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
	435048	A. BUILDING _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

(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 4/12/23 through 4/14/23. Avantara Groton was found not in compliance with the following requirements: F550, F559, F561, F636, F655, F658, F756, F761, and F883.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §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 or resident of the United States.	F 550	1. Resident 10 will be properly transported in her wheelchair. Her care plan has been updated to reflect that. Staff will verbally communicate with resident 17 appropriately. All residents have the potential to be at risk. 2. The Resident Dignity and Privacy Policy was reviewed with no revisions needed. (BC-05/10/23) The DON or designee will educate all staff, including CNA G and COTA I, on safe wheelchair transporting and appropriate verbal communication no later than 5/29/2023. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 5 staff members weekly x 4 weeks then 3 staff members weekly x 2 months for proper wheelchair transporting and appropriate verbal communication. Results of the audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	05/29/2023 (BC-05/10/23)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	Administrator	05/05/2023

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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§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:
Based on observation, interviews, record review, and policy review, the provider failed to provide care in a considerate manner for two of thirteen (10 and 17) sampled residents. Findings include:

1. Observation on 4/13/23 at 10:31 a.m. revealed:
*Certified nursing assistant (CNA) G pulled resident 10 backwards on a shower chair with her feet dragging on the floor through the hallway towards the spa.
*Resident 10 was holding the strap of a small clutch bag between her teeth.

Interview on 4/13/23 at 10:35 a.m. with CNA G after resident 10 was positioned in the spa room revealed:
*That was the way she always transported resident 10 for her bath.
*She had brought resident 10's wheelchair to the spa room before transporting her to the spa room on the shower chair.
*If resident 10 was transported to the spa room in her wheelchair, she would have completed an additional transfer using the mechanical lift and the sling in the spa room into the shower chair.

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*She had not considered dignity or safety as concerns when pulling her backward.

Interview on 4/13/23 at 11:05 a.m. with resident 10 revealed she:
*Needed more hands so she could hold onto her clutch bag while being transported.
*Had not offered a comment on being pulled backward but stated a compliment for how the staff had taken care of her.

Review of resident 10's electronic medical record (EMR) revealed:
*She had been a resident since 8/3/19.
*Her diagnoses included post-polio syndrome, muscle wasting and atrophy, and pain in both shoulders.
*Her care plan for physical functioning deficit related to self-care and mobility impairments directed interventions for:
-"Total assistance of two [persons] with full lift" for transferring between surfaces, initiated on 9/23/19 and revised on 5/9/22.
-"Independent with electric scooter" [wheelchair] for locomotion [moving between locations], initiated on 9/23/19 and revised on 10/27/22.
-"Total dependence with bathing; staff assists as needed," initiated on 2/5/20 and revised on 10/27/22.
*The care plan had not specified how staff would assist the resident to the spa room.
*The 1/12/23 Minimum Data Set (MDS) coded:
-A score of 13 for the Brief Interview for Mental Status (BIMS), which reflected resident 10's cognition was intact.
-Transferring was totally dependent on two persons providing physical assistance between surfaces.
-Locomotion as supervision for self-performance

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with one person's physical assistance.

Interview on 4/13/23 at 11:43 a.m. with administrator (ADM) E, emergency permit holder (EPH) A, and director of nursing (DON) B revealed CNA G transporting resident 10 backward in the shower chair was a concern related to both dignity and safety.

Interview on 4/13/23 at 2:30 p.m. with ADM A revealed:
*The provider's policy on dignity was the only policy that had addressed the observed concern regarding CNA G with resident 10.
*They had no policy regarding safe locomotion while transporting residents.
*How residents were moved between locations safely should have been addressed in the resident's care plan.

Review of the provider's policy, "Resident Dignity and Privacy," created in September 2019, revealed:
*"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy."
*The "guidelines" to be followed included, "The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences."
*There was no guideline regarding transporting residents to the spa room.

2. Observation on 4/13/23 at 10:00 a.m. revealed:
*Certified occupational therapy assistant (COTA) I walked with resident 17 in the hallway.

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*COTA I supported resident 17's left arm with her left hand, and held onto a gait belt around resident 17's waist with her right hand.
*As they neared a medication cart parked along the wall, resident 17 reached out her right hand towards a computer mouse setting on the top of the cart.
*COTA I said in a firm tone with increased volume, "No, No, No," and then reached behind resident 17s right arm to move it away from the mouse.

Interview on 4/13/23 at 10:30 a.m. with COTA I, after continued observation of her interaction with resident 17, revealed:
*Resident 17 often reached out for things and needed physical prompts or cues to perform physical actions.
*Resident 17 vocalized with "huffs and puffs" in response to some conversations, and very seldom spoke words.
*COTA I had not offered a comment about the way she said "No" to resident 17.

Review of resident 17's EMR revealed:
*Her admission date was 4/24/19.
*Her diagnoses included Alzheimer's Disease and dementia with anxiety disorder.
*Her care plan noted focus areas for:
-Dependent on staff for emotional, intellectual, physical and social stimulation, initiated on 5/7/19 and revised on 5/10/22, with interventions for "all staff to converse with [resident 17] while providing care," initiated on 5/7/19 and revised on 5/18/21.
-"Difficult or troubled past" and "parents were mentally/emotionally abusive as well as physical abuse from her brother," initiated on 10/1/20 and revised on 11/19/21, with interventions to "observe [resident 17] for signs of fear and

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insecurity during delivery of care...Help her feel safe," initiated on 10/1/20 and revised on 5/18/21.
-"Impaired thought processes and intermittent communication issues," initiated on 4/28/22 and revised on 4/12/23, with interventions to "cue, redirect and supervise her as needed," initiated on 10/31/19 and revised on 11/19/21.
*The 1/24/23 MDS coded:
-A score of 00 for the BIMS, which reflected resident 17's cognition was severely impaired.
-Mood and behavior sections as no symptoms occurred.
-Walking in the room as guided maneuvering with one-person physical assistance.
-Walking in the corridor as only occurred once or twice.
-Transferring as totally dependent with two persons providing physical assistance between surfaces.
-Locomotion as supervision for self-performance with one person's physical assistance.

Interview on 4/13/23 at 10:40 a.m. with licensed practical nurse (LPN) H confirmed:
*Resident 17 said a few more words than she used to but usually responded with a huff or puff.
*Resident 17 did reach out and was distracted by things around her. She used to walk into other residents' rooms and take things.
*LPN H was sitting at the nurse's desk when COTA I walked with resident 17 by the medication cart parked in the hallway.
*She observed COTA I move resident 17's arm by reaching behind her arm and moving it away from the computer mouse.
*COTA I should not have spoken to resident 17 with the tone of voice she used but LPN H felt COTA I had not intended it to be disrespectful.

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F 550	Continued From page 6 Interview on 4/13/23 at 11:43 a.m. with ADM E, EPH A, and DON B confirmed COTA I's tone of voice could be defined as disrespectful and they would follow-up with her about that. Interview on 4/13/23 at 4:30 p.m. with ADM E revealed they had no policy related to dementia care and approaches for effective communication.	F 550		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on interview, medical record review, and document review, the provider failed to notify two of thirteen sampled residents (12 and 20) of a room and/or roommate change. Findings include: 1. Interview on 4/12/23 at 2:57 p.m. with resident 20 regarding her room and roommate revealed she: *Said there was "kind of a ruckus" when staff started to rearrange residents into new rooms.	F 559	1. Residents 12 and 20 report being content with their current rooms and having a roommate. All residents have the potential to be at risk. 2. The administrator or designee will educate all applicable staff, including SSD F, on timely resident and responsible party notification of room changes and documentation of such by 5/29/23. Those not in attendance will be educated prior to their next shift worked. The social worker or designee will interview all residents and responsible parties, if applicable, who had recent room changes to ensure satisfaction or resolve dissatisfaction of current room/roommate and documentation of such by 5/29/23. 3. No additional policy is needed, the room change notification form will be used as previously directed. Staff will be educated on the expected use and completion of the form by 5/29/23. (BC-05/10/23)	05/29/2023 (BC-05/10/23)

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F 559	Continued From page 7 *Used to have a bedroom to herself. *Indicated staff had not informed her of the room change or that she was getting a roommate prior to moving her to another room. 2. Interview on 4/12/23 at 4:01 p.m. with resident 12 regarding his room and roommate revealed he: *Said staff had not given him a choice about having a roommate. *Said, "They just sprang it on me." *Was very upset and said that his roommate had the "bigger half" of the room. *Experienced increased anxiety about having a roommate because of the following: -His roommate would put items in the walking space, making him feel trapped. -He was worried that his roommate might sift through his personal belongings. -Since his roommate moved in, there was not enough room to have his bed, his electric scooter, and his recliner. He had to get rid of his recliner. -He worried about having a bathroom accident if his roommate was using the bathroom at the time he needed to use the bathroom. 3. Interview on 4/13/23 at 9:19 a.m. with social services director (SSD) F regarding the recent room reassignments revealed: *They had started to move residents around about two months ago due to renovations. *She said she had conversations with both residents and their families about the upcoming room reassignments about a week prior to moving the resident. -At that time, she also informed the residents about their new roommates and would introduce the residents to each other. *She confirmed there was no documentation	F 559	4. The Administrator or designee will audit 5 resident charts x 4 weeks then 1 weekly x 2 months for resident and applicable responsible party tim notification of room changes and documentation of such. Results audits will be presented by the Administrator or designee at t QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	

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indicating the residents and family members had been informed about the room reassignments.

4. Interview on 4/13/23 at 10:46 a.m. with director of nursing (DON) B regarding resident room and roommate changes revealed:
*They considered a resident's personality and similar likes/dislikes when making roommate assignments.
*Due to remodeling on the 200-hallway, she and her staff rearranged room assignments and congregated the residents on the 100- and 300-hallways.
*They started moving residents around in January.
*The new roommate assignments coincided with their new staffing models.
*They were working on gathering documentation for resident 12 to have his own room due to his increased anxiety and social isolation since getting a roommate.
*She confirmed that if SSD F could not find documentation indicating the residents and family members had been informed about the room reassignments, then there was likely no such documentation.

Interview on 4/14/23 at 11:04 a.m. with DON B about a room change notification policy revealed:
*They had no formal room change policy or procedure.
*She provided a "Notification of Room Change" form.
-She said that was the form they should have been using for each resident room change.
-She confirmed they had not been using the form.

5. Review of resident 20's medical record revealed:

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F 559	Continued From page 9 *She was moved from a private room to a semi-private room on 2/9/23. *There was no documentation indicating that she had been informed of the room and roommate change prior to 2/9/23. 6. Review of resident 12's medical record revealed: *He was admitted on 4/8/22 and had been staying in the same room. *There was no documentation indicating that he had been informed of the roommate change. 7. Review of the provider's "Notification of Room Change" form revealed: *There was space for a staff person to check "Yes" or "No," and write the date that the resident had been notified, and that the resident's representative had been notified. *There was space for the resident to check "Yes" or "No" to the following statement: "I voluntarily agree to move to room [blank space]." -Underneath, there was a statement that read, "You may have the right to appeal the decision to transfer you to another room. If you have any questions about this transfer or would like help to appeal, contact the staff representative whose signature appears below or [your] State Long Term Agency or your State Ombudsman at the phone number listed below."	F 559		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561	1. Resident 5's applicable medications have been ordered to reflect the requested time of administration and are being administered as ordered. All residents that receive early morning medication have the potential to be at risk.	05/29/2023 (BC-05/10/23)

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(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and policy review, the provider failed to support the sleep schedule for one of nine residents (5) interviewed. Findings include:

1. Resident 5 stated during an interview on 4/12/23 at 9:42 a.m. that the staff "sometimes" wake her up to "give me my pills" at 5:00 a.m.

Interview on 4/13/23 at 9:49 a.m. with certified nursing assistant (CNA) J revealed:
*She assists resident 5 to get dressed sometime between 6:00 a.m. and 6:30 a.m.
*Sometimes she was awake and sometimes she

F 561 2. The Resident Dignity and Privacy policy was reviewed with no revisions needed. (BC-05/10/23) The DON or designee will interview residents with ordered early morning administration times to determine if they would prefer a change in administration time. If they do, the DON or designee will contact their primary care provider to request a change in orders and follow any order changes. The DON or designee will train all nursing staff of this process no later than 5/29/23. Those not in attendance will be educated prior to their next shift worked.

3. The DON or designee will interview 2 current residents weekly for continued satisfaction with medication administration times and all new admissions weekly to identify any medication administration time preferences and communicate the request to the primary care provider for review and order changes, if applicable. Audits will be completed for 3 months. Results of the audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.

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was not awake but she "doesn't seem to mind" getting awakened.
*Resident 5 had previously told CNA J that she had gotten awakened at 5:00 a.m. for her medication.

Review of the electronic medical record for resident 5 revealed:
*The following care plan focuses and interventions had not addressed her sleep schedule:
-Physical functioning deficit, initiated on 1/13/20 and revised on 9/29/22, indicated that the resident required extensive assist and a stand-up mechanical lift to transfer from bed and limited assist of one staff person to get dressed, initiated on 10/5/21 and revised on 1/14/23.
-At risk for fluctuating blood sugars, initiated on 1/2/20 and revised on 10/5/21, with an intervention to administer oral glycemic medications as ordered, initiated on 1/2/20 and revised on 4/3/20.
*The Brief Interview for Mental Status (BIMS) score was 15 on the 9/14/22 annual Minimum Data Set assessment, which reflected resident 5's cognition was intact.
*The April 2023 medication administration record noted the following orders scheduled at 6:00 a.m.:
-Semaglutide Tablet 7 MG [milligrams], 1 tablet by mouth one time a day, related to diabetes mellitus, start date 6/24/22.
-Farxiga Tablet 10 MG, 1 tablet by mouth in the morning, related to diabetes mellitus, start date 2/16/22.
-Weekly skin assessment every day shift every Friday, start date 1/3/20.
-Check daily BP [blood pressure] every day shift for 1 week, start date 4/7/23.

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F 561	Continued From page 12	F 561		

Interview on 4/13/23 at 10:55 a.m. with licensed practical nurse (LPN) H revealed her shift started at 6:00 a.m., and the night nurse or medication assistant administers medications scheduled at 6:00 a.m.

Interview on 4/13/23 at 10:57 a.m. with qualified medication aide (QMA) K revealed her shift started at 6:00 a.m., and she gave resident 5 her medications "in the dining room with breakfast", but she received "two pills" before her shift started.

Interview on 4/13/23 at 11:43 a.m. with director of nursing B, emergency permit holder A, and administrator E revealed:
*They agreed that residents should not have been awakened for medications.
*The DON confirmed resident 5 usually woke up daily sometime between 6:00 a.m. and 6:30 a.m., and there would be time for those medications to be administered before breakfast.

Review of the provider policy, "Resident Dignity and Privacy," with a creation date of September 2019 revealed:
*"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity."
*"The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences."

F 636 SS=E — Comprehensive Assessments & Timing
CFR(s): 483.20(b)(1)(2)(i)(iii)

F 636

§483.20 Resident Assessment

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F 636	Continued From page 13 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff	F 636	1. No immediate corrections could be made to past assessments for residents 4,5,9,13 and 17. All residents have the potential to be at risk. 2. The DON or designee will educate all IDT members, including SSD F and Activities director L, and all licensed nurses on completing assessments within the required timeline and key dates/ timeframes of the MDS assessment, no later than 5/29/23. (BC-05/10/23) Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 5 residents' most recent assessments/MDS for timely completion weekly x 4 weeks then 3 records weekly x 2 months. Results of the audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	05/29/2023 (BC-05/10/23)

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members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the provider failed to ensure Minimum Data Set (MDS) assessments for 5 of 13 sampled residents (4, 5, 9, 13, and 17) were completed in a timely manner. Findings include:

1. Review of Section C. Cognitive Patterns in the significant change in status MDS, with an assessment reference date (ARD) of 12/27/22 in resident 4's electronic medical record (EMR) revealed:
*Item C0100 "Should Brief Interview for Mental Status [BIMS] be conducted?" was coded as "Yes."
*The interview items C0200 to C0400 were coded as "Not assessed."
*Section C was signed by social services director (SSD) F on 12/29/22.

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Review of the user-defined assessments (UDA) that supported the coding on the MDS in resident'4 EMR revealed the social services UDA for the 12/27/22 MDS had not been completed.

Review of the Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.17.1, dated October 2019, revealed:
*On page 2-9, the ARD "refers to the last day of the observation (or 'look back') period that the assessment covers for the resident."
*On page C-2, the BIMS interview "is conducted during the look-back period" of the ARD and if the interview "was not conducted within the look-back period (preferably the day before or the day of)...the standard 'no information' code (a dash)" was entered in the interview items.

2. Review of Section F. Preferences for Routine and Activities in the annual MDS with an ARD of 9/14/22 in resident 5's EMR revealed:
*Item F0300, "Should Interview for Daily and Activity Preferences be conducted?" was coded as "Not assessed."
*All the interview items in F0400 and F0500 were coded as "Not assessed."
*Item F0700, "Should the Staff Assessment for Daily and Activity Preferences be conducted? was coded as "Not assessed."
*All the items in F0800 were marked with a dash, which was appropriate if staff were unable to determine the responses.
*Section F was signed by Registered Nurse - Clinical Care Coordinator (RN - CCC) M on 9/29/22, 16 days after the start date of 9/14/22.

Review of the CMS RAI 3.0 User's Manual,

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Version 1.17.1, dated October 2019, revealed:
*On page 2-19, an annual MDS was required to be completed no later than 14 calendar days after the ARD.
*On page F-2, the "is conducted during the look-back period" of the ARD and if the interview "was not conducted within the look-back period...the standard 'no information' code (a dash)" was entered in the interview items.

Review of UDAs in resident 5's EMR revealed no activity evaluation had been completed for the 9/14/22 MDS, and the most recent activity evaluation was dated 9/22/21.

Interview on 4/13/23 at 3:01 p.m. with director of nursing (DON) B revealed:
*Activity director (AD) L confirmed she "had missed" completing her activity evaluation UDA.
*AD L "had started in her position in April 2022."

Review of Section C. Cognitive Patterns in the 12/15/22 and 3/17/23 quarterly MDS assessments for resident 5 revealed:
*Items C0100 "Should Brief Interview for Mental Status [BIMS] be conducted?" in both MDSs were as "Yes."
*The interview items in C0200 to C0400 were in both MDSs were coded as "Not assessed."
*Both MDSs were signed by SSD F.

3. Review of Section F. Preferences for Routine and Activities in the annual MDS with an ARD of 6/28/22 in resident 9's EMR revealed:
*Item F0300, "Should Interview for Daily and Activity Preferences be conducted?" was coded as "Yes."
*All the interview items in F0400 and F0500 were coded as "Not assessed."

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*Those items were signed by RN - CCC N on 7/6/22.

Review of UDAs in resident 9's EMR revealed the activity evaluation for the 6/28/22 MDS had not been completed.

4. Review of Section C. Cognitive Patterns for the quarterly MDS with an ARD of 4/21/22 in resident 17's EMR revealed:
*Item C0100 "Should Brief Interview for Mental Status [BIMS] be conducted?" was coded as "Yes."
*The interview items in C0200 to C0400 were coded as "Not assessed."
*Item C0600, "Should the Staff Assessment for Mental Status be conducted?" was coded as "Not assessed."
*Items in C0700 through C1000 and C1310 were coded as "Not assessed."
*Section C was signed by SSD F on 4/28/22.

5. Review of Section C. Cognitive Patterns for the 2/19/23 quarterly MDS for resident 13 revealed:
*Item C0100 "Should Brief Interview for Mental Status [BIMS] be conducted?" was coded as "Yes."
*The interview items in C0200 to C0400 were coded as "Not assessed."
*Item C0600, "Should the Staff Assessment for Mental Status be conducted?" was coded as "Yes."
*Section C was signed by SSD F on 2/20/23.

Interview on 4/13/23 at 10:30 a.m. with SSD F revealed:
*She was not able to complete the BIMS within the required MDS time frame so she had to code

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F 636	Continued From page 18 the interview items with dashes. *Section C BIMS items were to have been completed by 2/19/23. *She agreed the answers for Section C did not accurately reflect resident 13's cognitive status. *She had not discussed her inability to complete this section with the MDS coordinator. F 655 Baseline Care Plan SS=E CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	F 636 F 655	1. Corrective Actions for resident(s) found to have been affected by this deficiency: Past timeframe for baseline care plan implementation for residents 228, 229 and 230. Corrective action for residents that may be affected by this deficiency: All residents admitted to the facility in the last 48 hours have the potential to be affected.	05/29/2023 (BC-05/10/23)

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F 655	Continued From page 19 this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure three of three newly admitted sampled residents (228, 229, and 230) had a baseline care plan that had been established and reviewed with the resident, their representative, or their responsible family member. Findings include: 1. Review of residents 228, 229, and 230 revealed no baseline care plan. There was no documentation that the resident, their representative, or their responsible family member and received the baseline care plan. Interview on 4/13/23 at 11:15 a.m. with SSD F revealed she was not aware of any baseline care plan requirement. She only provided a copy of the comprehensive care plan to the resident and/or representative at the care conference meetings. Interview on 4/13/23 at 11:30 a.m. with licensed practical nurse H revealed: *When a resident was admitted the nurse	F 655	2. Measures that will be put into place to ensure that this deficiency will not reoccur: Under the direction of the DNS the Facility Nursing Staff will receive in-service training regarding care plan implementation by 5/29/23. Those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. Under the direction of the administrator or designee the SSD will receive in-service training regarding baseline care plan implementation by 5/29/23. DNS/Designee will review all resident charts of those admitted in the 48 hours prior to 5/6/23 to ensure the completion and communication of the baseline care plan to resident or their representative. DNS/Designee will review all new admissions weekly for 4 weeks and monthly for 2 months or as directed by the QAA committee. 3. Measures that will be implemented to monitor the continued effectiveness of the corrective action taken to ensure that the deficient practice has been corrected and will not reoccur.	

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F 655	Continued From page 20 completed the initial assessment. *She had not completed a baseline care plan to give to the resident, their representative, and/or their responsible family member Interview 4/13/23 at 3:30 p.m. with emergency permit holder A revealed no baseline care plans had been completed for residents 228, 229, and 230. Interview on 4/14/23 at 8:00 a.m. with director of nursing (DON) B revealed she thought social services director (SSD) F completed the baseline care plan for a newly admitted resident. She would have then presented it to the resident, their representative, or their responsible family member for their review. Review of the provider's September 2019 Care Planning policy revealed the DON was responsible for holding the team accountable to initiate and complete the admission care plan within 48 hours.	F 655	SSD will review the resident charts of newly admitted residents the following business day to ensure the completion of the baseline care plan and provide a copy of the plan to the resident or representative. Reporting concerns in daily morning meeting. The Quality Assessment & Assurance Committee will review findings submitted by the different sub-committees to monitor continued compliance and opportunities for improvement. Administrator or resource nurse will monitor the QA process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. The Quality Assurance Committee will review facility progress on the identified concerns monthly. Facility alleges compliance with this deficiency on 5/29/23.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the provider failed to provide appropriate follow-up interventions for one of one sampled residents (20) who had made suicidal ideations. Findings include:	F 658	1. No immediate action was required for resident 20's past comment. All residents have the potential to be at risk.	05/29/2023 (BC-05/10/23)

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1. Interview on 4/12/23 at 2:57 p.m. with resident 20 regarding her room and roommate revealed:
*She was quite upset when she had to move rooms and get a roommate.
*She had not liked her roommate at first but had since warmed up to her.

2. Review of resident 20's medical record progress notes revealed a "Health Status Note" from 2/12/23 that read the following:
*"As [resident 20's] daughter [daughter's name] was leaving, she informed writer that [resident 20] asked to leave some pills for her so she could end her roommate situation faster. [Resident's daughter] stated she told [resident 20] that her comment was inappropriate and she shouldn't talk like that."

3. Interview on 4/13/23 at 9:19 a.m. with social services director (SSD) F regarding resident 20 revealed:
*She learned of resident 20's comments the next day on 2/13/23.
*She could not remember if resident 20 was making comments about taking the pills herself or giving the pills to her roommate.
*When she interviewed resident 20 on 2/13/23, she said that resident 20 did not have any specific plan.
*Resident 20 had again expressed to her that she was upset about having a roommate.
*SSD F said that she offered counseling services to resident 20, but the resident declined.
*She confirmed she had not documented any of her follow-up interventions, such as her discussion with resident 20 on 2/13/23, offering counseling services, or any conversations with her family members.

2. Mental health adjustment difficulties related to trauma PTSD or other mental health issues policy was reviewed and will be implemented no later than 5/29/23. The administrator or designee will educate all staff on timely intervention and documentation of such circumstances, including SSD F, no later than 5/29/23. Those not in attendance will be educated prior to their next shift worked.

3. The Administrator or designee will audit progress notes for concerning statements and appropriate action daily x 4 weeks then weekly x 2 months. Results of the audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.

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*There had been no other incidences regarding resident 20.
*She was unable to determine if any interventions had been initiated on 2/12/23 when resident 20 had made those comments, such as separating the resident and her roommate, informing the director of nursing or her physician, putting resident 20 of 15-minute checks, or taking her to a safe room.

4. Interview on 4/13/23 at 9:44 a.m. with licensed practical nurse H regarding resident 20's comments revealed she:
*Remembered that resident 20 was very upset about having to move rooms and move in with a roommate.
*Was not aware of the comments that resident 20 had made on 2/12/23.

5. Phone interview on 4/13/23 at 10:24 a.m. with resident 20's daughter regarding comments her mother had made on 2/12/23 revealed she:
*Confirmed that resident 20 had a change in behavior and was very upset about having to change rooms and move in with a roommate.
*Visited resident 20 more often than usual during that time due to her change in behavior.
*Clarified that resident 20 asked for pills to end her own life, not to give the pills to her roommate.
-Resident 20 had been through a tough couple of years with several of her close family members passing away and had made statements of wanting to die so she could be with her loved ones again.
*Was not aware if the provider contacted resident 20's physician to inform him of her comments.

6. Interview on 4/13/23 at 10:46 a.m. with director of nursing (DON) B regarding resident 20's

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comments revealed:
*Resident 20 had made those comments on a Sunday.
*She had not been made aware of those comments until the following day.
*She said resident 20's comments would have been considered suicidal ideation.
*If a resident made comments of suicidal ideation, she expected staff to notify her, the administrator, the assistant DON, the resident's physician, and the resident's representatives.
-She confirmed that none of those steps had been completed.
*She expected staff to follow-up with the resident to ask them what they meant by their comments, if they had an active plan or intent, and place the resident on 15-minute checks.
-If the resident expressed that they had a plan, she would have expected staff to either move them to a safer area or obtain physician orders to send the resident to a mental health unit.
*She could not determine if the staff had provided any interventions for resident 20 after she had made the suicidal ideation comments due to the lack of documentation.
*Resident 20 had an increase in behaviors such as crying, yelling at staff and her roommate, and isolating herself after they had moved her to a new room with a roommate on 2/9/23.
*She confirmed that resident 20's physician had not been contacted about her behaviors until 3/1/23 when they requested an increase for her duloxetine (a medication used to treat depression and anxiety) due to her behaviors.

7. Interview on 4/13/23 at 3:35 p.m. with regional nurse consultant D about the provider's policy on self-harm and suicidal ideation revealed:
*They had no policy on resident self-harm or

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suicidal ideation.
-They recently drafted a policy, but it had not been approved yet.
*She agreed that resident 20's statements would have been suicidal ideation.
*She would have expected the nurse on staff that day to follow-up immediately, assess the resident, and notify the DON and the resident's physician for further orders.

8. Interview on 4/13/23 at 3:37 p.m. with emergency permit holder A regarding policies and procedures revealed:
*They had no policies or procedures for the following:
-Documentation standards.
-Standard of practice reference guide for social services.
-Resident self-harm prevention or suicidal ideation.

9. Review of resident 20's medical record revealed:
*There was a "Behavior Note" from 2/9/23 that read:
-"Behavior: Resident crying about her room change. States she doesn't care for her new [roommate]. States she feels as if she has to 'babysit' her. States [she is] afraid she'll fall because she doesn't call for help during transfers. Refuses to let anyone hang up her pictures and refusing to get into her bed. 'I'll just sleep in my recliner.'"
-"Non Pharmacological Interventions: Reassurance provided. Called her daughter and gave her an update earlier and asked if she could talk to [resident 20]. Daughter talked to her for appx 15 min."
-"Summary/Outcomes: Continues to be upset but

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no longer crying. Will continue to monitor."
*There was a "Social Service Note" from 2/10/23 that read:
-"[CNA's name] stated when he'd left the room and gone into another room he heard yelling coming from [resident 20's] room. When [CNA names] returned to the room they found [resident 20's] roommate going through the mail on her bed. [Resident 20] was screaming and yelling at her roommate telling her that wasn't her mail. Her roommate was telling her that she just wanted to check it. At one point [resident 20's] roommate became upset and threw her mail on the floor and then kicked it multiple times until it was under the bed. [CNA name] also reported [resident 20's] roommate appeared confused and was trying to get into [resident 20's] bed at one point instead of getting into her own. Writer directed [CNA names] to let both [resident 20] and her roommate know they can not be touching each other's things."
*There was a "Behavior Note" from 2/11/23 that read:
-"Behavior: CNA informed writer that when she walked by [resident 20's] room. [resident 20] was yelling at roommate for being on her side of the room. Roommate was trying to cross the room to use the bathroom but had got her wheelchair stuck on the bed frame."
-"Non Pharmacological Interventions: CNA helped roommate across the room to the bathroom."
*The daily skilled nursing assessments from 2/12/23 to 2/14/23 indicated that no behavioral problems were noted.
*Her care plan had a section addressing her mental health which included:
-The focus area read "[Resident 20] is receiving anti-depressant medication. [History] of depression," which was initiated on 1/5/22 and revised on 3/14/22.

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-The goal read "[Resident 20] will have intended effect of the medication through next review," which was initiated on 1/5/22, revised on 7/11/22, and had a target date of 1/6/23.
-The interventions read:
--"Administer the medications as ordered."
--"Keep call light within reach."
--"Monitor for side effects and report to physician: Antidepressant-Sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia, muscle tremor, agitation, headache, skin rash, photo sensitivity and excess weight gain."
--"Monitor labs as ordered by [medical doctor]."
--"Provide Medications as ordered by physician and evaluate for effectiveness. Utilize [Patient Health Questionnaire]-9 scale and notify [primary care provider] [for] scores of 10 or more."

10. Review of the provider's December 2019 "Notification of Change of Condition" policy revealed:
*"Policy Statement"
-"The facility will provide care to residents and provide notification of resident change in status."
*"Procedures"
-"1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:"
--"b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);"
--"c. A need to alter treatment significantly (i.e., a need to discontinue an existing form on treatment due to adverse consequences, or to commence a new form of treatment) ..."

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F 756 SS=D	Continued From page 27 Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756 F 756	1. The DON faxed pharmacy recommendations for resident 4 to the primary care provider for review and response on 04/14/23. Response was received on 04/17/23 with order to discontinue. Order was followed. All residents have the potential to be at risk. 2. The Consultant Pharmacist Report Policy was reviewed with no revisions needed. (BC-05/10/23) The DON or designee will continue to fax pharmacy recommendations to the primary care provider when received from the pharmacy. A tracking log will be utilized to ensure responses are received and acted upon in a timely manner. The DON or designee will educate all licensed nursing staff of this process no later than 5/29/23. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit all most recent pharmacy recommendations x 4 weeks, then 5 weekly recommendations x 2 months for timely response and action. Results of the audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	05/29/2023 (BC-05/10/23)

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when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:
Based on record review, interview, and policy review, the provider failed to ensure the resident's physician and the director of nursing (DON) acted upon the pharmacist's recommendations for one of five sampled residents (4). Findings include:

1. Review of resident 4's electronic medical record (EMR) revealed:
*The pharmacist medication regimen review user-defined assessments (UDA) on 8/24/22, 10/26/22, and 12/29/22 noted "See report for any noted irregularities and/or recommendations."
*No scanned reports with the the physician's and the DON's response to the above pharmacist medication regimen reports.

DON B provided copies of:
*The "Pharmacist Recommendations to MD" (medical doctor) for each of the UDAs on 8/24/22, 10/26/22, and 12/29/22, which revealed the statement, "Resident has an order for Hydroxyzine PRN [as needed] with no stop date indicated."
*The physician orders from the clinic that prescribed the hydoxyzine, which revealed:
-On 10/25/22, "Increase hydroxyzine to 25 mg BID [twice a day] PRN." No rationale was noted by the physician to increase the frequency.
-On 1/31/23 and on 4/3/23, "Continue hydroxyzine 25 mg BID." No rationale was noted to continue the physician's order.

Interview on 4/13/23 at 4:48 p.m. with DON B revealed:
*She was unable to find a physician's note in

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response to the above pharmacist reports.
*The pharmacist's recommendations were to "discontinue the hydroxyzine prn for anxiety."
*Resident 4 "goes to a clinic visit once a month for an infusion related to his MS (multiple sclerosis). They think his behavior reflects anxiety, but we do not see that behavior here."
*Resident 4 had not been administered the hydroxyzine at the facility.
*She received monthly pharmacy reports by email from the pharmacist, which she then faxed to the physician.
*She "keeps the stack (of pharmacist recommendations) on her desk" to ensure she received a reply from physician.
*She confirmed she had failed to ensure the physician had responded to the pharmacist recommendations for resident 4.

Review of the medication administration record for resident 4 revealed orders for and the administration of hydroxyzine (an antihistamine for symptoms of itching and a sedative for anxiety) 25 MG [milligrams] PRN [as needed] for anxiety on the following dates:
*Order start date on 7/19/22 for one tablet daily. It was given only on 9/26/22.
*Order start date on 10/26/22 for one tablet twice a day. It was given only on 11/22/22.
*Order start date on 12/20/22 for one tablet twice a day. It was given only on 12/29/22.
*There was no hydroxyzine given in January, February, March, or April 2023 to date.

Review of the 12/27/22 significant change in status Minimum Data Set assessment revealed:
*Section C - Cognitive Patterns was coded with no cognitive or decision-making limitations.
*Section E - Behavior was coded with no

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indicators or symptoms of behavior concerns.

Review of resident 4's care plan revealed the following focus areas:
*Physical functioning deficit related to related to diagnosis of "MS" and anxiety, initiated on 8/6/21 and revised on 10/27/22, with interventions for supervision and assistance with activities of daily living as needed.
*"Weekly infusions" related to diagnosis of MS, initiated on 9/16/21.
*Significant mood distress/depression with social service interventions and counseling with a mental health service, initiated on 10/18/21.
*Altered respiratory status/difficulty breathing related to diagnosis of anxiety, initiated on 10/27/22, with interventions to provide adequate rest periods and use pain management as appropriate, initiated on 10/27/22.

Review of the provider policy, "Consultant Pharmacist Reports," revealed:
*The pharmacist "findings are phoned, faxed, or e-mailed within (24 hours) to the director of nursing or designee and are documented and stored with the other consultant pharmacist recommendations in the resident's [active record]."
*"The prescriber is notified as needed."
*The consultant pharmacist "identifies irregularities through a variety of sources including the resident's clinical record, pharmacy records, and other applicable documents."
**Resident-specific irregularities and/or clinical significant risks resulting from or associated with medications are documented in the resident's [active record] and reported to the Director of Nursing, Medical Director and/or prescriber as appropriate."

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F 756	Continued From page 31 *"If a continuing irregularity is deemed to be clinically insignificant, or evidence of a valid clinical reason for rejecting the recommendation is provided, the consultant pharmacist will reconsider whether to report the irregularity again or make a new recommendation on an annual basis." *"Recommendations are acted upon and documented by the facility staff and/or the prescriber." *"Prescriber accepts and acts upon suggestion or rejects and provides an explanation for disagreeing."	F 756		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761	1. All expired meds in the Nexsys system were reviewed and discarded if expired by the DON on 04/12/23. All residents have the potential to be at risk. 2. The pharmacy will audit the medications stored in the Nexsys machine monthly for upcoming expired medications and notify the DON and Administrator. The DON or designee will remove and discard them prior to expiration. The DON or designee will educate all licensed nursing staff of this process no later than 5/29/23. Those not in attendance will be educated prior to their next shift worked.	05/29/2023 (BC-05/10/23)

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 761	Continued From page 32 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: Based on observation, interview, record review, and policy review, the provider failed to dispose of expired medications in one of one Nexsys automated dispensing cabinet (ADC). Findings include: 1. Observation and Interview on 4/12/23 at 3:36 p.m. with director of nursing B during an inspection of the medication room revealed: *She was on the phone with the provider's contracted pharmacy to clarify the process for how she would remove expired medications from the Nexsys ADC. *On 3/31/23, the pharmacy had emailed her a list of expired medications in the Nexsys ADC. *Medications she should have removed from the Nexsys ADC included the following: -Prednisone 5 milligrams (mg) 20 tablets expired on 1/31/23. -Acyclovir 400 mg 10 tablets expired on 3/31/23. -Amoxicillin/Clavulanic Acid 875/125 mg 12 tablets expired on 12/31/22. -Simvastatin 10 mg 10 tablets expired on 3/31/23. -Risperidone 1 mg 14 tablets expired on 1/31/23. -Meclizine 12.5 mg 8 tablets expired on 10/31/22. -Olanzapine 5 mg 3 tablets expired on 3/31/23. -Memantine 5 mg 10 tablets expired on 3/31/23. -Phytonadione 5 mg 2 tablets expired on 2/28/23. -Celecoxib 100 mg 8 tablets expired on 10/31/22. -Scopolamine 1 mg transdermal 2 patches expired 3/23. -Piperacillin/Tazobactam 2.25 gram (gm) 4 vials expired 11/2022. -Meropenem 500 mg 5 vials expired 2/23.	F 761	3. The Administrator or designee will audit this process weekly x 4 weeks then monthly x 2 months. Results of the audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	

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F 761	Continued From page 33 -Ampicillin/Sulbactam 1.5 gm 4 vials expired 2/23. -Hydrocodone/Acetaminophen 7.5/325 mg 10 tablets expired 3/2023. Review of the provider's undated Medication Destruction For Non-Controlled and Controlled Medications policies revealed: *"Unused, unwanted and non-returnable medications should be removed from their storage area and secured until destroyed." *There was no documentation in the policy regarding when an audit of the Nexsys ADC should have been completed. *There was no procedure in the policy for ensuring medications were removed by the expiration date.	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883	1. The medical records for 6 and 25 have been updated to reflect the offer/administration of the pneumococcal vaccine. All residents have the potential to be at risk.	05/29/2023 (BC-05/10/23)

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F 883	Continued From page 34 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review, interview, policy review, and Centers for Disease Control and Prevention (CDC) recommendations, the provider failed to ensure two of five randomly sampled residents (6	F 883	2. The Pneumococcal Vaccination Policy was reviewed with no revisions needed. The DON or designee will review all resident medical records for complete documentation of the offer, administration or refusal of the appropriate pneumococcal vaccine and act upon findings accordingly. The RNC or designee will re-educate the DON/ Infection control nurse on the policy and the DON or designee will educate all licensed nursing staff on resident vaccinations by 5/29/23. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 5 resident's medical records weekly x 4 weeks then 3 resident weekly x 2 months for documented offering and/or administration or refusal of the pneumococcal vaccine. Results of the audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations for at least 3 months.	

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and 25) had documented pneumonia vaccination administration or the refusal of the vaccine in their medical records.
Findings include:

1. Review of resident 6's immunization record revealed there was no documentation of the administration or the refusal of a pneumococcal conjugate vaccine.

2. Review of resident 25's immunization record revealed there was no documentation of the administration or the refusal of a pneumococcal conjugate vaccine.

Interview on 4/14/23 at 9:30 a.m. with director of nursing B revealed she had been unable to find documentation of resident 6 and 25's pneumonia immunization. She was aware a new resident should have been offered and provided the immunization if their physician was in agreement.

Review of the provider's revised 1/24/23 Pneumococcal Vaccination - Resident policy revealed:
*All residents would have been offered and encouraged to receive the immunization.
*Each resident's immunization status would have been determined prior to the vaccination.

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
	435048	A. BUILDING _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

(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
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 4/12/23 through 4/14/23. Avantara Groton was found in compliance.	E 000		

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

Brenda Carda | Administrator | 05/05/23

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.

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
	435048	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	**1106 NORTH SECOND STREET** **GROTON, SD 57445**

(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 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/13/23. Avantara Groton 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 K222 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	1. All residents are at risk. The main entrance/exit door both have signage to indicate they are delayed egress and instructions on how to exit them. 2. Administrator will in-service maintenance director to ensure the facility follows the NFPA 101 guidance by May 29, 2023. 3. The Administrator or designee will complete monthly audits for 3 months to ensure egress and magnetic lock doors comply with regulation. Results of audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/ or continuance/discontinuance of audits.	05/29/2023 (BC-5/10/23)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Brenda Carda	Administrator	05/05/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	**1106 NORTH SECOND STREET** **GROTON, SD 57445**

(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 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/13/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	**1108 NORTH SECOND STREET** **GROTON, SD 57445**

(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 222	Continued From page 2 failed to maintain egress doors as required at two of six-door locations (main entrance and 300 wing cross-corridor doors). Findings include: 1. Observation on 4/13/23 at 10:15 a.m. revealed the main entrance exit door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was no required signage mounted on the door indicating it was delayed egress and how to exit. Interview at the time of the above observation with the administrator confirmed that finding. She stated work had been performed on the door recently but the sign had not been replaced. 2. Observation on 4/13/23 at 10:30 a.m. revealed the cross-corridor doors from the center core area to the 300 wing were equipped with magnetic lock devices. The magnetic locks were not activated, but the doors had the steel plates still attached. Interview with the administrator at the time of the observation revealed the 300 wing had previously been a secure wing and had not been delayed egress magnetic locks. The plates on the door must be removed to render the function of the doors as magnetically lockable impossible. 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.	K 222		

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	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

(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 222	Continued From page 3 Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
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) 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	K 321	1. All residents are at risk. The door noted in the deficiency is now self-closing in accordance with Hazardous Enclosure NFPA 101CFR guidelines as of April 14, 2023. 2. Administrator will in-service maintenance director to ensure the facility follows the self-closing door guidance by May 6, 2023. 3. The Administrator or designee will complete monthly audits for 4 months to ensure self-closing doors comply with regulation. Results of audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance/discontinuance of audits.	05/29/2023 (BC-5/10/23)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

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K 321	Continued From page 4 failed to maintain one randomly observed hazardous area (kitchen pantry) as required. Findings include: 1. Observation on 4/13/23 at 9:00 a.m. revealed the dietary pantry storage was approximately 100 square feet in the area with canned goods and other combustible items. The pantry was connected to the kitchen with an opening that was provided with a door that was not equipped with a self-closing device. The kitchen door to the residents' dining room was not a self-closing door. With the pantry connected to the kitchen either the pantry door must be self-closing and latching or the door from the kitchen to the residents' dining room must be self-closing and latching. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 321		

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
	10626	A. BUILDING: _____ B. WING _____	04/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 N 2ND ST GROTON, SD 57445

(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 4/12/23 through 4/14/23. Avantara Groton was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brenda Carda — TITLE: Administrator — (X6) DATE: 05/05/2023