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
	435039	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

(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 Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/27/21 through 9/30/21. Avantara Norton was found not in compliance with the following requirements: F558, F572, F575, F584, F609, F656, F658, F700, F732, F801, F812, and F880.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 29354 Surveyor: 45095 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (4) received personal care promptly during the night. Findings include: 1. Observation and interview on 9/28/21 at 3:10 p.m. with resident 4 in his room revealed he: *Was sitting up in his wheelchair. *A pressure reduction mattress was on his bed and a pressure reduction cushion was on his wheelchair. *Stated he had waited up to one and a half hours during the night for staff assistance with toileting. *Stated call light answering times were a	F 558	1. Resident 4 care plan was updated with caregiver preference. Resident was educated that facility would try to meet his preference of caregivers of same ethnicity but may not be able to always meet this preference. Educated all night shift care staff on answering call lights in a timely manner, and if a staff member of the same ethnicity is not available at the time care is requested, getting another staff member to assist that is of the preferred ethnicity. Night shift caregiver staff were also educated on resident 4's preferences for care. 2. All residents are at risk for not receiving personal care promptly during the night. 3. The Director of Nursing or designee will educate all care staff on answering call lights in a timely manner, and if a staff member of the same ethnicity is not available at the time care is requested, getting another staff member to assist that is of the preferred ethnicity. Caregiver staff were also educated on resident 4's preferences for care. Education will occur no later than 10/29/21 and 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.	10/29/21

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

Blake Dehnke, Administrator | | 10/22/21

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 558	Continued From page 1 continuous issue during the night, but call lights were answered in a reasonable time during the day. *Had a sore, red bottom due to incontinence that sometimes started to get better but then returned to being sore and red, and felt it was due to his being incontinent and having to wait during the night for long periods for staff to answer his call light. Interview on 9/29/21 at 7:45 a.m. with agency licensed practical nurse (LPN) L regarding resident 4 revealed: *His dressing changes were completed between 6:00 a.m. and 6:30 a.m. prior to getting him up in the morning. *He refused to wait for the surveyor to observe his dressing changes. *He was transported to the veteran's administration (VA) hospital daily for a intravenous (IV) antibiotic infusion related to a Methicillin-Resistant Staphylococcus Aureus infection in his left second toe. *The call light logs for him were requested from the provider on 9/29/21 at 11:30 a.m. Corporate nurse consultant H stated no call light logs were available as the facility's system was too old to track that. Review of resident 4's medical record revealed: *An admission date of 7/17/20. *His Brief Interview for Mental Status examination score was eleven indicating moderately impaired cognition. *Diagnoses of lymphedema, body mass index [BMI] 32.0-32.9, muscle wasting and atrophy unspecified site, other forms of dyspnea, abnormal posture, shortness of breath, cellulitis	F 558	4. The Administrator or designee will audit five resident call lights at random times to ensure that call lights are being answered timely. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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 558	Continued From page 2 of left lower limb, heart failure, history of falling, low back pain, other dystonia, other recurrent depressive disorders, peripheral vascular disease, diabetes mellitus with diabetic neuropathy, venous insufficiency(chronic) (peripheral). *The 6/11/21 quarterly Minimum Data Set assessment revealed he: -Required extensive assistance of two for bed mobility and toilet use. -Was always incontinent of bowel. -Was at risk of developing pressure ulcer/injuries. -Was not on a turning/repositioning program. -Required limited assistance of one person for personal hygiene. *The 9/10/21 quarterly Braden Scale score was fourteen and revealed he was at high risk for pressure ulcer/injury. *The 9/16/21 skin evaluation revealed he had alteration in skin integrity, with a pressure ulcer to his left and his right buttock. *The 9/23/21 skin evaluation revealed resident without alteration in skin integrity. *Wound assessment details reports dated 8/26/21 revealed the following wounds with wound care being completed for: -Left ankle unstageable pressure ulcer. -Left dorsal vasculitis. -Left second toe venous stasis ulcer. -Left lower extremity lateral vasculitis. Care Plan with most recent revision date of 8/12/21 had the following focus areas as follows: *Impairment of skin integrity. *He had extensive care needs and required the support/services of the long-term care setting. *He was at risk for alteration of bowel and bladder functioning related to decreased mobility and weakness.	F 558		

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F 558	Continued From page 3 *The goals listed were as follows: -He would not develop signs and symptoms of infection on his pressure ulcer sites and would show improvement of healing through his next review period, and resident's care needs would be provided during the stay at the facility. -He would remain free from skin breakdown due to incontinence through his next review period. *The interventions listed were as follows: -Apply wound treatments as ordered by the physician, see treatment administration record (TAR). -Assess for pain and administer pain medication as ordered, observe feedback, and notify medical doctor as necessary. -Encourage good nutrition and hydration to promote healthier skin. -Heel boots. -Keep air mattress on my bed and pressure reducing cushion in his wheelchair, encourage to lie down for leg elevation. -Lymphedema pumps to bilateral legs twice daily. -Monitor/document location, size, and treatment of skin injury. -Turn and reposition every two hours. -Wound care to left lower extremities. -A thin layer of Zinc to buttock/gluteal cleft area as needed and every shift for maceration. -Barrier cream to inner buttocks and surrounding skin twice a day and as needed. -The facility will provide care to enable the resident to function at their most practical level and support my adjustment towards the residence in a homelike environment. -If incontinent, apply moisture barrier to the peri-area after incontinent episode. -Keep call light within reach. -Remind, offer, and assist with toileting as needed. Will use urinal, keep within his reach,	F 558		

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will use bedpan if in bed.
-Report to nurse any signs and symptoms of discomfort on urination or defecation and frequency.

The provider's orders listed on the treatment administration record (TAR) included:
*Barrier cream to inner buttocks and surrounding skin twice daily and as needed.
*A thin layer of Zinc to buttock/gluteal cleft area as needed and every shift for maceration.
*Skin assessment every Friday.

Interview on 9/29/21 at 2:35 p.m. with resident 4 regarding the call light response time during the night revealed:
*He had just returned from the VA hospital where he received his IV antibiotic infusion.
*He was in his room, lying in bed, and the staff had been in approximately fifteen minutes ago, and had applied his cream for his sore, red bottom.
*He denied any history of having had pressure ulcers to his bottom.
*His room had a large clock on the wall opposite from his bed.
*He knew how long it had taken for his call light to be answered because he looked at his clock on the wall.
*Some nights had been worse than others for answering his call light.
-It depended on who the charge nurse on duty was.

Interview on 9/29/21 at 2:45 p.m. with nurse aide in training N regarding the condition of resident 4's skin revealed:
*She had been in his room that afternoon and had assisted another certified nursing assistant

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(CNA) to put him in his bed.
*They had completed a brief change that included skin care and the application of his barrier cream kept in his room.
*His bottom had been red, irritated without any opened areas.

Interview on 9/29/21 at 3:05 p.m. with CNA O regarding the condition of resident 4's skin revealed:
*She had applied barrier cream to his bottom after they had laid him down and completed a brief change that afternoon.
*His bottom had been red and irritated without any opened areas.
*She had not reported that to the nurse as it was not new and the red, irritated skin on his bottom had been ongoing.

Interview on 9/29/21 at 3:25 p.m. with LPN L regarding the condition of resident 4's skin revealed:
*She reported she had applied barrier cream with Zinc on 9/28/21 during the evening part of her shift to his bottom.
*His bottom continued with macerated, redness, and irritation, but she stated his skin on his bottom had been improving with the opened areas now closed.
*His zinc barrier cream had been kept in his room for the CNAs to apply with brief changes and as needed during the day.
*The treatment was signed off on the TAR by nursing when they had confirmed the CNAs had applied the barrier cream.

Interview on 9/30/21 at 7:58 a.m. with resident 4 regarding long call light wait times revealed:
*He had reported the long call light wait times

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F 558	Continued From page 6 during the night "over and over, multiple times." *He had reported it at resident council meetings stating "and I am not the only one." *It would be so nice to get something done about it. *He reported we had lost a lot of good night workers, not just people, but numbers, they had gone from having four workers at night to two workers at night. Interview on 9/30/21 at 8:08 a.m. with social service designee K regarding call light response times during the night revealed: *Her expectations were for call lights to be responded to within fifteen minutes. *She was aware of ten to twelve residents that had complained at resident council about long call light response times at night and one of them had been resident 4. *Residents had verbalized they were aware they had to wait a little longer at night to have call lights answered and were aware there were less staff at night. *She denied being aware of complaints that resident 4 had waited one and a half hours for a call light to be answered during the night. *She reported call light audits had been completed as a follow-up to the complaints for the long waiting at nighttime for the call lights to have been answered. *Call light audit reports were requested by the surveyor. Interview on 9/30/21 at 8:22 a.m. with director of nursing (DON) B, assistant DON I, and corporate nurse consultant H regarding call light response times revealed: *She was aware resident 4 had complained regarding long waits for call light response times	F 558		

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F 558	Continued From page 7 during the night. *She had been made aware of the issue through staff reports. *She stated he was not accurate, he exaggerated, and she had attributed that as mood-related and staff-related. *She stated the issue had been due to his not liking black staff and he had chosen to wait for other staff to help him. *Her expectation for call light response times were as soon as staff had seen the call light. *She agreed resident 4 had been at risk for developing a pressure ulcer/skin injury. *His Braden assessment, care plan, and progress notes had been reviewed during the interview and a paper copy of each had been provided. *She agreed: -One and a half hours was too long to wait. -They should have been able to provide accommodations for him and answered his call light. -The resident's choice to wait for a different staff to help him during the night should have been on his care plan. Interview on 9/30/21 at 8:33 a.m. with resident 4 regarding call light response times revealed: *He had chosen to wait for a different staff to help him sometimes. *"Not all of the black staff were bad, a few were good." *He would not turn down good help. *He had gotten into a conflict with a few of the staff. Review of the provider's Call Light audit reports dated 6/18/21 and 7/12/21 revealed resident 4 had not been included in the call light audits.	F 558		

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F 558	Continued From page 8 Review of the provider's resident council minutes dated 7/12/21, 8/9/21, and 9/13/21 revealed: *Call lights were being answered timely, sometimes it had taken a little longer on the weekends or during mealtimes. *All cares were being met. Review of the provider's September 2019 Resident Dignity and Privacy policy revealed: *"2. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences." *"10. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source." Review of the provider's September 2019 Care Planning policy revealed: *"1. Each resident is an individual. The personal habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patterns as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins at the moment the resident is admitted to the facility and doesn't end until discharge or death." Review of the provider's April 2021 Skin Program policy revealed: *"To provide care and services to prevent injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds."	F 558		

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F 558	Continued From page 9 Review of the provider's January 2020 Call Lights policy revealed: "It is the policy of the facility that there is prompt response to the resident's call for assistance. 1. Facility shall answer call lights in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff members will be back to assist them shortly."	F 558		
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Surveyor: 43021	F 572	1.Residents, and when applicable, resident representative, were provided and educated on updated resident rights booklet by 10/29/21. Resident Rights posters have been posted in facility as of 10/18/21 and are viewable to residents and visitors. Social Services Director (SSD K) was educated by administrator on 10/20/21 regarding coordination of resident council meetings and informing residents of specific rights each month, as well as posting the resident rights poster, furnished by the Office of Long-Term Care Ombudsman in a in a location accessible to residents, visitors, and families. 2. All residents are at risk for not being informed of their rights either orally or in writing. 3. Administrator educated Social Services Director on informing residents of their rights listed in the updated resident rights booklet on 10/20/21. 4. The Social Services Director or designee will complete 5 interview audits of random residents weekly to ensure they are aware of the location of the residents' rights poster. Audits will be weekly for four weeks, and then monthly for two months. Will also audit resident council meeting	10/29/21

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F 572	Continued From page 10 Based on observation, interview, and document review the provider failed to ensure residents were informed of all of his or her rights prior to or upon admission and during the resident's stay. Findings include: 1. Interview with the resident group on 9/28/21 with ten residents from 1:30 p.m. through 2:00 p.m. revealed when resident rights were discussed and asked if the staff provide ongoing communication to residents about their rights, either orally or in writing, the group's response was no. 2. Interview on 9/29/21 at 8:45 a.m. with the social service designee (SSD) K revealed she was: *Not aware of a poster displaying all of the resident rights of the residents of this facility. *New to coordinating the resident council meetings for the last four months.: 3. Review of the last three months of resident council meeting minutes revealed: *July and September 2021 reviewed the same resident right of dignity. *August 2021 no resident right was reviewed. Review of the documents provided upon admission revealed: *The facility's admission agreement referred to the resident's rights handbook and incorporated it into the admission agreement. *The "Long Term Care Facilities Resident's Bill of Rights" provided by the facility was from the South Dakota Department of Social Services dated September 2012. -The most updated resident's rights handbook was dated August 2019.	F 572	minutes monthly for four months to ensure 2 resident rights are reviewed at each monthly resident council meeting. Results of audits will be discussed by the Administrator 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 572	Continued From page 11 -The August 2019 handbook contained significant updates from the older, September 2012 version. 4. Interview on 9/29/21 at 1:02 p.m. with administrator A, SSD K, and corporate nurse consultant H revealed and confirmed: *There were significant changes between the September 2012 resident's rights handbook provided by the facility upon admission and the current August 2019 updated resident's rights handbook. *No comprehensive resident's rights poster was posted in the facility. *They would look into getting this information. *The last three months of resident council meeting minutes revealed: -Two months the same resident right of dignity was reviewed. -One month no resident right was reviewed.	F 572		
F 575 SS=F	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or	F 575	1.The Ombudsman and SD Department of Health (SD DOH) information has now been posted in a location accessible to residents, visitors, and families on 10/18/21. SSD K was educated on 10/20/21 regarding posting Ombudsman and SD DOH contact information in a location accessible to residents, visitors, and families 2. All residents are at risk for not having access to the Ombudsman and SD Department of Health information. 3. Administrator educated Social Services Director on 10/20/21 on ensuring the Ombudsman and SD Department of Health information is posted. 4. The Social Services Director or designee will conduct an interview audit of 5 residents to ensure the residents know where to find the	10/29/21

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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
F 575	Continued From page 12 federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation and interview the provider failed to ensure the ombudsman and South Dakota Department of Health (SD DOH) information had been posted in a location accessible to the residents, visitors, and families. Findings include: 1. Interview with the resident group on 9/28/21 from 1:30 p.m. through 2:00 p.m. revealed: *The residents were unaware of where to find contact information for the Ombudsman. *The residents were not aware they could contact the SD DOH directly and/or file a complaint with the SD DOH. 2. Observations on 9/28/21 at 2:00 p.m., following the resident group meeting, 9/29/21 at 8:30 a.m., and 9/30/21 at 1:00 p.m., when exiting the facility, did not find: *The ombudsman's contact information posted. *The SD DOH contact information posted. *A statement that the resident may file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 3. Interview on 9/29/21 at 8:45 a.m. with the social service designee (SSD) K confirmed: *Ombudsman's contact information was not	F 575	information for the Ombudsman and SD Department of Health. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	09/30/2021

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F 575	Continued From page 13 posted. *SD DOH contact information was not posted. *A statement was not posted that the resident may file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 4. Interview on 9/29/21 at 1:02 p.m. with administrator A, SSD K, and corporate nurse consultant H confirmed: *Ombudsman's contact information was not posted. *SD DOH contact information was not posted. *A description of how to file a complaint with the state survey agency, SD DOH, was not posted. *They would look into getting the information posted.	F 575		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	1.Spider webs were removed from west wing kitchen. Wallpaper was repaired in the hallway containing rooms 218 to 225, including the area between rooms 222 and 223. Resident room door frames were painted. The white wall board on the bottom half of the wall in the dining room was painted. Wall paper in the 200-wing area was repaired. Cobwebs and dead bugs in the dayroom across from room 224 were removed. Ceiling tiles with water stains in hallway and on ceiling in room 226 were repaired. Dead bugs near baseboard of room 224 were removed. The dining room ceiling work has been initiated & completion date is open at this time. 2. All residents are at risk of having an environment that is not homelike. The facility will audit all resident areas to ensure wallpaper, door frames, ceilings, & paint are in good repair, and spider webs & bugs are removed. 3. The maintenance and housekeeping staff will be educated by Administrator or designee on ensuring the facility is kept clean and in good	10/29/21

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F 584	Continued From page 14 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, and record review the provider failed to ensure safe/clean/comfortable/homelike environment had been maintained in two of two wings (West and Center).: *Spider webs had been in multiple areas of the building. *Peeling wallpaper, *Chipped paint on walls. *Numerous water stains on ceiling tiles. Findings include: Observation on 9/29/21 at 3:58 p.m. revealed: 1. Satellite kitchen in the West wing had spider webs in windows, on the outside, extending the	F 584	condition by 10/29/21. Additionally, all staff will be educated to report any disrepair noted as soon as it is observed. Those not in attendance at the education session due to vacation, sick leave, or casual work will be educated prior to their first shift worked. Ô. Administrator or designee will audit the facility to ensure resident areas to ensure wallpaper, door frames, ceilings, & paint are in good repair, and spider webs & bugs are removed. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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 584	Continued From page 15	F 584		

length of the window and extending upwards approximately 4", they were very thick and white in color.

Review of contracting pest control company records revealed:
*Service was provided on 2/16/21, 3/15/21, 4/19/21, 5/26/21, 6/16/21, 7/13/21, 8/16/21, and 9/21/21.
-There had been no record of the interior of the building being treated for spiders.

Interview on 9/30/21 at 11:30 a.m. with maintenance director C revealed:
*He was aware of spider webs in various locations outside of the facility.
-The contracting pest control company had not treated the interior of the building for spider's due to concerns it may cause to resident's health.

Interview on 9/30/21 at 8:32 a.m. with administrator A revealed he agreed there were spider webs attached to the outside of the windows in the dining room.

2. Observation on 9/29/21 at 2:55 p.m. revealed there had been:
*Multiple areas of peeling wallpaper in the hallway containing rooms 218 to 225, which 12 residents resided in.
-A strip of torn and missing wallpaper between Rooms 222 and 223, measuring approximately 1.5 foot by 2 inches, next to the handrail.

3. Observation throughout 9/27/21 from 4:03 p.m. to 6:00 p.m. and on 9/28/21 from 8:00 a.m. to 4:00 p.m. revealed:
*There had been numerous door frames that had paint chipped and missing.

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F 584	Continued From page 16 *The white wall board on the bottom half of the walls in the dining room had chipped and missing paint in many areas. Interview on 9/30/21 at 8:42 a.m. with administrator A revealed he had been aware of the environmental concerns. Surveyor: 45383 4. Observation on 9/28/21 at 8:30 a.m. of the walls on the 200 wing of the facility revealed wallpaper peeling in numerous areas down the hallway. *Cobwebs with dead bugs near the ceiling by the dayroom across from room 224. *Dead bugs near the base board next to room 224. *Water stains on the ceiling in the hallway and on the ceiling in resident room 226. Observation on 9/29/21 at 9:00 a.m. of the walls on the 200 wing revealed: *Cobweb with dead bugs and the dead bugs near the base boards were still present. Interview on 9/29/21 at 2:30 p.m. with housekeeping supervisor G revealed: *She had been short-staffed and is finally getting a full staff. *She is planning on stripping the peeling wall paper and painting the walls. *She said she would remove the cobweb with dead bugs and sweep the base board to remove dead bugs before she left work today. Observation on 9/30/21 at 9:30 a.m. of the walls on the 200 wing revealed: *Cobweb with dead bugs and the dead bugs on	F 584		

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F 584	Continued From page 17 the base board were still present.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Surveyor: 45383 Based on observation, interview and record	F 609	1.No immediate correction could be made for delay in thoroughly investigating and notification to SD Department of Health for resident 54's accident/injury. Thorough investigation of resident 54's accident/injury were completed and SD Department of Health initial report was submitted on 9/28/21 and final reported submitted and accepted on 10/1/21. 2. All residents are at risk for a thorough investigation of an incident not being completed timely and reported to SD Department of Health. 3. Clinical leadership was educated on completing a thorough investigating and timely reporting reportable incidents to SD DOH on 10/1/21 by regional nurse consultant. All staff educated on what are reportable events, who to report the incidents to, and when to report them by 10/29/21. Those not in attendance at the education session due to vacation, sick leave, or casual work will be educated prior to their first shift worked. 4. The DON or designee will audit 5 accidents/ incidents ensure they were thoroughly investigated, and if applicable, reported to SD DOH within the reporting time frame. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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.	10/29/21

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F 609	Continued From page 18 review, the facility failed to: *Ensure a thorough investigation had been completed for one of one sampled resident (54) with an injury. *Ensure that the South Dakota Department of Health had been notified of a reportable incident for one of one sampled resident (54). Findings include: 1. Observation and interview on 9/28/21 at 10:58 a.m. with resident 54 revealed: *She was sitting in her wheelchair with a noticeable yellow and green bruise to her entire face. *She stated she fell last Thursday night 9/16/21. *She had felt dizzy while going to the bathroom and she fell and hit her head on the wall in her room. Review of resident 54's medical record revealed: *Brief Interview for Mental Status of 15, indicating she was cognitively intact. *9/8/21 order for Warfarin 3 mg orally to be given at bedtime related to abnormal coagulation severe *9/17/21 4:49 p.m. Unidentified nurse author identified resident 54 had bruising on her forehead and resident 54 reported falling last night. -"Vital signs, neurological assessment and orientation are within normal limits. -She had a purple and slight swelling area approximately 4 cm x 5 cm on resident's forehead. -Pain noted upon palpation to her forehead. Ice given. -Management and Joan, emergency contact were notified of fall and bruise." *9/18/21 at 1:23 a.m. Unidentified nurse author	F 609		

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F 609	Continued From page 19	F 609		

documented "resident 54" reported falling last HS[bedtime] after asked about bruised forehead. Neurological assessment within resident 54's baseline. No pain reported. Will continue to monitor for changes in mental status."
*On 9/18/21 11:52 a.m. bruise to resident 54 forehead is worse.
-"She is complaining of more pain and dizziness".
- E-care was notified and video visit done with Certified Nurse Practitioner.
-"Last Protime/International Normalized Ratio was high on 8/24/21. Due to bruising and coumadin use."
-They had received orders from the certified nurse practitioner to send resident 54 to the emergency room.
*Review of resident 54 care plan revealed she had the potential for bruising, hemorrhage due to anticoagulant use.
*No goals or interventions for this were on resident 54's care plan.

Interview on 9/29/21 at 1:10 p.m. with director of nursing (DON) B revealed:
*No risk management form was completed at the time of the incident.
-Risk management form guides to reportable incidents to the South Dakota Department of Health.
*Resident 54's physician or E-Care was not notified at the the time of the incident.
-Provider notified on 9/18/21 at 11:52 a.m.
*Although management was in the facility at the time of the incident, they were not notified.
*Nursing did not follow facilities fall policy.

Interview on 9/30/21 at 8:45 a.m. with administrator A regarding resident 54's fall revealed:

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F 609	Continued From page 20 *The process for investigating falls was: -Risk management form was to be filled out at the time of the incident. -Notify E-care. -Call on call nurse to notify of incident. -The nurse on call nurse determines if incident is reportable to the South Dakota Department of Health. *They had taken disciplinary action with the nurse involved in the incident. *Nursing did not complete the post fall assessment form. *They did not have a policy on reportable incident to the South Dakota Department of Health.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	1.Resident 3 care plan updated to reflect location of current pressure injury and treatment, dietary interventions, and repositioning resident at least every 2 hours. Resident 4 care plan updated to reflect concerns with staff assisting him, refusing certain staff, and interventions put in place for this. 2. All residents are at risk for failure to provide comprehensive care plan. All resident care plans will be reviewed by 10/29/21 to ensure all residents have comprehensive person-centered care plans. 3. IDT was educated on updating resident care plans timely to reflect resident conditions and interventions by 10/29/21. 4. The DON or designee will audit 5 random residents care plans to ensure they are comprehensive and person centered. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for	10/29/21

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F 656	Continued From page 21 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Surveyor: 45383 Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents had comprehensive care plans: Provider failed to ensure two of two sampled residents' (3 and 4) care plans had included: *One resident (3) with a pressure injury. *One resident (4) with concerns with staff assisting him. Findings include: 1. Observation on 9/27/21 at 3:35 p.m. revealed resident 3 lying on his back in his bed. *Resident 3 had an air mattress on his bed. *He was wearing Prevlon boots while in bed.	F 656	analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 656	Continued From page 22 Interview with director of nursing (DON) B on 9/28/21 at 1:10 p.m. revealed: *Resident 3 was admitted 2/20/21 with a pressure ulcer. *Skin assessment was performed weekly and documented in the electronic medical record (EMR). Interview with resident 3 revealed: *He has a pressure injury, but is not sure where it is located on his body. *Resident's brief interview of mental status (BIMS) on 9/11/21 was 11, meaning he was moderately impaired. Record of resident 3's record review revealed: *On 6/22/21 treatment order received for coccyx/sacral wound care: "Cleanse with soap and water. Apply No-Sting around the wound. Apply Medihoney in/in wound, cut white foam to size over wound and around three of four edges, but not cover 6:00. Cover with boarded foam Mepilex. Change every 3 days and as needed for if loose or soiled". *Skin assessment was performed every week and documented in EMR. *Care plan focus for resident 3 stated I am at risk for skin impairment related to immobility. *Goal for resident 3 stated my skin will be intact through next assessment period. *Interventions listed were: -Air mattress on bed. -Monitor skin when providing personal cares. Notify nurse of any skin concerns. *Facility failed to comply with facility's own care plan policy, resident 3's care plan does not include: -Current pressure ulcer and treatment.	F 656		

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F 656	Continued From page 23 -Dietary notes for dietary modification for wound healing. -Reposition resident at least every 2 hours. Surveyor: 45095 2. Observation and interview on 9/28/21 at 3:10 p.m. with resident 4 in his room revealed he: *Was sitting up in his wheelchair. *A pressure reduction mattress was on his bed and a pressure reduction cushion was on his wheelchair. *Stated he had waited up to one and a half hours during the night for staff assistance with toileting. *Stated call light answering times were a continuous issue during the night, but call lights were answered in a reasonable time during the day. *Had a sore, red bottom due to incontinence that sometimes started to get better but then returned to being sore and red, and felt it was due to his being incontinent and having to wait during the night for long periods for staff to answer his call light. Interview on 9/29/21 at 2:35 p.m. with resident 4 regarding the call light response time during the night revealed: *He had just returned from the veteran affairs (VA) hospital where he received his intravenous antibiotic infusion. *He was in his room, lying in bed and the staff had been in approximately fifteen minutes ago, and had applied his cream for his sore, red bottom. *He denied any history of having had pressure ulcers to his bottom. *His room had a large clock on the wall opposite from his bed.	F 656		

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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
F 656	Continued From page 24 *He knew how long it had taken for his call light to be answered because he looked at his clock on the wall. *Some nights had been worse than others for answering his call light. -It depended on who the charge nurse on duty was. Interview on 9/30/21 at 7:58 a.m. with resident 4 regarding long call light wait times revealed: *He had reported the long call light wait times during the night "over and over, multiple times." *He had reported it at Resident Council meetings stating "and I am not the only one." *It would be so nice to get something done about it. *He reported we had lost a lot of good night workers, not just people, but numbers, they had gone from having four workers at night to two workers at night. Interview on 9/30/21 at 8:22 a.m. with the director of nursing (DON) B, the assistant DON I and the corporate nurse consultant H were present, regarding call light response times revealed: *She was aware resident 4 had complained regarding long waits for call light response times during the night. *She had been made aware of the issue through staff reports. *She stated he was not accurate, he exaggerated, and she had attributed that as mood-related and staff-related. *She stated the issue had been due to his not liking black staff and he had chosen to wait for other staff to help him. *Her expectation for call light response times was as soon as staff had seen the call light. *She agreed:	F 656		

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	435039	A. BUILDING _____ B. WING _____	09/30/2021

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F 656	Continued From page 25 -One and a half hours was too long to wait. -They should have been able to provide accommodations for him and answered his call light. -The resident's choice to wait for a different staff to help him during the night should have been on his care plan. Interview on 9/30/21 at 8:33 a.m. with resident 4 regarding call light response times revealed: *He had chosen to wait for a different staff to help him sometimes. *"Not all the black staff were bad, a few were good." *He would not turn down good help. *He had gotten into a conflict with a few of the staff. Review of resident 4's medical record revealed: *The 6/11/21 quarterly Minimum Data Set assessment for resident 4 revealed he: - Required extensive assistance of two for bed mobility and toilet use. - Was always incontinent of bowel. - Was at risk of developing pressure ulcer/injuries. - Was not on a turning/repositioning program. *Care Plan with most recent revision dated 8/12/21 had the following: -Keep air mattress on my bed and pressure reducing cushion in his wheelchair, encourage to lie down for leg elevation. -Turn and reposition every two hours. -The facility will provide care to enable the resident to function at their most practical level and support my adjustment towards the residence in a homelike environment. -Remind, offer, and assist with toileting as	F 656		

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F 656	Continued From page 26 needed. Will use urinal, keep within his reach, will use bedpan if in bed. *It did not include he refused certain staff and did not have interventions for this. Review of the provider's September 2019 Care Planning policy revealed: *"1. Each resident is an individual. The personal habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patterns as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins at the moment the resident is admitted to the facility and doesn't end until discharge or death." Refer to F558	F 656		
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: Surveyor: 45383 A. Based on observation, interview, record review and policy review,the provider failed to ensure that professional standards were followed for one of one sampled resident (54) who had fallen and hit her head while taking an anticoagulant. Findings include:	F 658	1. No immediate corrective action could be completed for facility failing to follow professional standards for resident 54's fall and for insulin pen not being primed for resident 38 during survey. RN J was educated on facility fall policy and protocol, and insulin administration, including priming an insulin pen prior to administering insulin. RN J no longer works at the facility. Resident 54 care plan updated and revised to reflect risk of falls. 2. All residents are at risk for failure to receive care in accordance with professional standards. All resident care plans have been reviewed and updated to reflect risk of falls if fall assessment score is 8 or greater. All nurses to be educated by 10/29/21 by Assistant Director of Nursing on properly administering insulin including priming insulin pens prior to administration. Those not in	10/29/21

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F 658	Continued From page 27 1. Observation and interview on 9/28/21 at 10:58 a.m. Resident 54 revealed she: * Was sitting in her wheelchair with a noticeable yellow and green bruise to her entire face. *" Had fallen last Thursday night 9/16/21." *"Had felt dizzy while going to the bathroom and she fell and hit her head on the wall in her room." Record review of resident 54 medical medical record revealed she: *She had the potential for bruising and hemorrhage due to anticoagulation use. *On 9/8/21 order for Warfarin 3 milligrams orally to be given at bedtime related to abnormal coagulation. *On 9/17/21 4:49 p.m. Unidentified nurse author identified bruising on her forehead and had reported falling last night. *"Management and resident 54's emergency contact were notified of fall and bruise." *"Vital signs , neurological assessment and orientation are within the normal limits." *No documentation of notifying E-care or physician at the time of incident. *ON 9/18/21 at 1:23 a.m. Unidentified nurse author documented" resident reported falling last [HS] bedtime after being asked about her bruised forehead. Neurological assessment within resident 54's baseline." *On 9/18/21 11:52 a.m. an Unidentified nurse author noted the bruising to her forehead is worse. -"She is complaining of feeling dizziness." -E-care was notified and video visit done. -They received orders from the certified nurse practitioner (CNP) to transfer resident 54 to the ER. *She did not have a care plan that addressed risk	F 658	attendance at the education session due to vacation, sick leave, or casual work will be educated prior to their first shift worked. 3. IDT to be educated on care plans to include ensuring there is a fall focus and interventions when fall risk assessment score is 8 or greater by 10/29/21. 4.The DON or designee will audit 5 random resident care plans to ensure they have a fall risk assessment completed, if there is a score of 8 or greater, they have a fall focus in their care plan that is comprehensive. Randomly audit 3 nurses per week on various shifts and at various times to ensure insulin pens are primed prior to administration. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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 28 for falls. Interview on 9/29/21 at 1:10 p.m. with director of nursing (DON) B revealed: * Management was in the facility at the time of the incident, they were not notified. *Risk management form was not completed by nurse for resident 54 fall. *The providers post fall assessment was not completed by nurse. *E-care of resident 54's provider was not notified by nurse at the time of the incident. *Provider via E-care video visit was notified on 9/18/21 at 11:52 a.m. *Providers fall policy was not followed by nurse. *They use Lippincott's Nursing Procedures as their reference for professional standards. Surveyor: 29354 B. Based on observation, interview, and manufacturer's recommendation review, the provider failed to ensure insulin pen preparation and administration for one of one sampled resident (38) by one of one observed registered nurse (RN) (J) had been completed according to the manufacturer's instructions to ensure an accurate dose had been given. Findings include: 1. Observation on 9/27/21 at 5:10 p.m. with RN J in the hallway beside the medication cart revealed: *She removed two insulin pens from the top drawer of the medication cart. -Took the NovoLog Flex Pen, cleansed the end of the pen, inserted a needle, and dialed the gage to 4. -Took the Tresiba Flex Touch, cleansed the end of the pen, inserted a needle, and dialed the gage	F 658		

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F 658	Continued From page 29 to 12. *She had not primed the insulin pens before selecting the units to be administered. *She went into resident 38's room and administered both insulin pens. Interview on 9/29/21 at 8:30 a.m. with director of nursing B and corporate nurse consultant H regarding the above observation of RN J not priming the NovoLog Flex Pen and the Tresiba Flex Touch insulin pens before administration revealed their expectations would have been for the insulin pens to have been primed before administration. Review of the manufacturer's NovoLog FlexPen instructions revealed: *"Remove the cap. -Pull off the pen cap and wipe the rubber stopper with an alcohol swab." *"Attach a new needle. -Pull off the paper tab. -Push and twist the needle on until it is tight. -Pull off both needle caps." *"Prime your pen. -Turn the dose selector to select 2 units. -Press and hold the dose button. -Make sure a drop appears." *"Select your dose. -Turn the dose selector to select the number of units you need to inject." Review of the manufacturer's Tresiba Flextouch insulin pen instructions revealed: *"Attach a new needle. -Pull off the paper tab. -Push and twist the needle on until it is tight. -Pull off both needle caps." *"Prime your pen.	F 658		

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F 658	Continued From page 30 -Turn the dose selector to select 2 units. -Press and hold the dose button. -Make sure a drop appears." *"Select your dose. -Turn the dose selector to select the number of units you need to inject."	F 658		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of three sampled residents (18 and 25) had quarterly safety assessments for bed rail usage.	F 700	1. Residents 18 & 25 quarterly safety assessments for bed rail usage were completed on 10/13/21 (R18) and 9/29/21 (R25). Resident 25 risk versus benefit of use and informed consent obtained and completed on 9/29/21. 2. All residents with bed rails are at risk for quarterly safety assessments & risks versus benefits of use not being completed. All residents with bed rails have been reviewed, assessments completed, risk versus benefits of use completed & informed consent obtained by 10/29/21. 3. All nurses to be educated by Assistant Director of Nursing on restraint free environments policy including assessment upon admission, quarterly, and with any significant change/risk vs benefit of use, & obtaining informed consent for bed rails prior to use by 10/29/21. Those not in attendance at the education session due to vacation, sick leave, or casual work will be educated prior to their first shift worked. 4. The DON or designee will audit 5 random residents to ensure that if a resident has bed rails to ensure they have quarterly assessment, risk vs benefit of use, and informed consent obtained. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and	10/29/21

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F 700	Continued From page 31 *One of three sampled residents (25) had received risk of use versus benefits of use education and had obtained informed consent for bed rail. Findings include: 1. Observation on 9/28/21 at 11:32 a.m. of resident 18's room revealed: *She had been in her room. *Side rails on the upper half of her bed that were in the up position. *She was not in her bed at this time. Interview on 9/29/21 at 8:20 a.m. with certified nursing assistant (CNA) AA revealed resident 18 does use her side rails to assist in positioning when in bed. Review of resident 18's medical record revealed: *Her care plan had included the use of side rails. *She had safety assessments for the use of side rails completed on 1/25/21 and 4/19/21. -There had been no safety assessments for use of side rails completed after 4/19/21. Surveyor: 45095 2. Observation and interview on 9/28/21 at 9:13 a.m. of resident 25 revealed: *He had been assisted to the bed by CNA BB and CNA CC. *There were side rails on the upper half of his bed that were in the up position. *He was not observed using the side rails. Observation on 9/29/21 at 10:57 a.m. revealed resident 25's bed had side rails in the up position, he was not in the bed at that time.	F 700	recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 700	Continued From page 32 Review of resident 25's medical record revealed: *His care plan stated he used side rails to assist with increased independence with bed mobility and repositioning. *There had been side rail/other device assessments completed on 1/23/21 and 7/29/21 which indicated he did not use side rails or other devices. *There had been no risk of use versus benefit of use education provided to him. Interview on 9/29/21 at 1:20 p.m. with corporate nurse consultant (CNC) H regarding side rail use for resident 25 revealed the provider did not have a side rail informed consent or a safety side rail assessment completed for him. Interview on 9/29/21 at 1:55 p.m. with director of nursing (DON) B and CNC H revealed the consent and risk versus benefit of use education had not been completed. Interview on 9/29/21 at 4:25 p.m. with DON B revealed: *She did not know why the consent and risk of use versus benefits of use education had not been completed for resident 25. *She did not know why the safety side rail assessment showed resident 25 did not use side rails. -The nurse manager would have been responsible to complete them. Review of the provider's November 2019 restraint policy revealed: *"Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot	F 700		

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F 700	Continued From page 33 remove easily, which restricts freedom of movement or normal access to one's body. -Physical restraint may include, but are not limited to:" -"b. Using bed rails to keep resident from voluntarily getting out of bed." *Resident 25 did not have any side rail assessments completed to determine if the side rails were a restraint or not.	F 700		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732	1. Daily nurse staffing data was posted on 9/29/21 in a prominent place readily accessible for residents and visitors and in a clear & readable format. Central supply/scheduler Y was educated on posting daily nurse staffing data in a prominent place readily accessible for residents and visitors and in a clear & readable format 2.All residents are at risk for not being able to readily access the daily nursing staffing data. 3. Central supply/scheduler Y was educated by Administrator on posting daily nurse staffing data in a prominent place readily accessible for residents and visitors and in a clear & readable format by 10/29/21. 4. The Administrator or designee will audit 5 random dates each week to ensure daily nurse staffing data is posted in a prominent place readily accessible for residents and visitors and in a clear & readable format. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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.	10/29/21

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F 732	Continued From page 34 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, interview, and review of posted direct care staffing information, the provider failed to post the daily nurse staffing information. Findings include: 1. Random observations on 9/27/21 from 3:30 p.m. to 6:00 p.m.; 9/28/21 from 7:30 a.m. to 6:00 p.m.; and 9/29/21 from 7:30 a.m. to 1:00 p.m. did not find the daily nurse staffing information posted in the facility. 2. Interview on 9/29/21 at 1:00 p.m. with administrator A revealed that daily nurse staffing information was: *Not posted. *Completed by central supply/scheduler Y. *Kept in the nurse schedule binder. *Discussed with the director of nursing B on 9/29/21. *In process of getting posted in the facility. 3. Interview on 9/29/21 at 1:47 p.m. with central supply/scheduler Y confirmed that the nurse staffing information was kept in the nurse schedule binder and not posted before today. However, she stated that the nurse staffing	F 732		

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F 732	Continued From page 35 information was posted today, 9/29/21 by the center nursing station. 4. Observation on 9/29/21 at approximately 2:00 p.m., following the interview with central supply/scheduler Y confirmed that the form "Nursing Staff Directly Responsible for Resident Care" dated 9/29/21 was posted on the bulletin board beside the activity bulletin board across from the center nursing station.	F 732		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the	F 801	1. The Dietary Manager has enrolled and started the Certified Dietary Manager Course. The dietary manager will complete the course within 18 months. 2. Educational and certification requirements for a Dietary Manager have been reviewed by the Regional Dietary Specialist and discussed with the facility Administrator, Registered Dietitian, and the Dietary Manager. 3. The Dietary Manager has started the CDM class and will have progress monitored by the Administrator. The Registered Dietitian or Regional Dietary Specialist will meet with the Dietary Manager at least monthly to review completed lessons. The Registered Dietitian be full time until the dietary manager has finished the certification process. The Registered Dietitian or regional Dietary Specialist will provide ongoing support to facility as the dietary manager completes their necessary credentials. 4.The Administrator or designee will perform weekly audits to ensure the following: Administrator or designee will audit Dietary Manager's coursework to ensure progress is made in course weekly. Audits will be weekly for	10/29/21

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F 801	Continued From page 36 supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for	F 801	one month and then monthly until the dietary manager completes the Certified Dietary Manager Course.	

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F 801	Continued From page 37 food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Surveyor: 43844 Based on interviews and job description review, the provider did not employ a full-time qualified registered dietitian (RD), and failed to ensure the dietary manager (DM) met the requirements to serve as a certified dietary manager (CDM). Findings include: 1. Interview on 9/29/21 at 1:40 p.m. with DM D revealed she: *Was not a CDM. *Had registered for the CDM course. -Was not able to start the program until the provider sent a check to pay for the program. *Stated RD E came each week on Tuesday's and was available by phone at all times. Telephone interview on 9/30/21 at 8:04 a.m. with RD E revealed she: *Did not work full-time for the provider, typically worked 5 to 8 hours per week. *Had been available as needed for any questions or concerns. *Had been aware that DM D was not a certified dietary manager. Interview on 9/30/21 at 8:51 a.m. with administrator A revealed: *The dietitian was not full-time.	F 801		

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F 801	Continued From page 38 *He needed to mail a check to CDM program in order for the DM to start it. Review of provider's undated DM job description revealed the requirements included "Proven experience as a manager and meets all education requirements needed for the position."	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Surveyor: 43844 Based on observation, interview, and policy review, the provider failed to ensure: *The kitchen and multiple food storage areas within were maintained in a clean and sanitary	F 812	1. Kitchen floors & dishwashing area was cleaned on 10/21/21: cardboard, gloves, saltshaker on dishwasher area shelf removed, unlabeled items were removed, vent above dishwasher was cleaned and repainted, dish room floor was cleaned, fan was cleaned. In the main kitchen, the counter & microwave were cleaned, plate warming covers were replaced, face shields and speaker were removed, and counters cleaned. In the pantry area: floor was cleaned, food was put away on shelving, expired/unlabeled/open food items discarded, non-food items labeled, Janitor's closet drain repaired. In the Walk-in Cooler: Ham and hamburger were discarded. In the Walk-in Freezer: Ice crystalized & unlabeled foods discarded, frost was removed. Items on top of ice machine were removed. In refrigerator: Rolaid's package & tortillas were discarded. In main dining room: water & ice dispenser was cleaned and calcium deposits removed, grill sink was cleaned. In Warren & Family Room Lounge refrigerators, refrigerator and freezer were cleaned, food items discarded, & temperatures are now being taken daily. Broken brown fridge was removed. 2.All residents are at risk for food borne illness related to improper stored food item storage and unsanitary kitchen conditions. 3.Administrator will educate dietary staff on obtaining fridge temperatures daily, and	10/29/21

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F 812	Continued From page 39 manner. *Food was appropriately labeled and stored. *Refrigerators and freezers were appropriately maintained for best temperature control. *Water dispenser was maintained to avoid calcium build up. *Face shields and assorted gloves were appropriately maintained when not being used by staff. *Sanitizing buckets were maintained in good condition and sanitizing solution tested. *Janitor's closet was maintained with an effective drain. Findings include: 1. Observation on 9/27/21 at 3:45 p.m. during initial tour of the kitchen revealed: *Food particles in crevices of the floor through out the kitchen. *Dishwashing area had: -A metal shelf, measuring approximately three feet by one foot that had: --What appeared to be cardboard dried on to it, measuring approximately five inches by two inches. ---Making the shelf an uncleanable surface. --A salt shaker. --Two boxes of clean gloves, that had been opened. --A pair of obviously dirty yellow rubber gloves. -A dirty vinyl glove on the floor. *Counter near the juice dispenser had a dirty rag laying on it. *A white refrigerator contained: -An open carton of milk with no open date. -Two boxes of apple juice opened with no open date. -Eight covered glasses of milk and juice with no open date.	F 812	discarding of unlabeled or expired food items, storing food and non-food items properly, keeping counters clean, cleaning refrigerators daily, completing kitchen cleaning tasks, reporting maintenance items immediately, and storing eyewear appropriately by 10/29/21. 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. 4. The Administrator or designee will audit the kitchen to ensure it is properly maintained and cleaned, & refrigerators to ensure temperatures are being recorded daily. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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 812	Continued From page 40 *The vent above dishwasher had chipped paint on the edges that extended over the clean dish area and the dirty dish area. *Clean dish room had dirty water on the floor. -A fan running, that had accumulated dust on the grill guard. *Main kitchen: -The counter by the juice dispenser had: --A bottle of hand sanitizer with a red spray lid sitting on top of an open box of unused vinyl gloves and next to an open box of drinking straws. --A wet wash cloth lying on the counter. *Microwave had dried spills on the inside of the door, the glass turning plate and the bottom and sides. *Two oranges had been on a gray serving tray that had crumbs of food and clean dessert dishes on it. *Numerous plate warming covers that had worn edges exposing the underlying plastic on them. *A face shield on the counter next to the toaster. *Two additional face shields on the counter, next to a food processor and a visibly dirty blue tooth speaker. -There had been crumbs of food on this area of the counter. Observation and interview on 9/27/21 at 3:49 p.m. with dietary aide F revealed: *She agreed there had been a wash cloth on the counter, and it should have been in a bucket of sanitizer. -Was not sure why it was there, she had just came to work. -Would have put it in a bucket with sanitizer. -Did not know how to test the sanitizer in the bucket to ensure there was enough. --Did not know she would need to verify there was	F 812		

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F 812	Continued From page 41 enough sanitizer. -Agreed there had been one red plastic bucket used as a sanitizing bucket that had a crack on the side, approximately one and one-half inches long, and extending from the top downward. Continued observation on 9/27/21 at 3:51 p.m. revealed: *In the pantry there had been: -Debris on the floor. -Eight cases of food had been sitting on the floor. -Long-grained rice with a date of being opened of 9/3, inside a blue plastic sack, in a cardboard box, with rice exposed to the air. -Two Ziploc gallon bags of cereal not dated, that had been removed from the original container. -Gallons of mayonnaise and ranch dressing that did not have a use by date or an expiration date on them. -Five packages of grits had been expired on 9/17/21. *Janitors closet opposite of the food storage room had a drain that did not work properly and produced a foul odor. *The walk-in cooler had ham in plastic Ziploc bag that had been stored on the same cookie sheet as two rolls of thawed hamburger. *The walk-in freezer had in it: -A plastic bag labeled "shepherd's pie", dated 8/9/21 with ice crystals inside the bag. -A plastic bag labeled 'Chix", with no date on it and ice crystals inside the bag. -Frost on the left side of the circulating fan box measuring approximately one inch thick by eight inches wide. *The ice machine had stored on top of it: -Two face shields stored on top of it. -A pint-size mug with an unwrapped straw in it and no liquid in it.	F 812		

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F 812	Continued From page 42 -A salt shaker. *The double door refrigerator had: -A Rolaids package with one piece left in it was stored on the top shelf. -A package of tortillas with an open date of 9/15. *The main dining room had a water and ice dispenser that had: -A white substance, that appeared to be calcium, on the dispensing spouts. -The grill sink area covered in a brown substance, that appeared to be grime. Interview on 9/27/21 at 4:24 p.m. with dietary manager (DM) D revealed she agreed: *Mayonnaise and ranch dressing did not have a use by or expiration date on them. *Two packages of cereal did not have an open date. -Stated the cereal is normally kept in Ziploc bags with an open date written on them and discarded 7 days after that. *The rice had not been stored safely. *Grits had been outdated. *The walk-in freezer had frost build up the circulating fan box. -Stated the walk-in freezer was defrosted "every couple of days". Interview on 9/27/21 at 4:30 p.m. with DM D revealed: *She agreed the drain in the janitor closet had not been working properly. -They do not normally use the drain and had been disposing of dirty water somewhere else. Interview on 9/27/21 at 4:45 p.m. with DM D revealed she: *Agreed the ham and hamburger should not have been stored together.	F 812		

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F 812	Continued From page 43 *Agreed that the plastic bags containing food in the walk-in freezer had been freezer burnt. *Had been aware one of the sanitizing buckets had a broken handle. -Was not aware one of them had a crack in it. *Staff were to test buckets of sanitizing solution least once a day. -They should be changed every two hours whether or not they had been used. *Agreed the plate covers were worn. -Had been planning on asking the administrator for approval to order new ones. *Agreed the water dispenser had not been cleaned for an unknown amount of time, and that it should have been cleaned at least daily. 2. Observation on 9/28/21 at 8:45 a.m. of the satellite kitchen revealed: *There had been a refrigerator labeled "resident food only". -It had a temperature log taped to the freezer door. --There had been no temperatures taken for the month of September. -It contained the following foods: --A container of grape juice that had been opened and had no open date. --A carton of apple juice that had been opened and had no open date. --A carton of tomato juice with an open date of 9/3. --4 individual cartons of chocolate milk that had been outdated on 9/25. -The freezer portion of this refrigerator had a white substance that appeared to be ice-cream dried on the bottom shelf towards the back in the middle covering approximately 4 inches by 12 inches.	F 812		

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F 812	Continued From page 44 Interview on 9/28/21 at 4:45 p.m. with DM D revealed the satellite kitchen refrigerators had not been used for months and she had thought housekeeping had been responsible to monitor the temperatures of them. 3. Observation on 9/29/21 at 9:05 a.m. of the "Lounge" at the end of the 218 hallway revealed: *There had been two refrigerators labeled "resident only", they were labeled #1 and #2. -#1 had been missing temperatures for September on days 2, 6, 8, 12, 21, 22, 24, and 25. -#2 had been missing temperatures for September on days 2, 8, 11, 12, 21, 22, 24, 25, and 26. -There had been a small brown refrigerator with a broken handle that had sharp edges exposed. Interview on 9/29/21 at 1:40 p.m. with DM D regarding face shields revealed she: *Agreed face shields had been stored on top of the ice machine: -Stated the dietary staff had picked up the face shields when checking in to work, had worn them in the hallway on their way to the kitchen, and put them on top of the ice machine. -Stated, "We don't usually wear our masks or face shields when we are in the kitchen, just when we deliver trays in resident care areas." *Agreed face shields had been stored on kitchen counter tops and should not have been. *Agreed face shields had been worn by dietary staff, were contaminated, and had not been stored appropriately. Observation and interview on 9/29/21 at 2:30 p.m. with housekeeping supervisor (HKS) G revealed:	F 812		

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F 812	Continued From page 45 *Refrigerators 1 of 2 labeled resident use in the lounge at the end of 218 hallway findings include: -In refrigerator 2 there were two 2 pack of parboiled eggs dated 8/24/21. --Two 4 pack of parboiled eggs dated 9/4/21. --Two separate packaged bunches of green grapes that were not labeled or dated. ---All above items were discarded upon finding. *Housekeeping supervisor G agreed that items were outdated and should have been discarded sooner. *She states she thought the CNA's were helping with monitoring refrigerator 1 and 2. Interview on 9/29/21 at 2:32 p.m. with housekeeping supervisor HKS G revealed she: *Had started monitoring the resident refrigerator in the satellite kitchen on 9/28/21. -Thought dietary had been monitoring it until then. *Did take temperatures on the refrigerators in the "Lounge". -Was not aware several days had not had temperatures recorded. *Was not aware of the brown refrigerator. Interview on 9/29/21 at 2:36 p.m. with DM D revealed she thought the brown refrigerator had been in a medication room that had been moved to a new location. 4. Review of provider's 5/17 food safety requirements policy revealed: *"Policy: It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods including those brought to residents by family and other visitors." -"The food service workers, cooks, dietary aides, dishwashers, food prep aides, or any person(s)	F 812		

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F 812	Continued From page 46 who are in the kitchen working with any type of food, are responsible for to adhere to the food safety requirements." Review of provider's 10/19 food storage-dry goods policy revealed: *"Policy statement: It is the center policy to insure all dry goods will be appropriately stored in accordance with guidelines of the FDA [Food and Drug Administration] Food Code. Action Steps: Dry Storage 1. The Dining Services Director or designee is responsible to store all items 6 inches above the floor on shelves." "5. The Dining Services Director or designee ensures that all packaged and canned food items shall be kept clean, dry, and properly sealed. 6. The Dining Services Director or designee ensures that the storage will be neat, arranged for easy identification, and date marked as appropriate." Review of the provider's 10/19 food storage: cold policy revealed: *"Policy Statement: It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code." "Attachments: 1. Food storage and retention guide." Review of provider's 5/17 food safety requirements policy (use and storage of food and beverage brought in for residents, food procurement) revealed: *"Policy:	F 812		

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F 812	Continued From page 47 It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors....This includes the storage, preparations, distribution, and serving food in accordance with professional standards for food service safety." *"Objective of policy": -"(2) Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling process." *"Procedure": "c. Monitor i. Facility staff will be appointed to check resident refrigerators for proper temperatures, food containment and quality, and disposal of items per facility policy." "D. Refrigeration: a.....The following are methods to determine the proper working order of the refrigerators and freezers; b. Document the temperature of external and internal refrigerator gauges. Refrigerators must be 41 degrees or less. Freezers must be cold enough to keep foods frozen solid to the touch."	F 812		
F 880 SS=D	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.	F 880	1.No immediate correction could be made for appropriate hand hygiene & glove use as well as procedural technique with dressing change and providing personal cares not being completed on Resident 3. Hand Hygiene policy was reviewed and is up to date. All care staff will be educated/re-educated by 10/29/21 by Director of Nursing or Designee. 2.ALL residents have the potential to be affected if staff do not adhere to appropriate	10/29/21

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F 880	Continued From page 48 §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; (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	F 880	hand hygiene and glove use as well as procedural technique with dressing change and providing personal cares not being completed. Policy education/re-education about roles and responsibilities for the above identified assigned tasks will be provided by 10/29/21 by the Director of Nursing or designee. 3.Root cause analysis conducted answered the 5 Whys: CNA Z and CNA AAA were interviewed. Will reinforce proper hand hygiene with these two staff and complete auditing across care staff for proper hand hygiene and glove use. RN J was interviewed. RN J acknowledged that she did not complete the glove change as she was nervous due to being observed by surveyors. RN J no longer works at facility. Will complete auditing across nurses to ensure dressing changes are being completed properly. DON or designee to complete hand hygiene competencies with all care staff, and dressing change competencies with all nurses to ensure appropriate hand hygiene and glove use as well as procedural technique with dressing change and providing personal cares. Administrator & Director of Nursing contacted the South Dakota Quality Improvement Organization (QIN) on 10/20/21 at 2pm and discussed root cause analysis of both situations, discussed auditing practices to use, and provided direction on importance of enforcing strictness in auditing staff year-round so that they are familiar with it when surveyors come into the building. 4.DON or designee to conduct random audits across multiple shifts and times to ensure staff are completing hand hygiene appropriately and nurses are completing dressing changes appropriately. Audits will be weekly across all	

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	435039	A. BUILDING _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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F 880	Continued From page 49 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: Surveyor: 43844 Surveyor: 45383 Based on observation, interview, and policy review, the provider failed to maintain appropriate hand hygiene and glove use as well as procedural technique during: *Provision of personal cares for resident 3 by certified nursing aides (CNAs). *Dressing change for resident 3 by registered nurse (RN) J. Findings include: 1. Observation on 9/28/21 at 9:00 a.m. of personal care for resident 3 who was incontinent of bladder and bowel. Both CNA Z and CNA AA performed hand hygiene and put on clean gloves. CNA Z and CNA AA wear changed an incontinent brief. Resident 3 was incontinent of bowel. CNA	F 880	shifts for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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 880	Continued From page 50 Z used peri care cloth to remove BM[bowel movement] CNA Z tucked the soiled incontinent brief under the resident 3, then CNA Z placed a new incontinent brief under resident 3 without performing hand hygiene or changing gloves. CNA Z continued to secure resident 3 incontinent brief and pull his clean clothes up. CNA Z and CNA AA removed soiled items without wearing gloves. No hand hygiene performed. *Reviewed process with CNA Z and CNA AA. They agreed that they had missed hand hygiene and glove changes. *Interview with DON B on 9/28/21 at 10:00 a.m. regarding the step the CNA used. DON B agree that they did not change their gloves and perform hand hygiene while performing resident 3 brief change. *Review of facilities hand hygiene policy revealed CNA Z and CNA AA failed to comply with hand hygiene policy. *CNA Z and CNA AA failed to perform hand hygiene and put on clean gloves before moving from a contaminated body site to a clean body site during resident cares. 2. Observation on 09/30/21 9:40 a.m. of dressing change for resident 3 with a pressure ulcer. RN J prepared a clean surface, putting a clean towel down to lay dressing change supplies. RN J washed her hand prior to procedure and donned clean gloves. *RN J flushed the wound with saline removed gloves and washed hands then put on clean gloves. -Opened package for NO-Sting skin prep. -Applied NO-Sting skin prep to resident's skin. -Grabbed a scissor from a bag with dressing supplies.	F 880		

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F 880	Continued From page 51 -Cut foam dressing for wound. -Applied Medihoney with her gloved finger. -Placed foam dressing over wound. -Opened Mepilex dressing, dated dressing with a sharpie marker. -Applied Mepilex dressing to wound all without changing her gloves and performing hand hygiene. Interview on 9/30/21 at 10:00 a.m. RN J following above dressing change revealed: *She stated that is how she performs it. *Review of steps of dressing change with RN J and she agreed she missed gloves changes and hand hygiene. Interview on 9/30/21 at 1:00 p.m. with assistant director of nursing (ADON) RN I and DON B revealed: *Both are working together with Infection Control. *Reviewed steps that RN J used to change resident's dressing. *Both agreed that glove changes had been missed in that procedure. Review of facilities dressing change competency-aseptic technique, RN J failed to comply with hand hygiene and putting on clean gloves after she cleansed the wound. *Did not use a clean gauze or tongue blade to apply medihoney.	F 880		

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E 000	Initial Comments Surveyor: 16385 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 9/27/21 through 9/30/21. Avantara Norton was found not in compliance with the following requirement: E001.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	1. The following Policy/Procedures were added to the Emergency Preparedness Program: Sewage & waste disposal, Fire Alarms, Track Location of On Duty Staff & Sheltered Residents Under Facility Care During an Emergency, Track Location of Staff & Residents During an Emergency Evacuation-Including Specific Name & Location of the Receiving Facility or Other Location, & Addition of a Communication Plan that Includes Names & Contact Info for Resident's Physicians, and a method to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. 2. All residents are at risk due to not having a thorough emergency preparedness program in place 3. Administrator to educate all staff on the above added policies and procedures by 10/29/21. 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. 4.The Administrator or designee will perform weekly audit of 5 staff per week to ensure they know where these policies and procedures are	10/29/21

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

Blake Dehnke, Administrator 10/22/21

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E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on interview and record review, the provider failed to establish a complete emergency preparedness program that included policies, procedures, communication plan, and contact information. Findings include: 1. Interview on 9/30/21 at 8:34 a.m. and review of provider's emergency preparedness program documentation with administrator A revealed: *They did not have a complete emergency preparedness program. *They had not: -Addressed policies and procedures for sewage and waste disposal. -Addressed policies and procedures for fire alarms. -Addressed policies and procedures to track the location of on-duty staff and sheltered residents in their care during an emergency. -Addressed policies and procedures to track the	E 001	located within the emergency preparedness plan. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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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E 001	Continued From page 2 location of staff and residents during an emergency evacuation, including the specific name and location of the receiving facility or other location. -Developed a communication plan that had: --Included names and contact information for resident's physicians. --Included a method to provide information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E 001		

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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 09/28/21. Avantara Norton 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 K211, K293, K321, K363 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=E	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General 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. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to provide operable egress doors as required at two randomly observed exit door locations (center dining room and warren dining room). Findings include: 1. Observation and testing beginning on 9/28/21 at 12:16 p.m. revealed the marked exit door for the center dining room was unable to be easily	K 211	1. Center Dining Room & Warren Dining Room exit doors were inspected on 10/6/21 by vendor. Warren Dining Room door was repaired. Quote received on 10/21/21 to replace Center Dining Room door. Quote received for new door and awaiting delivery date. Due to the extended delivery time for this door, a waiver extension was granted by Medical Facilities Engineering Supervisor for K211 for the door replacements. This will be completed on or before 01/1/22. Once the work has been completed Maintenance Director or designee will contact the Life Safety Code surveyor. Exit Door in Warren Dining Room was fixed so it is now easily able to be opened. 2. All residents are at risk due to exit doors failing to provide operable egress. 3. Administrator to educate Maintenance Director on testing and maintenance of egress doors by 10/29/21. 4.The Maintenance Director or designee will perform weekly audits of 5 random egress	10/29/21

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

Blake Dehnke, Administrator | | 10/22/21

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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K 211	Continued From page 1 opened. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated he was unaware that door was not able to be opened. 2. Observation and testing beginning on 9/28/21 at 12:59 p.m. revealed the exit door for the warren dining room was unable to be easily opened. Testing of the door by applying greater than fifty pounds of force in the direction of the path of egress revealed it would not open. That door was a marked exit door and had an electric lock that did not operate as delayed egress. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He stated he was unaware that door did not meet the special locking requirements for exit doors. 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)	K 211	doors to ensure egress doors are operable. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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.	
K 293 SS=C	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in	K 293	1. Exit door to the west of the East Nurse's Station back up battery was replaced & is now in full working order. 2. All residents are at risk due to exit signs not illuminating on battery backup	10/29/21

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K 293	Continued From page 2 accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to furnish illuminated exit signs at one randomly observed location (west of east nurse station). Findings include: 1. Observation on 9/28/21 at 12:45 p.m. revealed the west exit sign in the corridor nearest the east nurse station did not operate on the back-up battery when tested. Interview with the maintenance supervisor at the time of the observations confirmed those conditions. Further interview with the maintenance supervisor revealed he was not aware of the testing requirements for battery back-up exit signs and had not been testing them. The deficiency affected one location required to be provided with a marked and identifiable path of egress.	K 293	3. Administrator to educate maintenance director on testing and maintenance of exit signs with battery backups by 10/29/21. 4.The Maintenance Director or designee will perform weekly audits of 5 random battery backup exit lights to ensure exit lights are operable. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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.	
K 321 SS=E	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.	K 321	1. Maintenance Shop door now shuts properly as door block was removed. Door vendor on site on 10/6 to inspect east basement boiler room door & center basement boiler room door. Quote received on 10/21/21 to replace the doors. Due to the extended delivery time for these doors, a waiver extension was granted by Medical Facilities Engineering Supervisor for K321 for the door replacements. This will be	10/29/21

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K 321	Continued From page 3 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: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain the smoke resistive partition for three separate hazardous areas (maintenance shop, east basement boiler room, center basement boiler room) as required. Findings include: 1. Observation on 9/28/21 at 10:35 a.m. revealed the door to the maintenance shop was propped open with a large piece of steel. That door prop prevented that door from automatically latching into the door frame as required for hazardous	K 321	completed on or before 01/1/22. Once the work has been completed, Maintenance Director or designee will contact the Live Safety Code surveyor. 2. All residents are at risk due to failure of smoke resistive partition for hazardous areas not being in place. Ó. Administrator to educate maintenance director on testing and maintenance of smoke doors by 10/29/21. 4.The Maintenance Director or designee will perform weekly audits of 5 random smoke doors to ensure doors are operable. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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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K 321	Continued From page 4 areas. Interview with the maintenance director at the time of that observation confirmed that condition. He stated he was unaware of that condition. The deficiency had the potential to affect 100% of the occupants of that smoke compartment. 2. Observation and testing on 9/28/21 at 11:10 a.m. revealed the door to the boiler room in the east basement was not automatically latching into the door frame as required for hazardous areas. Interview with the maintenance director at the time of that observation confirmed that condition. He stated he was unaware of that condition. The deficiency had the potential to affect 100% of the occupants of that smoke compartment. 3. Observation and testing on 9/28/21 at 11:10 a.m. revealed the door to the boiler room in the center basement was not automatically latching into the door frame as required for hazardous areas. Interview with the maintenance director at the time of that observation confirmed that condition. He stated he was unaware of that condition. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 321		
K 363 SS=C	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363	1. West Corridor Door and Corridor Door to the Time Clock room were repaired 2. All residents are at risk due to corridor doors not positively latching.	10/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	**3600 SOUTH NORTON AVENUE** **SIOUX FALLS, SD 57105**

(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 363	Continued From page 5 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the	K 363	3. Administrator to educate maintenance director on testing and maintenance of corridor doors by 10/29/21. 4.The Maintenance Director or designee will perform weekly audits of 5 random corridor doors to ensure doors are operable. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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AVANTARA NORTON	**3600 SOUTH NORTON AVENUE** **SIOUX FALLS, SD 57105**

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K 363	Continued From page 6 facility failed to provide positive latching for two randomly observed corridor doors (west kitchen door and time clock room door) as required. Findings include: 1. Observation and testing on 9/28/21 at 12:08 p.m. revealed the west corridor door to the kitchen did not close and positively latch into the door frame when operated. That door needs to latch into the door frame to maintain the integrity of the smoke separation of the corridor. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment. 2. Observation and testing on 9/28/21 at 12:27 p.m. revealed the corridor door to the time clock room did not close and positively latch into the door frame when operated. That door needs to latch into the door frame to maintain the integrity of the smoke separation of the corridor. Interview with the maintenance supervisor at the time of the observation and testing confirmed that finding. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 363		
K 918 SS=C	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source	K 918	1. 30 Kilowatt generator was repaired on 10/2/21 as a new relay switch was installed. 2. All residents are at risk due to alternate power source being incapable of supplying service within 10 seconds as required	10/29/21

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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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AVANTARA NORTON	**3600 SOUTH NORTON AVENUE** **SIOUX FALLS, SD 57105**

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K 918	Continued From page 7 and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, interview, and record review, the facility failed to provide an alternate power source capable of supplying service within 10 seconds as required.	K 918	3. Administrator to educate maintenance director on testing and maintenance of generators by 10/29/21. Ô.The Maintenance Director or designee will perform weekly test of the generator to ensure it is in proper working condition. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator 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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	435039	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/28/2021**

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K 918	Continued From page 8 1. Observation and testing on 9/28/21 at 2:48 p.m. revealed the 30-Kilowatt generator did not start when tested using the test function on the transfer switch. Further testing at that same time revealed that generator would also not run when the switch on the generator was placed in the run position. Interview with the maintenance supervisor at the time of the observation and testing revealed he was unaware of that condition. He further stated that generator had ran the previous day as part of its weekly testing program. Record review that same day confirmed that statement. The deficiency affected numerous requirements for emergency electrical systems.	K 918		

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
	10682	A. BUILDING: _____ B. WING _____	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTON	3900 S NORTON AVENUE SIOUX FALLS, SD 57105

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/27/21 through 9/30/21. Avantara Norton was found not in compliance with the following requirements: S157 and S301.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in four randomly observed toilet rooms (toilet rooms for resident rooms 100, 101, 110, and 201). Findings include: 1. Observation and testing on 09/28/21 at 12:38 p.m. revealed the exhaust ventilation for the toilet room of resident room 100 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 2. Observation and testing on 09/28/21 at 12:40 p.m. revealed the exhaust ventilation for the toilet room of resident room 101 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 3. Observation and testing on 09/28/21 at 1:02 p.m. revealed the exhaust ventilation for the toilet	S 157	1.Two motors for exhaust system for room 100, 101, 110, 201 were ordered on 10/20/21. Exhaust for 201 will be inspected by vendor week of 10/25. A waiver extension was granted by Medical Facilities Engineering for S157 for the door replacements. This will be completed on or before 01/1/22. Once the work has been completed Maintenance Director or designee will contact the Life Safety Code surveyor. 2. All residents are at risk due to exhaust ventilation not being maintained. 3.Administrator will educate Maintenance Director on ensuring exhaust ventilation is maintained and in working order by 10/29/21. 4. Maintenance Director or designee will audit five random resident bathrooms weekly to ensure exhaust ventilation is functional. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator 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.	10/29/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blake Dehnke, Administrator — TITLE — (X6) DATE: 10/22/21

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S 157	Continued From page 1 room of resident room 110 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. 4. Observation and testing on 09/28/21 at 1:38 p.m. revealed the exhaust ventilation for the toilet room of resident room 201 was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding. Interview with the maintenance supervisor at the same time as those observations confirmed those findings. He revealed he was unaware as to why the exhaust ventilation was not working at those locations.	S 157		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43844 Based on interviews, record review, and job description review the provider failed to ensure 11 of 11 (D, F, P, Q, R, S, T, U, V, W, and X) dietary employees had completed the required yearly training on 2 of 9 topics: *Time and temperature controls for food preparation and service. *Food-borne illnesses.	S 301	1. Dietary manager was educated by the Regional Dietary Manager on the need to educate all dietary staff on the required dietary topics, including time & temperature controls food preparation/service and food borne illnesses annually. New staff will receive required training during orientation. 2. All residents are at risk due to dietary staff were not educated on time and temperature controls for food preparation/service and food borne illnesses. 3. Administrator to educate all dietary staff on time and temperature controls for food preparation/service and food borne illnesses by 10/29/21. 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. 4.The Administrator or designee will perform weekly audits to ensure dietary education is scheduled & completed. Audits will be weekly for four weeks and then monthly for two	10/29/21

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S 301	Continued From page 2 Interview on 9/29/21 at 1:44 p.m. with dietary manager (DM) D revealed: *A contracted company had been managing the dietary department for less than one year. -This company had not provided any of the required training. *She started in 8/21 to provide the required training to dietary staff. -Had not provided training for time and temperature controls for food preparation and service or food-borne illnesses. *She thought these two trainings had been completed prior to the new management company taking over the dietary department. -Would provide documentation of those trainings if she found them. Interview on 9/30/21 at 8:56 a.m. revealed he was unaware the trainings had not been completed and would try to find documentation that they had been completed in the last year. Review of provider's undated dietary manager job description revealed the responsibilities for this position included, "Ensure all staff is trained properly on all aspects of the culinary departments policies and procedure and continued in-servicing as required." The provider did not provide documentation of training for time and temperature controls for food preparation and service or food-borne illnesses by the end of this survey.	S 301	months. Results of audits will be discussed by the Administrator 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.	
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the	S 000		

South Dakota Department of Health

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S 000	Continued From page 3 Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/27/21 through 9/30/21. Avantara Norton was found in compliance.	S 000		