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	435060	A. BUILDING _____ B. WING _____	10/26/2023

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AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/26/23. Avantara Saint Cloud was found not in compliance with the following requirements: F658, F686, and F742.	F 000		
F 658 SS=E	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, record review, review of the South Dakota Board of Nursing website, and policy review, the provider failed to ensure professional standards of care were followed for: *Medication administration practices by one of one licensed practical nurse (LPN) (H) for three of three observed residents (2, 7, 17, and 22). *Ensuring physician's orders for Tylenol were written for two-325 miligram (mg) tablets for three of three sampled residents (8, 33, and 65) to eliminate the need for a dose calculation by one of one unlicensed medication aide (UMA) (I). *Insulin administration by one of one LPN (F) for one of one sampled resident (25). *Deceased note was documented in the medical record of one of one sample resident (71). *A follow-up appintment was made for one of one sampled resident (49) to receive a new lower partial denture. Findings include:	F 658	1. No immediate corrective action could be taken for the improper medication administration practice performed by licensed practical nurse (LPN) H. No immediate corrective action could be taken for unlicensed medication aid (UMA) I calculating the prescribed dose of Tylenol. No immediate corrective action could be taken for improper insulin administration performed by LPN G. No immediate corrective action could be taken for failure to document a deceased note for resident 71. Follow-up appointment for lower partial denture has been scheduled for resident 49 on December 4, 2023.	11/22/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Brothers | TITLE: Administrator | (X6) DATE: 11-20-23

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

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F 658	Continued From page 1 1. Observation and interview on 10/24/23 at 11:20 a.m. with LPN H in the 300 hallway revealed: *In one of her opened medication (med) cart drawers there were two medication (med) cups; one had resident 22's name on it and contained her crushed Seroquel and Tylenol. -She preferred to take those meds with coffee and coffee was served in the dining room with the noon meal. -LPN H planned to administer those meds to resident 22 after she was taken to the dining room. *The second cup in the opened med cart drawer was unmaked, it contained resident 2's Tylenol. -When LPN H prepared meds, she did it according to resident room numbers. -When she prepared resident 7's meds she had prepared resident 2's meds and left them in the med cart drawer. *LPN H stated the medication administration process was more "time effective" for her to do it as she had done it. *In another drawer of the med cart, there was a third unmarked med cup. -That med cup contained resident 17's crushed Norco (a controlled pain medication) and Tylenol. -She had prepared those meds prior to determining the resident was not in her room for administration of those medications. -LPN H thought resident 17's son had taken her to the dining room for the noon meal. *She had not wanted to take her medication cart into the dining room to administer those medications. -She agreed that she could have just taken the prepared med cup to the dining room and administered those medications.	F 658	2. All residents are at risk for adverse effects resulting from improper medication administration practice. All residents requiring insulin are at risk for adverse effects resulting from improper insulin administration practice. All residents are at risk for lack of documentation of a deceased note. All residents are at risk for adverse effects resulting from not having a follow-up appointment to receive their dentures. All residents who have received dental treatment in the last 3 months are being reviewed to ensure that all follow-up dental appointments have been made. The review will be completed no later than November 22, 2023.	

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F 658	Continued From page 2 2. Observation and interview on 10/25/23 at 11:00 a.m. with LPN F during resident 25's insulin administration revealed: *He prepared the insulin pen and then entered the resident's room. *After using an alcohol pad to cleanse the resident's abdominal area LPN F inserted the insulin pen needle into the resident's abdomen. *He depressed the injection button on the pen and held it for three seconds prior to withdrawing the needle from the resident's skin. *LPN F confirmed he should have left that needle inserted in the resident's abdomen for ten seconds prior to having withdrawn it. 3. Observation, review of the electronic medication administration record, and interview on 10/25/23 at 11:15 a.m. with UMA I during medication administration revealed: *Residents 8, 33, and 65 had physician's orders to have received one-650 mg (milligram) tablet of Tylenol. *UMA I used a stock bottle (a bulk supply of an over-the-counter medication kept on hand at the facility and not labeled for use by a specific resident) of Tylenol 325 mg to remove two-325 mg tablets from that bottle for each resident. -She was aware that she needed to administer two-325 mg Tylenol tablets to each resident because 325 mg plus 325 mg equaled a total of 650 mg as ordered by the physician. *It was not within her scope of practice as a UMA to have calculated medication doses but she thought it was acceptable if "it's something simple, like Tylenol." Interview on 10/25/23 at 11:45 a.m. with director of nursing A regarding the observations referred to above revealed she:	F 658	3. The Director of Nursing (DON) or designee will educate all nurses and UMAs, to include LPN H, on the Medication Administration General Guidelines policy to ensure medications are administered at the time they are prepared. The DON or designee will educate all nurses, to include LPN F, on the Medication Administration Subcutaneous Insulin policy to ensure the proper insulin administration procedure is followed ensuring the full dose of insulin is delivered. The DON or designee will educate all UMAs, to include UMA I, on the Medication Aides policy to ensure medication aides do not calculate medication dosages. The DON or designee will educate all nurses on the procedure for documenting a deceased note following the death of resident in the facility.	

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F 658	Continued From page 3 *Expected resident medications to have been administered at the time of the preparation and not set-up and then stored in the medication cart for administration at a later time. *Expected after depressing the insulin pen injection button that staff counted to ten prior to removal of the insulin pen needle from the resident's skin. *Agreed the physician's dosing orders for residents 8, 33, and 65's Tylenol should have been modified to reflect the administration of two-325 mg tablets in order to eliminate the need for a dose calculation. 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." Review of the May 2016 Medication Administration Subcutaneous Insulin policy revealed: "C. Keep the injection button pressed all the way. Slowly count to 10 before you withdraw the needle from the skin. This ensures that the full dose will be delivered." Review of the South Dakota Board of Nursing chapter 20:48:04.01:12 revealed: Medication administration tasks that may not be delegated included "5. Calculation of any medication dose." 4. Review of resident 71's electronic medical record (EMR) revealed: *She was originally admitted on 11/9/22 with Brief Interview for Mental Status (BIMS) of 3 indicating severe cognitive impairment, was transferred to the emergency department (ED) on 8/15/23.	F 658	3. (cont.) The DON or designee will educate the Interdisciplinary Team (IDT) and all nurses on the Hearing, Vision and Dental policy to ensure necessary dental follow-up appointments are made for residents to receive their dentures. Education will occur no later than November 22, 2023. Those not in attendance at education sessions due to vacations, sick leave, or casual work status will be educated prior to their first shift worked.	

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F 658	Continued From page 4 *On 8/15/23, she returned from ED with diagnosis of sepsis and a physician orders for comfort care. *On 8/16/23 at 4:25 p.m. her body was picked up by a local funeral home. Interview on 10/26/23 at 10:51 a.m. with director of nursing A, assistant administrator B, and regional nurse consultant C revealed: *Resident 71 returned to facility on 8/15/23 from the ED on comfort cares. *Resident 71 passed away on 8/16/23. *Was not aware there was no decease note in resident 71's medical record. *A note regarding the resident's death was expected to have been documented in a residents EMR. -Resident death documentation should include the following information: --The time, date and location of assessment. --Describes signs of irreversible death. --Who was contacted and the date and time. *Nurses were trained during orientation to thoroughly document the required information after the death of a resident. A requested to director of nursing A on 10/26/23 for policy on required documentation of a resident death, and no policy was provided prior to survey exit. 5. Observation and interview on 10/24/23 at 2:42 p.m. with resident 49 revealed: *His bottom two front teeth were missing. -He was unable to answer questions regarding his teeth. Review of resident 49's medical record revealed: *He was admitted on 12/14/21. *His 9/22/23 Brief Interview of Mental Status	F 658	4. The DON or designee will audit 5 nurses during medication administration, including LPN H, to ensure medications are administered at the time they are prepared. The DON or designee will audit 5 insulin administrations, including LPN F, to ensure the proper insulin administration procedure is performed ensuring the full dose of insulin is delivered. The DON or designee will audit 5 UMAs during medication administration, including UMA I, to ensure medication aides do not calculate medication dosages. The DON or designee will audit the medical record following all resident deaths to ensure a deceased note has been documented.	

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F 658	Continued From page 5 score was 5, indicating he had severe cognitive impairment. *His diagnoses included: -Post-Traumatic Stress Disorder. -Alcohol-induced persisting dementia. -Alzheimer's Disease. -Anxiety. -Obstructive sleep apnea. -Hearing loss. *A 5/30/23 nurse's progress note revealed: -Resident returned to facility from dental appointment with tooth extraction. -Partial denture would be made to replace the missing teeth. -No complaints of pain or discomfort noted, pleasant with staff, and resting in bed. -No significant weight loss. *A 9/22/23 progress note that indicated he had "upper dentures and lower partial". Interview on 10/25/23 at 3:36 p.m. with LPN F revealed resident 49: -Had received a new lower partial denture since 5/30/23. -Lost the new lower partial dentures sometime in August 2023. Interview on 10/25/23 at 3:38 p.m. with DON A regarding resident 49's lower partial denture revealed: *DON A was not aware of him having new lower partial denture or that the resident had lost the lower partial denture. -She would have to call the family to see if he had received a new lower partial denture or if he had lost the lower partial denture.	F 658	4. (cont.) The DON or designee will audit 5 residents with dentures to ensure necessary dental follow-up appointments have been made and resident has attended the appointment to ensure their dentures have been received. Audits will be weekly for four weeks, then biweekly for one month, and then monthly for two months. Results of the audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with IDT and Medical Director for analysis, recommendation for continuation/discontinuation/revision of audits based on findings.	

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F 658	Continued From page 6 Continued interview on 10/25/23 at 4:35 p.m. with DON A regarding resident 49's lower partial denture revealed: *He had not received a new lower partial denture. *DON A confirmed the provider should have followed-up on the appointment from 5/30/23 to determine when resident 49 would have a new lower partial denture made. Interview on 10/26/23 at 2:24 p.m. with social service designee E regarding resident 49's dental appointments revealed: *She was not aware that a follow-up appointment was needed for resident 49 for a new lower partial denture. *Their process included: -The family would normally transport resident 49 to his appointments. --When the family was not available the facility would have made transportation arrangements. -The family would initiate the appointment-making process. --Then the nurse would scheduled the medical appointments. -Nurses would make follow-up medical appointments that might have been needed. Review of the provider's 3/23/23 Hearing, Vision, and Dental policy revealed: *"Policy: -The facility must, if necessary, assist the resident in making appointments and arrange the transportation to and from the office of a practitioner specializing in the treatment of vision, dental or hearing impairment and/or provide these services by professionals in-house, if able. -The resident/resident representative has the right to refuse these services, Refusals should be documented."	F 658		

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F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (19) who had a history of moisture-associated skin damage (MASD) and had a current pressure ulcer (PU) had physician-ordered interventions implemented to promote healing. Findings include: 1. Observations of resident 19 revealed: *On 10/24/23 at 10:00 a.m. she laid on her left side in bed with a pillow positioned behind her back to help her maintain that position. -The mattress on her bed was blue. *On 10/25/23 at 4:45 p.m. she was seated on a ROHO cushion (a pressure reducing device) in her tilt-in-space wheelchair (a customized wheelchair) in her room in front of the television. -There was a pool of liquid on the floor beneath the seat of her wheelchair that appeared to have been urine. *On 10/26/23 at 8:45 a.m. she was transferred by	F 686	1. Overlay air mattress was placed on the resident 19's bed on October 25, 2023, upon discovery during survey. Resident 19 was admitted to hospice on October 26, 2023, and she expired on November 3, 2023.	11/22/23

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F 686	Continued From page 8 staff from her wheelchair to her bed to have her incontinence brief changed, barrier cream applied to her sacrum, and then she was positioned onto her left side. Review of resident 19's electronic medical record (EMR) revealed her: *Diagnoses included Alzheimer's dementia, protein calorie malnutrition, repeated falls, hypertension, anxiety, depression, pain, and a stage III pressure ulcer. -There was no indication where that pressure ulcer was located. *8/14/23 Brief Interview for Mental Status score was "99" indicating she had severe cognitive impairment. *3/1/23 Braden scale (used to evaluate a resident's risk for skin breakdown) score was 16. -That score indicated she was at high risk for skin breakdown. *A 6/13/23 facimile communication to the resident's physician revealed: -"Resident noted to have new area of pressure to her sacrum..." -A physician's order (PO) was requested for the resident to have a ROHO cushion for her wheelchair. *The provider responded on that same date: "May order Roho cushion due to skin impairment." *A 6/20/23 Skin/Wound Note indicated the "Maceration to sacrum has resolved." Interview on 10/26/23 at 8:30 a.m. with director of rehabilitation (Rehab) D revealed the department: *Had several ROHO cushions available for residents use. *Was notified by nursing staff when a physician had ordered a ROHO cushion for a residents use. -Educated staff on the purpose and how to use	F 686	2. All residents at risk for pressure injuries, or with actual pressure injuries, are at risk for developing or worsening of pressure injuries due to not having appropriate interventions in place or following physician orders for interventions. All residents will have a current Braden scale completed to identify their risk for pressure injuries, ensure appropriate interventions are in place, physician orders are followed for interventions and interventions are care planned.	

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F 686	Continued From page 9 the cushion prior to its use. -Ensured the ongoing maintenance of that cushion while it was used. *Nursing staff had not notified the Rehab department of resident 19's 6/13/23 PO for a ROHO cushion so a ROHO cushion had not been provided to the resident. Interview on 10/26/23 at 10:15 a.m. with assistant director of nursing (ADON)/infection preventionist (IP)/wound care nurse K revealed she: *Was aware of the 6/13/23 PO for a ROHO cushion for resident 19 but had not known if she had received it. *Had thought that PO was "more of a positioning order" but agreed inadequate or improper positioning caused by not having had the ROHO cushion had the potential to have worsened her MASD. Interview on 10/26/23 at 2:48 p.m. with director of nursing (DON) A revealed: *It was the responsibility of the nurse who had taken the PO for the ROHO cushion to have completed the following: -Called the Rehab department and notified them of the new order and/or have placed a copy of that PO in the mailbox for Rehab staff. 2. Continued review of resident 19's EMR revealed: *An 8/11/23 Health Status Note completed by DON A had first identified a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed) PU to resident's 19's sacrum. -Physician's orders for treatment of that PU had been obtained and interventions including a pressure relieving mattress, offloading, and	F 686	3. The Administrator, DON, and the IDT in collaboration with the medical director and the governing body reviewed the Skin and Pressure Injury Prevention Program policy and the Following Physician Orders policy. The wound care certified nurse practitioner L or designee will educate all staff, to include LPN G, on their roles and responsibilities for active pressure ulcer prevention program, including completion of the Braden Scale assessments, following physician orders for interventions, ensuring appropriate interventions are in place and are care planned properly to prevent pressure injuries and ensure existing pressure injuries do not worsen. The DON or designee will educate nurses on the new process to place Braden Scale assessment order on the Treatment Administration Record (TAR) to alert nurses to complete and sign off on monthly.	

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F 686	Continued From page 10 continuation of nutritional interventions. *An 8/14/23 Braden scale score was 14 indicating the resident was at high risk for skin breakdown. *ADON/IP/wound care nurse K had completed weekly Skin Alteration Evaluations beginning on 8/15/23 at which time the PU had measured 1.0 cm (centimeters) in length X 0.5 cm wide, and 0.3 cm in depth. *Wound care certified nurse practitioner (CNP) L had been consulted and had begun caring for the resident's wound on 9/5/23. -She documented the resident's PU as a stage III (full-thickness tissue loss-subcutaneous fat might have been visible) and it had measured 1.0 cm X 0.5 cm X 1.0 cm. *Occupational therapy (OT) was consulted on 9/14/23 to evaluate resident 19 for wheelchair positioning options. -On 10/4/23 OT had recommended a tilt-in-space wheelchair with a ROHO cushion for resident 19. *Wound care CNP L ordered an air mattress (specialized pressure-reducing mattress) on 10/17/23 to replace the existing blue mattress that was observed on resident 19's bed on 10/24/23 at 10:00 a.m. -Her 10/17/23 Health Status Note read: "New order for air mattress to alleviate pressure from coccyx wound." *Wound care CNP L measured resident 19's pressure ulcer on 10/24/23 as 0.8 cm X 0.3 cm X 0.2 cm. Interview on 10/25/23 at 4:00 p.m. with licensed practical nurse (LPN) F regarding resident 19 revealed: *She had not received the air mattress that was ordered by wound care CNP L on 10/17/23. -LPN G had acknowledged the PO and was responsible for ensuring someone from the	F 686	3. (cont.) ADON/IP/wound care nurse K has resigned her position effective November 18, 2023. A new ADON/IP/wound care nurse that is wound care certified has been hired. The cited deficiency will be reviewed during the education. Education will occur no later than November 22, 2023, and those not in attendance due to vacation, illness, or casual work status will be educated prior to first shift worked.	

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F 686	Continued From page 11 management team was notified so the mattress could have been ordered. Interview on 10/25/23 at 4:45 p.m. with maintenance director M regarding resident 19 revealed: *An air mattress like the one ordered by wound care CNP L was available on-site in a storage shed. -He had kept one of those mattresses available for emergent use. *He relied on staff to have let him know when a physician-ordered air mattress for resident use so that he could have set it up. *He had not been notified of resident 19's PO for an air mattress. Interview on 10/25/23 at 11:00 a.m. with ADON/IP/wound care nurse K regarding resident 19 revealed she had: *Incorrectly staged resident 19's wound as a stage II when she first assessed it on 8/15/23. -It should have been a stage III. *Read wound care CNP L's progress notes after her visits for any new orders or recommendations that had required her follow-up. -Continued to stage resident 19's pressure ulcer as stage II through 10/11/23 even after wound care CNP L had documented it as a stage III on the first day she assessed the resident on 9/5/23. *Not known about wound care CNP L's 10/17/23 PO for resident 19 to have had an air mattress because it had not been referred to in her progress note. -Agreed resident 19 not having had prompt access to the air mattress had the potential to have worsened her PU. *Not routinely met face-to-face during or after wound care CNP L's resident visits to have	F 686	4. The DON or designee will audit 5 residents, including residents with existing pressure injuries, to ensure Braden Scale assessment is completed per policy, physician ordered interventions are followed and appropriate interventions to prevent development or worsening of pressure injuries are in place and are care planned. Audits will be weekly for four weeks, then biweekly for one month, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING _____ B. WING _____	10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

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F 686	Continued From page 12 discussed pertinent resident findings related to their skin conditions such as appropriate staging of the PU, a resident's need for a specific skin intervention or the need for durable medical equipment. Interview on 10/26/23 at 3:15 p.m. with DON A, interim administrator B, regional nurse consultant C, and nurse supervisor N revealed: *Nursing staff used a 24-hour report to communicate pertinent resident information between shift changes such as new POs, specific resident concerns, or significant resident changes. -That report was reviewed during daily department head briefings. *If resident 19's need for an air mattress had been identified on a 24-hour report and reviewed during a department head briefing, it would not necessarily have been rediscussed in subsequent department head briefings to ensure the air mattress had been obtained. -That process would have ensured resident 19 received her durable medical equipment (the ROHO cushion and air mattress) in a timely manner. *Face-to-face communication was expected to have occurred between ADON/IP/wound care nurse K or her designee following wound care CNP L's resident visits to ensure consistent care had occurred. Review of the revised 3/23/23 Skin and Pressure Injury Prevention Program revealed Policy: "To provide care and services to prevent pressure injury development and to promote the healing of pressure injuries/wounds that are present."	F 686		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns	F 742		

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F 742	Continued From page 13 CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and policy review the provider failed to assess, document and provide interventions per their policy for one of one sampled resident (49) who had suicidal ideations. 1. Observation and interview on 10/24/23 at 2:42 p.m. with resident 49 revealed: *His door was closed. *CNA J knocked on resident 49's door. -Resident 49 opened the door and came into the hallway. *Resident 49 was smiling and answered basic questions before returning to his room. Interview on 10/24/23 at 2:50 p.m. with CNA J revealed resident 49 often barricaded his door from the inside. Review of resident 49's medical record revealed: *He was admitted on 12/14/21. *His diagnoses included: -Post-Traumatic Stress Disorder. -Alcohol-induced persisting dementia.	F 742	1. Social Service Director met with resident 49 and completed a PHQ-9 mood interview October 25, 2023, upon discovery of his statement during survey. 2. All residents are at risk for adverse effects resulting from failure to assess, document and implement interventions for residents with suicidal ideations. Education will be provided to all staff on appropriate reporting of all suicidal ideations so immediate interventions are implemented.	11/22/23

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F 742	Continued From page 14 -Alzheimer's Disease. -Anxiety. -Obstructive sleep apnea. -Hearing loss. *His 9/22/23 Brief Interview of Mental Status score was 5, indicating he had severe cognitive impairment. *A 9/22/23 nurse's progress note revealed: -His speech was clear. -He was usually able to make his needs and wants known. -He could usually understand verbal context from staff and family. Review of resident 49's behavior notes included: *A 10/14/2023 behavior progress note that read, "Resident was monitored tonight for self harm." -There were no non-pharmacological interventions documented. -There had been no pharmacological interventions documented. --The summary note included, "Resident was disoriented last evening and verbalized frustration as "he could not remember whether that was his room or whether he had ever been there". He was reported to have verbalized to the CNA "I wish I could just commit suicide, but I will be stupid to do it". He was redirected multiple times before he was able to settle down and sleep. All this time he displayed a lot of frustration to the fact that he could not remember anything. Later in the night, he did not display any negative behaviors." *There was no other documentation related to his suicidal statement or interventions that were implemented by staff. *There was no documentation that his physician was notified.	F 742	3. The DON or designee will educate all staff on the Suicide Threats/Suicide Precautions policy to ensure that when a resident exhibits suicidal ideation, the proper procedure is followed to include assessment of the resident, appropriate notifications are made, appropriate interventions are implemented, and details of the situation are documented. Education will occur no later than November 22, 2023, and those not in attendance due to vacation, illness, or casual work status will be educated prior to first shift worked.	

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F 742	Continued From page 15 Review of resident 49's 10/25/23 care plan revealed: *A 6/23/23 revised focus of "Continues to barricade himself in his room, History of Threatening Behavior, Rejection of care." -Interventions for the above focus included: --"My behaviors will not cause harm to myself or others through the next review". --"My behaviors will not impede staff's ability to provide me my necessary care through the next revew." --"Behavior Committee to monitor mood/behavior quarterly and as needed." --On 11/10/22, "I am unable to have a roommate due to my behaviors." --A 3/24/22, "I am territorial about my room and where I usually sit in Town Square dining room". --Revised 9/21/23 interventions of, —"If I am resistive, stop the task, leave and allow me time to calm my self." —"My ability to retain information is very short, I need frequent cueing". —"Provide reassurances as needed that I am safe and you are here to help me." Interview on 10/26/23 at 2:24 p.m. with social service designee E revealed: *She was not aware of resident 49's episode of suicidal ideation. *The process when a resident had a suicidal ideation would include the following: -The resident should been on suicide checks every 20 minutes. -There should have been a complete room search to ensure there was nothing the resident could have used to commit suicide. -The nurse should have notified her. --She would visit with the resident. --She would have completed a PHQ-9	F 742	4. The DON or designee will audit 5 resident medical records to ensure incidents of suicidal ideations have been reported, resident has been assessed, appropriate notifications were made, appropriate interventions have been implemented, and the details of the incident were documented. Audits will be weekly for four weeks, then biweekly for one month, and then monthly for two months. Results of audits will be discussed by the DON at the monthly 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 742	Continued From page 16	F 742		

assessment (a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) with the resident.

Interview and resident 49's medical record review on 10/25/23 at 4:37 p.m. with DON A revealed she:
*Had not been aware of the documentation that resident 49 had an episode of suicidal ideation.
*Should have been notified of the episode when it occurred.

Review of the provider's Suicide Threats/Suicide Precautions policy revealed:
*"Policy
-Resident suicide threats shall be taken seriously and addressed appropriately.
*Procedures
-1. Staff should report any resident threats of suicide or comments of "wanting to die" immediately to the Nurse Supervisor/Charge Nurse.
2. A staff member should remain with the resident until the Nurse Supervisor/Charge Nurse arrives to evaluate the resident.
3. The Nurse Supervisor/Charge Nurse should immediately assess the situation and notify the Charge Nurse/Supervisor and/or Director of Nursing Services of such threats.
4. After assessing the resident in more detail, the Nurse Supervisor/Charge Nurse should notify the resident's Attending Physician and resident representative.
5. Provide 1:1 [one to one] supervision and removal all equipment from room that could be used and/or cause harm (sharps, cords, belts, etc.). 1:1 Supervision will continue until the resident is transferred or deemed not a threat to themselves or others by the physician or mental

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F 742	Continued From page 17 health professional. 6. A psychiatric consultation or transfer for emergency psychiatric evaluation may be initiated. 7. If the resident remains in the facility, staff will monitor the resident's mood and behavior and update care plans accordingly, until a physician or mental health professional has determined that a risk of suicide does not appear to be present. 8. Document details in the resident's medical record, including entry into Risk Management." Interview and policy review on 10/26/23 at 4:05 p.m. with DON A revealed the provider had not followed their policy for residents who expressed suicidal ideation.	F 742		

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 10/24/23 through 10/26/23. Avantara Saint Cloud was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Gardner — TITLE: Administrator — (X6) DATE: 11/17/23

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

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	435060	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**10/24/2023**

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AVANTARA SAINT CLOUD	**302 ST CLOUD STREET RAPID CITY, SD 57701**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/24/23. Avantara Saint Cloud 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: Charlotte Turtheny — TITLE: Administrator — (X6) DATE: 11/17/23

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.

South Dakota Department of Health

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	10667	A. BUILDING: _____ B. WING _____	10/26/2023

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/24/23 through 10/26/23. Avantara Saint Cloud 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 10/24/23 through 10/26/23. Avantara Saint Cloud was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Pusthy — TITLE: Administrator — (X6) DATE: 11/17/23