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
	435040	A. BUILDING _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/21/23 through 8/23/23. Avantara Mountain View was found not in compliance with the following requirements: F658 and F880.	F 000		
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 observation, interview, and policy review, the provider failed to ensure the following: *One of one sampled resident's (48) medications were not left on her over-the-bed table by one of one licensed practical nurse (LPN) (E) without ensuring the resident had taken those medications. *One of one LPN (E) had not documented one of one sampled resident's (48) medications were administered without having observed the resident take those medications. *One of one LPN (H) had not documented she had administered one of one sampled resident's (68) medications were prepared and administered by one of one unlicensed medication aide (UMA) (I). Findings include: 1. Observation and interview on 8/22/23 at 4:05 p.m. with LPN E during the medication pass observation revealed she:	F 658	1. No immediate action could be taken for resident 48 related to the improper administration of medications. No immediate action could be taken for resident 68 related to the improper delegation of the medication administration. 2. All residents are at risk. 3. Director of Nursing (DON) will educate all nurses and medication aides on the Medication Administration General Guidelines policy and the Medication Aide policy. Education will occur no later than October 6th. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. DON or Designee will observe 5 opportunities for medication pass to audit for proper documentation after administration and PRN medications are only administered by a nurse.	10-6-23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Karlson	Administrator	09/08/2023

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

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F 658	Continued From page 1 *Entered resident 48's room with a medication cup holding the resident's scheduled Eliquis (blood thinner) and calcium supplement. *Set the medication cup on the resident's over-the-bed table then asked if she was having any pain or had any other needs. *Left the room, returned the medication cart, and documented on the resident's Medication Administration Record (MAR) that she had administered the medications referred to above. *Had "built trust" with the resident and that had made her comfortable leaving those medications without having observed if she had taken the medications. *Planned to check back with the resident when the evening meal trays were passed to ensure she had taken those medications. *Was not sure if resident 48 had been assessed and determined to have been able to self-administer her medications. *Agreed her MAR documentation supported she had administered the resident's medications but she had not observed the resident take those medications. 2. Observation and interview on 8/23/23 at 11:10 a.m. with UMA I and LPN H revealed: *UMA I entered resident 68's room and administered his scheduled gabapentin (seizure medication). -At that same time resident 68 also requested Tylenol for pain. *After UMA I notified LPN H of the resident's request LPN H assessed the resident's pain level. -Based on that assessment LPN H determined it was appropriate for the resident to receive a PRN (as needed) dose of Tylenol. *It was decided between LPN H and UMA I that UMA I would prepare and administer resident 68's	F 658	Audits will be completed weekly x4 weeks and then monthly for 2 months. Results of the audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	

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F 658	Continued From page 2 PRN Tylenol dose. -Resident 68 was administered two Tylenol tablets by UMA I. *LPN H documented on the resident's MAR the numerical pain score he had reported to her during the assessment for pain and that she had administered the PRN Tylenol that was administered by UMA I. *LPN H agreed she should have administered and documented resident 68's PRN Tylenol administration. Interview on 8/23/23 at 2:30 p.m with director of nursing B revealed: *Resident 48's medications should not have been left on the resident's over-bed-table by LPN E without the following steps: -A physician's order for the resident to have kept those medications at bedside and to self-administer the medications. -A medication self-administration assessment having been completed first. -The resident's care plan having been updated to reflect her ability to self-administer medications. *MAR documentation for medication administration was expected to have been completed by the UMA or licensed nurse who had administered those medications. Review of the September 2018 Medication Administration General Guidelines policy revealed: *Medication Administration: -"4. Medications are to be administered at the time they are prepared." -"5. The person who prepares the dose for administration is the person who administers the dose." -"15. Residents are allowed to self-administer	F 658		

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F 658	Continued From page 3 medications when specifically authorized by the prescriber, the nursing care center's Interdisciplinary Team (IDT), and in accordance with procedures for self-administration of medications and state regulations."	F 658		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 880		

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F 880	Continued From page 4 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, and policy review the facility failed to ensure infection prevention and control practices were implemented for the following:	F 880		

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F 880	Continued From page 5 *Continuous positive airway pressure (CPAP) tubing was cleaned once a week for one of one sampled resident (12). *Appropriate hand hygiene and glove use during: -A dressing change for one of one sampled resident (14). -Personal care provided for two of two sampled residents (29 and 74) by two of three certified nurse aides (CNAs) (D and F). -Medication administration performed by one of two licensed practical nurses (LPN) (E) for one of two residents (2). Findings include: 1. Observation on 8/21/23 at 4:50 p.m. with licensed practical nurse (LPN) E during resident 14's percutaneous endoscopic gastrostomy (PEG) tube dressing change revealed: *She entered the room and instructed the resident 14 to lay down. *Without washing or sanitizing her hands she: -Put on a pair of gloves, cleaned the PEG tube site, and applied a barrier with a cotton swab. -Removed her gloves. -With bare hands she placed drain gauze over the barrier cream and under the PEG tube site. *Assisted the resident with putting on a clean gown, picked up the garbage and left room without sanitizing or washing her hands. Interview on 8/21/23 at 5:00 p.m. with LPN E regarding the PEG tube dressing change revealed: *She should have: -Washed her hands upon entering the residents' room. -Washed or sanitized her hands prior to put a clean pair of gloves on her hands to apply the dressing and the barrier cream to the PEG tube	F 880	1. No immediate action could be taken for resident 14 related to hand hygiene during a dressing change. On August 22, 2023 an order to clean CPAP per manufacturer instructions was initiated for resident 12. No immediate action could be taken for resident 74 related to hand hygiene when performing resident cares. No immediate action could be take for resident 2 related to hand hygiene during medication administration. 2. All residents who require dressing changes are at risk. All residents who have an order for a CPAP/BIPAP are at risk. A facility wide review of all residents who use a CPAP/BIPAP were audited to ensure a weekly cleaning order is in place at the time of discover during survey. All other residents were found to be in compliance. DON will educate all nurses on the CPAP/BIPAP cleaning policy and procedure. Education will occur no later than October 6th. Those associates not in attendace at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	10-6-23

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F 880	Continued From page 6 site. -Washed or sanitizing her hands before assisting resident with clean gown. Interview on 8/23/23 at 3:05 p.m. with director of nursing (DON) B regarding LPN E's PEG tube dressing change revealed: *Hand hygiene should have been completed and clean gloves applied before applying the dressing to the PEG tube site. *Hand hygiene should have been performed before assisting the resident with a clean gown and before leaving the room. *She agreed LPN E missed hand hygiene and glove use opportunities during resident 14's PEG tube dressing change. 2. Observation and interview on 8/21/23 at 11:35 a.m. with resident 12 revealed she: *Was admitted on 3/17/23. *Had a CPAP machine at the bedside and had used nightly since her admission. *Could not recall if the tubing for her CPAP had been cleaned since her admission to the facility. Interview on 8/22/23 at 8:58 a.m. with LPN E revealed: *She was not aware that resident 12 had a CPAP. *Agreed that the Medical Administration Record (MAR) had no instruction regarding the cleaning of the CPAP. Interview on 8/22/23 at 3:38 p.m. with DON B revealed: *Cleaning of the CPAP tubing should have been completed once a week. *Resident 12's cleaning of the CPAP tubing had not been entered as an order until 8/22/23 after it had been brought to the staffs attention.	F 880	All residents are at increased risk of infection due to improper hand hygiene during dressing changes and medication administration. DON will educate all nursing staff on the Hand Hygiene policy. This education will include LPN E, CNA D, CNA F. Education will occur no later than October 6th. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. Administrator, DON, Medical Director and Infection Preventionist will ensure all nursing staff have recieved traning on the Hand Hygiene policy and have demonstrated competency. Administrator contacted the South Dakota Quality Improvement Organization (QIO) on August 31, 2023. A call was held on September 5th with QIO Advisor, along with the facilities Administrator, DON, Infection Prevention Nurse and Assistant Administrator.	

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F 880	Continued From page 7 *She agreed not cleaning the CPAP tubing per manufactuer's instructions placed the resident at risk for lung infection. Review of the revised January 24, 2023 CPCP and BiPAP [bilevel positive airway pressure] Cleaning policy revealed: *Procedures: -"3. The tubing will be replaced and the machine should be wiped down per manufactures's instructions on a weekly basis." Review of Avera Home Medical Equipment Sleep Well instructions revealed: *Weekly: -"Wash water tub and air tubing in warm water using mild soap." 3. Observation on 8/21/23 at 11:35 a.m. with certified nursing assistant (CNA) D during resident 74's morning care revealed she: *Washed her hands and put on a pair of gloves. *Placed a clean brief and the peri wipes container at the top of the resident's bed. *Cued and assisted the resident to ly on her right side. *Pulled the soiled brief back and grabbed two clean wipes and wiped the resident's skin. *Used those same gloves and placed barrier cream on her gloves and rubbed the cream into the resident's skin. *Removed the soiled wipes, the brief and removed her soiled gloves rolled them all up together and placed all of the soiled items into the trash can. *Had not performed hand hygiene before putting	F 880	During this conversation we discussed Root Cause Analysis (RCA) related to the non-compliance of the required cleaning of the CPAP. Further analysis showed that when the facility has a new admission or readmission with a CPAP the nurse manager inputs the CPAP order as well as a cleaning order. The CPAP order for resident 12 was taken by a floor nurse whom was not aware that she was responsible to have an additional order for cleaning of the CPAP. Adminsitrator, DON and the Medical Director will ensure all nurses are educated on the facility policy and procedure for CPAP/BIPAP cleaning to include order entry of both utilization and claning of CPAP/BIPAP. In addition, during this call we discussed the multiple missed opportunities for hand hygiene. We discessed that there is increased room for missed hand hygiene because there multiple steps and opportunities for hand washing and glove placement and replacement during dressing changes, peri care and medication administration.	

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F 880	Continued From page 8 on a new pair of clean gloves that she had removed from her top scrub pocket. *Put the clean brief on the resident and assisted her rolling onto her back and covered the resident with a blanket. *Removed those gloves, threw the gloves into the trash can and washed her hands. Interview on 8/21/23 at 12:02 p.m. with CNA D regarding above observation revealed she: *Had been a CNA for 13 years. -Was employed with the provider since 6/15/23. *Stated her normal routine was to have kept one of her gloved hands clean for the application of the barrier cream. -Agreed the glove had not always stay clean. *Agreed that she had not used her hand-held alcohol based sanitizer between each of her glove use. Interview on 8/23/23 at 4:08 p.m. with DON B regarding above care observation revealed: *Her expectation and trainings were to have two staff present when changing a resident's brief, one of the CNA's would have had the clean gloves and the other CNA would change the residents brief. *Her expectation was for the CNAs to perform hand hygiene between each glove use. *She agreed CNA D had missed some hand hygiene opportunities. 4. Observation on 8/22/23 at 9:25 a.m. of CNAs D and F providing resident 29's personal care	F 880	The Administrator, DON and Medical Director will ensure all nursing staff have been trained on proper hand hygiene and have demonstrated competency of hand hygiene while performing hands on tasks with residents. 4. Administrator, DON and/or designee will conduct auditing and monitoring of hand hygiene during dressing changes, resident care, and medication administration to ensure infection control is maintained. In addition, Administrator, DON and/or designee will audit for cleaning completion of the CPAP/BIPAP. These audits will be completed 2-3 times weekly over all shifts. After 4 weeks of monitoring demonstrating expecations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum of 2 months. Monitoring results will be reported by Administrator, DON or Designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 880	Continued From page 9 revealed: *With gloved hands CNA F cleaned the resident's buttocks with a peri-wipe while CNA D held the resident in a right side lying position. *CNA F then removed the resident's opened incontinent brief from between his legs and placed it in a plastic bag. *Without changing her gloves she reached inside of the clean barrier cream jar, removed some barrier cream, and applied it to the resident's cleaned buttocks. *She changed those same gloves used above, performed hand hygiene after she and CNA D had applied a clean brief, and placed a mechanical lift sling under the resident for transfer. Interview on 8/22/23 at 9:45 a.m. with CNA F regarding the observation referred to above revealed she: *Should have changed her gloves and performed hand hygiene after having discarded the resident's incontinent brief and before removing the barrier cream from inside of the clean jar. *Agreed her actions had posed an unnecessary infection control risk to the resident. 5. Observation and interview on 8/22/23 at 4:30 p.m. with LPN E preparing resident 2's medications for administration revealed: *She performed hand hygiene then used her hands to: -Handle the keys that unlocked and locked the medication cart. -Open and close the medication cart drawer after retrieving and returning individual blister packs of medications out of and then back into that medication cart. -Manipulate the computer mouse to navigate the	F 880		

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F 880	Continued From page 10 resident's electronic Medication Administration Record. -Grasp the handle of the pill crusher to crush the resident's medications. *Without performing hand hygiene after she had performed the above tasks he: -Opened and removed a straw from its wrapper, used her fingertips to bend the flexible tip of that straw, and placed it inside a cup of water. -Entered the resident's room with the medication cup that held the resident's medications and the cup of water with that straw. -Placed the unclean tip of the bent straw inside of the resident's mouth to sip water in between taking swallows of her crushed medications with applesauce. *Interview with LPN E immediately following the above observation revealed she: -Should have performed hand hygiene and applied a clean pair of gloves prior to removing the resident's straw from its wrapper and handling the flexible tip of the resident's straw. -Agreed not having performed proper hand hygiene could have posed an unnecessary infection control risk to the resident. Interview on 8/23/23 at 9:45 a.m. with infection control nurse G revealed she expected CNAs D and F to have: -Removed their gloves and performed hand hygiene after having handled a soiled or used incontinent brief. -Performed hand hygiene and applied a clean pair of gloves prior to having removed barrier cream from its clean container. *LPN E should have: -Left the paper from the tip of the straw wrapper intact until after she had entered resident 2's room then performed hand hygiene and applied a	F 880		

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F 880	Continued From page 11 clean pair of gloves prior to handling the resident's straw. -Performed hand hygiene prior to entering and leaving resident 2's room. Review of the revised 1/24/23 Hand Hygiene policy revealed: *Hand hygiene was expected to have been performed: -"a. Before and after direct contact with residents." -"b. When entering and leaving a resident care area/room." -"c. Before donning and after removing gloves." -"f. Before handling clean or soiled dressings, gauze pads, etc." -"h. After contact with a resident's skin." -"i. After handling used dressings, contaminated equipment, etc." -"j. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident."	F 880		

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(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 8/21/23 through 8/23/23. Avantara Mountain View was found in compliance.	E 000		

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

Laura Karlson | Administrator | 09/08/2023

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.

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
	435040	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**08/22/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	**916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702**

(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 8/22/23. Avantara Mountain View was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Laura Karlson | Administrator | 09/08/2023

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.

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
	10669	A. BUILDING: _____ B. WING _____	08/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW RD RAPID CITY, SD 57702

(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 8/21/23 through 8/23/23. Avantara Mountain View was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/21/23 through 8/23/23. Avantara Mountain View was found in compliance.	S 000		

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

Laura Karlson

TITLE

Administrator

(X6) DATE

09/08/2023

STATE FORM 6899 RPLN11 If continuation sheet 1 of 1