-easy eggs to resident 34. *A staff member assisted the resident with assembling an egg sandwich. -The egg yolk was runny when the sandwich was cut. Interview on 9/26/23 at 8:34 a.m. with cook V and dietary aide W about the shell eggs revealed: *They both thought the shelled eggs were pasteurized.	F 812		

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F 812	Continued From page 17 *Cook V confirmed that the shelled eggs were not pasteurized. *They confirmed they often made eggs to order, such as over-easy eggs, for the residents. *Dietary aide W indicated that resident 34 requested over-easy eggs every morning. Interview on 9/26/23 at 9:06 a.m. with dietary manager (DM) C about the shell eggs revealed: *DM C confirmed the eggs were not pasteurized. *She indicated that resident 34 requested over-easy eggs every morning. *She was not aware that shell eggs needed to have been pasteurized if the eggs were to have been served undercooked, such as with over-easy eggs with runny yolk. 3. Interview on 9/27/23 at 12:03 p.m. with certified nurse assistant (CNA) P about the resident's shared refrigerator revealed: *He was unaware of the spoiled and expired food in that refrigerator. *It was everyone's responsibility to assist residents with labeling and dating their food and clearing out the old food from the refrigerator. 4. Observation on 9/27/23 from 4:23 p.m. to 4:49 p.m. in the emergency food cupboards revealed the following foods were past its expiration date: *One box of jelly packets with a delivery date of 7/2/19 and a "Best by" date of 9/3/19. -The box was visibly damaged as if liquid had spilled on it at one point. *Five bags of powdered milk with a delivery date of 7/2/19. *Three cans of tuna in water with a handwritten note of "Received 7/17" and a "Best by" date of 12/6/20. *One case of juice base with a delivery date of	F 812		

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F 812	Continued From page 18 7/2/19 and a "Use by" date of 5/6/20. *Four cans of corned beef hash with a delivery date of 7/2/19 and a "Use by" date of "8/20." *Two cans of beef ravioli with a delivery date of 7/2/19 and a "Use by" date of 2/1/21. *Two cans of vanilla pudding with a manufactured date of 2018, a delivery date of 7/2/19, and a "Use by" date of 3/19/20. *Three cans of pineapple chunks with a "Use by" date of "6/2020." *Twelve cans of diced peaches with a delivery date of 6/8/2018 and a "Use by" date of 9/1/20. *Three cans of diced carrots with a delivery date of 7/2/19 and a "Use by" date of "12/2021." Interview on 9/28/23 at 9:15 a.m. with DM C and regional culinary manager (RCM) G about kitchen cleanliness, the expired/spoiled foods, and the emergency food supply revealed: *They had no checklists or audit sheets for staff to utilize to ensure the cleaning tasks were completed. *They had no documentation when the last time the kitchen equipment was cleaned. *The dietary staff were responsible for checking for outdated and spoiled foods on a daily basis, and especially twice per week when they received the food shipments. *The dietary staff monitored the temperatures of the shared resident refrigerator, and the CNAs were responsible for assisting residents with labeling and dating their food. *RCM G explained that it was ultimately the dietary manager's responsibility to ensure the kitchen was cleaned, the food was rotated, and the spoiled/expired food was discarded. *When asked about the emergency food supply, DM C indicated that she rotated the foods into the regular menu to use up the supply and rotate new	F 812		

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F 812	Continued From page 19 stock into place. She "checked the [stock] once a year." -She was not aware that all the food in the emergency supply cupboards was past the manufacturer's "Best by" or "Use by" dates. 5. Review of the provider's 8/31/18 "Cleaning Schedules" policy revealed: *Policy statement: "The Food and Nutrition Services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional. *Procedure: -"1. The Director of Food and Nutrition Services or other qualified nutrition professional shall record all cleaning and sanitation tasks for the Food and Nutrition Services Department." -"2. A cleaning schedule shall be posted with tasks designated to specific positions in the department." -"3. All tasks shall be addressed as to frequency of cleaning." Review of the provider's 11/28/17 "Food from the Outside Policy" revealed: *"POLICY: The facility will comply with sanitary food practices in storing, handling, and consumption of food brought by family and visitors from the outside of the facility." *"PROCEDURE:" -"1) All food brought by visitors and family members from the outside of the facility will be labelled with the date it was brought to the facility." -"3) After 3 - 5 days, these food items will be discarded."	F 812		

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F 812	Continued From page 20 -"4) All undated food items will be discarded to ensure safety of the residents." Review of the provider's 5/20/20 "Egg Cookery and Storage" policy revealed: *"POLICY: The Food and Nutrition or Dining Services department should ensure that eggs are prepared in a manner to preserve quality, maximize nutritional retention, and to be free of salmonella and acceptable to the resident." *"PROCEDURE:" -"4. Do not use raw eggs as an ingredient in the preparation of uncooked, ready-to-eat menu items unless using pasteurized eggs." -"5. Shell eggs must not be pooled. Pasteurized eggs should be substituted for shell eggs for such items as scrambled eggs, omelets, French toast, mousse, and meringue." -"6. Individually prepared shell eggs that will be served immediately should be cooked to 145[degrees Fahrenheit] for 15 seconds." --"The following cooking times are recommended:" ---"Fried, over easy - 3 minutes at 250[degrees Fahrenheit] on one side, turn over, fry 2 minutes on other side." -"8. A soft egg should not be served unless the yolk and white are firm." -"9. Pasteurized eggs in the shell may be cooked and served individually per resident's preference." Review of the provider's 12/28/20 "Refrigerated Storage Chart" policy revealed: *"Following is a recommended outline of proper storage times for opened and unopened refrigerated items. Where different, follow manufacturer's directions and expiration dates. Expiration dates or manufacturer guidelines supersede these recommended storage times."	F 812		

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F 812	Continued From page 21 *The chart recommended keeping fresh cucumbers and celery in the refrigerator for one week. *The recommendation for keeping "Coffee Lightener, non-dairy creamer, mocha mix (liquid)" was 3 weeks unopened, and 1 week from opening in the refrigerator. Review of the provider's 5/12/16 "Dry Storage Chart" policy revealed: *"Following is a recommended outline of proper storage times for opened and unopened dry items. Where different, follow manufacturer's directions and expiration dates. Expiration dates supersede these guidelines." *The following recommendations were included on the chart: -Jellies and jams unopened for 12 months. -Juice bases unopened for 18 to 24 months. -Condensed milk for 12 months. -Canned pudding, ravioli, meats, fish, fruits, and vegetables for 12 months unopened. -Canned soups for 6 to 12 months.	F 812		

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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 9/25/23 through 9/28/23. Avantara North was found in compliance.	E 000		

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

Celina Block | Administrator | 10/20/23

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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	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

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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 9/26/23. Avantara North 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 deficiencies identified at K321 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	1. The copious amounts of combustible items identified in the 2567 have been removed from the restorative room to proper storage areas to meet the requirement of hazardous areas are protected by a fire barrier or an automatic fire extinguishing system. The COVID items were placed inside the cabinets, then disposed the combustible items. 2. All residents are at risk for adverse effects of not maintaining separate hazardous storage areas per regulation.	11/12/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Celina Block

TITLE
Administrator

(X6) DATE
10/24/23

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2023**

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

(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
K 321	Continued From page 1 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain one separate hazardous area (restorative room) as required. Findings include: 1. Observation on 9/26/23 at 9:15 a.m. revealed the restorative room was over 100 square feet and contained copious amounts of combustible items but was not protected as a storage room. a. There were approximately 20 cardboard boxes measuring 18 inches by 18 inches by 18 inches and a metal shelving unit with Styrofoam cup storage on four shelves stored in the room. b. The corridor separation was only a folding partition, not a self-closing and latching 1-3/4 inch solid bonded wood core door (or equivalent). 2. Interview with the maintenance supervisor at the time of the observation confirmed those findings. He stated the boxed items were Covid supplies. The deficiency had the potential to affect 100% of the smoke compartment occupants.	K 321	3. The Administrator, DON, ADON and the IDT in collaboration with the governing body and Medical Director reviewed the life safety code related to hazardous area storage. The Maintenance Director or designee will educate all staff on this regulation and to ensure all hazardous material is kept in areas to meet requirement. Education will occur no later than October 26, 2023, and those not in attendance due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4.The Maintenance Director or designee will audit all areas of the facility to ensure hazardous material are kept in proper storage areas. Audits will be weekly for four weeks, bi-weekly for two months, and then monthly for two months. Results of the audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10665	A. BUILDING: _____ B. WING _____	09/28/2023

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

(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	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/25/23 through 9/28/23. Avantara North was found in compliance.	S 000		
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 9/25/23 through 9/28/23. Avantara North was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Celina Block

TITLE

Administrator

(X6) DATE

10/20/23