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

PRINTED: 06/29/2021
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435059 | A. BUILDING ______ B. WING ______ | 06/16/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA LAKE NORDEN | 803 PARK STREET<br>LAKE NORDEN, SD 57248 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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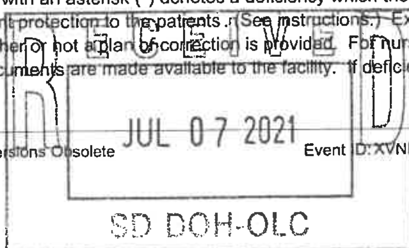
| F 000 | INITIAL COMMENTS<br><br>Surveyor: 26632<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/15/21 through 6/16/21. Avantara Lake Norden was found not in compliance with the following requirement: F655. | F 000 | DISCLAIMER STATEMENT: Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with state and federal laws. This plan of correction constitutes with Federal Medicare and Medicaid requirements. | |
| F 655 SS=E | Baseline Care Plan<br>CFR(s): 483.21(a)(1)-(3)<br><br>§483.21 Comprehensive Person-Centered Care Planning<br>§483.21(a) Baseline Care Plans<br>§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-<br>(i) Be developed within 48 hours of a resident's admission.<br>(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-<br>(A) Initial goals based on admission orders.<br>(B) Physician orders.<br>(C) Dietary orders.<br>(D) Therapy services.<br>(E) Social services.<br>(F) PASARR recommendation, if applicable.<br><br>§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-<br>(i) Is developed within 48 hours of the resident's admission.<br>(ii) Meets the requirements set forth in paragraph | F 655 | 1. Residents 4, 6, 10, 21, 36, 93, and 142 care plans were reviewed and updated.<br><br>2. All residents admitted to our facility could be affected if the baseline care plan is not completed and reviewed by them or their representative within 48 hours of admit.<br><br>3. Interdisciplinary Team educated by Administrator on June 21, 2021 of the Comprehensive Person-Centered Care Planning 483.21.<br><br>4. The Director of Nursing (DNS) or designee will complete audits weekly x 4 then monthly for 3 months to ensure the baseline care plans are developed and implemented within 48 hours of admission and document proof that the resident or representative receive a summary of the baseline care plan. The DNS or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations. | 8/2/2021 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Margaret Grimm
TITLE: Administrator
(X6) DATE: 07/01/2021

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 655 | Continued From page 1 | F 655 | | |

(b) of this section (excepting paragraph (b)(2)(i) of 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:
Surveyor: 16385

Surveyor: 26632
Based on record review, interview, and policy review, the provider failed to ensure:
*Seven of twelve (4, 6, 10, 21, 36, 93, and 142) sampled residents had received a copy of their baseline care plan.
*Two of twelve (36 and 142) sampled residents had participated in a review of their baseline care plan.
*Four of twelve (4, 10, 21, and 142) baseline care plans had been reviewed with the resident and/or representative within forty-eight hours.
Findings include:

1. Review of resident 4's medical record revealed:
*She had been admitted on 1/29/21.
*A multi-disciplinary care conference had been completed on 2/2/21 to review her baseline care plan.

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| F 655 | Continued From page 2<br>*There was no documentation she had been provided a copy of her baseline care plan.<br><br>2. Review of resident 6's medical record revealed:<br>*She had been admitted on 4/1/21.<br>*There was no documentation she had been provided a copy of her baseline care plan.<br><br>Surveyor: 16385<br>3. Review of resident 10's medical record revealed:<br>*She was admitted on 4/13/21.<br>*Her baseline care plan conference meeting date was 4/14/21.<br>*Resident 10's family had attended the baseline care plan conference meeting.<br>*There was no documentation that a copy of the baseline care plan had been provided to resident 10's family.<br><br>4. Review of resident 21's medical record revealed:<br>*He had been admitted on 5/7/21.<br>*His baseline care plan conference meeting date was 5/11/21.<br>*The baseline care plan conference meeting date was not within 48 hours of his admission.<br>*Resident 21 had attended the baseline care plan conference meeting.<br>*There was no documentation that a copy of the baseline care plan had been provided to resident 21.<br><br>Surveyor: 26632<br>5. Review of resident 36's medical record revealed:<br>*She had been admitted on 3/12/21.<br>*No multi-disciplinary baseline care conference | F 655 | | |

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| F 655 | Continued From page 3<br>meeting had been held.<br>*No documentation was found that the baseline care plan had been reviewed with her.<br>*No documentation she had received a copy of the baseline care plan.<br><br>Surveyor: 16385<br>6. Review of resident 93's medical record revealed:<br>*He was admitted on 6/2/21.<br>*His baseline care plan conference meeting date was 6/4/21.<br>*Resident 93's family had attended the baseline care plan conference meeting.<br>*There was no documentation that a copy of the baseline care plan had been provided to resident 93's family.<br><br>Surveyor: 26632<br>7. Review of resident 142's medical record revealed:<br>*He had been admitted on 6/8/21.<br>*A multi-disciplinary baseline care plan meeting had been held on 6/14/21.<br>*Resident 142 nor his representative had attended the meeting.<br>There was no documentation that a copy of the baseline care plan had been provided to resident 142 nor his family.<br><br>Interview on 6/16/21 at 10:44 a.m. with registered nurse/Minimum Data Set coordinator A revealed:<br>*A copy of the baseline care plain was not given to the  resident or their representative.<br>*Agreed they were not always reviewed within 48 hours of admission.<br>*Thought the forty-eight hours only was counted on business days. If a resident was admitted on a Friday, the care plan conference could be done | F 655 | | |

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| F 655 | Continued From page 4 | F 655 | | |

the next week.
*The care plan conference notes were written on a facility form and then the information was entered into the residents electronic medical record.

Interview on 6/16/21 at 3:00 p.m. with director of nursing B revealed:
*Was not aware a copy of the baseline care plan was to have been provided.
*Agreed some of the care conferences to provide the information on the baseline care plan had not been completed within forty-eight hours.
*There was no process that monitored if the baseline care plans had been completed on time.

Review of the provider's September 2019 Care Planning policy revealed:
*"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. "In doing so, the following considerations included:
-"The DON [director of nursing] will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours and the long term-care plan by day 21 and updated as necessary thereafter."
*"A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission."
*"Resident care conferences are held within the first 72 hours of admission."
*There was no direction that a copy of the baseline care plan should have been given to the resident and/or representative.

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| E 000 | Initial Comments<br><br>Surveyor: 26632<br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 6/15/21 through 6/16/21. Avantara Lake Norden was found in compliance. | E 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Margaret Grimm | Administrator | 07/01/2021 |

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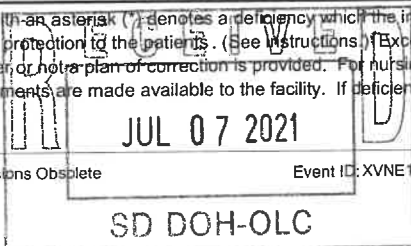
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| | 435059 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **06/15/2021** |

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 27198<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/15/21. Avantara Lake Norden was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K211 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | DISCLAIMER STATEMENT: Preparation and/or excution of this plan of correction in general, or this corrective action in particular, does not constitute an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of defeciencies. The plan of corrective actions are prepared and/or excuted in compliance with state and federal laws. This plan of correction constitutes with Federal Medicare and Medicaid requirements. | |
| K 211<br>SS=D | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 27198<br>Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at one randomly observed exit door location (south wing south exit door). Findings include:<br><br>1. Observation on 6/15/21 at 2:38 p.m. revealed the south exit door to the wing was unable to be easily opened. Testing of that door in the direction | K 211 | 1. On June 23, 2021 a bid was recieved and approved to correct the South Wing Exit door.<br>2. All residents could be affected by this deficient practice.<br>3. Maintenance or designee will check exit doors daily to ensure doors will open without applyiing force greater than fifty pounds in the direction of the path of egress.<br>4. Audits will be completed by Administrator or designee daily for 2 weeks, weekly for 6 weeks, then monthly for 2 months to ensure doors will open without applying force greater than fifty pounds in the direction of the path of egress. The Administrator or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations. | 8/2/2021 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Margaret Grimm | Administrator | July 1, 2021 |

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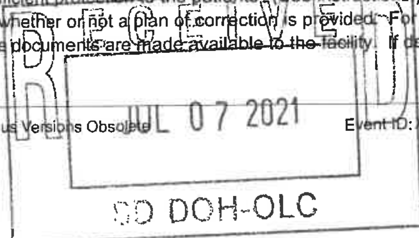

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| K 211 | Continued From page 1 | K 211 | | |

of the path of egress revealed it would not open without applying force greater than fifty pounds in the direction of the path of egress.

Interview at the time of the observation with the maintenance director confirmed those conditions. He stated he was unaware that door was not able to be easily opened.

Failure to provide working egress doors as required increases the risk of death or injury due to fire.

The deficiency affected 100% of the smoke compartment occupants.

Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.4.5.1(2)

South Dakota Department of Health

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| | 10639 | A. BUILDING: ______ B. WING ______ | 06/16/2021 |

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| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 27198<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/15/21 through 6/16/21. Avantara Lake Norden was found not in compliance with the following requirement: S445. | S 000 | DISCLAIMER STATEMENT:<br>Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitue an admission or agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or excuted in compliance with state and federal laws. This plan of correction constitutes with Federal Medicare and Medicaid requirements. | |
| S 445 | 44:73:12:36 Drainage System<br><br>Each drain line from sinks in which acid wastes may be poured shall be fabricated from an acid resistant material. Any piping over a food preparation center, food serving facility, food storage area, and other critical area must be kept to a minimum and may not be exposed. Special precautions shall be taken to protect these areas from possible leakage of necessary overhead piping systems. The building sewer shall discharge into a community sewerage system. If such a system is not available, a facility providing sewage treatment which conforms to applicable local and state regulations is required.<br><br>Water from roof systems shall be collected and discharged away from the building foundation. Rain gutters with downspouts and splash blocks shall be provided for pitched roof systems. Provisions shall be made to avoid having water accumulated on sidewalks and parking areas around the building.<br><br>The building sewer system shall have a cleanout located outside the perimeter of the building foundation.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Surveyor: 27198 | S 445 | 1. Four down spouts splash blocks were ordered on June 28, 2021 and will be properly placed once they arrive at the facility by maintenance.<br><br>2. Foundation may be affected if down-spouts and splash guards are not in place to direct water away from the building.<br><br>3. Upon receiving splash blocks they will be properly placed by maintenance. The maintenance man or designee will below the downspouts, and directing water away from the foundation. The maintenance man or designee will complete inspection audits weekly for 4 weeks then monthly for 3 months to ensure the down spouts splash blocks are in the proper placement to prevent soil erosion to the building's foundation.<br><br>4. The maintenance person or designee will bring the results of these audits to the monthly QAPI meetings for further review and recommendations. | |

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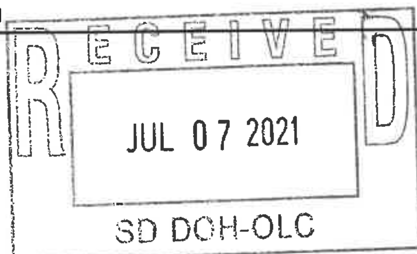
| Margaret Grimm | Administrator | July 1, 2021 |





South Dakota Department of Health

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| S 445 | Continued From page 1<br><br>Based on observation and interview the provider failed to furnish splash blocks at 3 randomly observed locations. Findings include<br><br>1. Observation starting at 3:50 p.m. on 6/15/21 revealed of the four down spouts from the roof on the northwest side of the building only one had been provided with a splash block. Further observation at that same time revealed the one downspout provided with a splash block did not line up with the location of the splash block provided. In that location the downspout had eroded the soil at the buildings foundation and started to degrade the foundation. Continued observation at that same time revealed the other three down spouts on that side of the roof were not provided any splash block and showed visible erosion of the soil next to the building's foundation in those locations.<br><br>Interview with the maintenance director at the time of the observation confirmed those findings. He stated he was unaware that the soil had been eroded from the building's foundation at those locations. | S 445 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 26632<br>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 6/15/21 through 6/16/21. Avantara Lake Norden was found in compliance. | S 000 | | |