STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/1/23 through 8/3/23. Avantara Huron was found in compliance. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/1/23 through 8/3/23. The area surveyed was resident neglect. Avantara Huron was found in compliance.	F 000		

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

Laurie L. Solem | Administrator | 08/18/2023

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

RECEIVED
AUG 18 2023
SD DOH-OLC

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
	435020	A. BUILDING _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 8/1/23 through 8/3/23. Avantara Huron was found in compliance.	E 000		

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

Laurie L. Solem | Administrator | 08/18/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	**1345 MICHIGAN AVENUE SW** **HURON, SD 57350**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/1/23. Avantara Huron 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 the deficiency identified at K223, K325, and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		9/15/2023
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain eight hazardous areas (the storage room located between resident rooms 114 and 116, rooms 501, 503, 504, 505, 510 and	K 223	1. A door closure was installed on the Central Supply Storage room located between resident rooms 114 and 116 on 8/10/2023. All combustible items were removed from rooms 501, 503, 504, 505, and 510, by 8/17/2023. The door closure on the soiled linen room door repaired so the door would latch properly on 8/1/2023. 2. Since all doors and all empty rooms in the facility are at risk, all doors in the facility were checked on 8/17/2023 to ensure they latched properly. All empty resident rooms were checked on 8/17/2023 to ensure there were no combustible items being stored in them. 3. All doors are included in the facility preventative maintenance program called TELS. All doors are checked monthly to ensure compliance for proper latching and condition of doors. A log of all resident rooms has been included in the facility TELS system to check monthly to ensure no combustible items are being stored in empty resident rooms. 4. Audits will be conducted on the Central Supply Storage room door closure to ensure proper operation, on the soiled linen room door to ensure proper latching, and on empty resident rooms weekly for one month and then monthly for 3 months to ensure compliance. These audits will be conducted by the Maintenance Supervisor/designee. 5. Audit findings will be reported by the Maintenance Supervisor/designee for 4 months for discussion of the effectiveness of the correction plan, reduce frequency of the audits or discontinue the audits based on audit findings. The Maintenance Supervisor is responsible for overall compliance.	09/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laurie L. Solem	Administrator	8/18/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

(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 223	Continued From page 1 the soiled linen holding room) as required. Findings include: 1. Observation on 8/1/23 at 11:00 a.m. revealed the storage room, located between resident rooms 114 and 116, was greater than 100 square feet, was being used for storage of combustible items and was not equipped with a closer. 2. Observation on 8/1/23 at 11:15 a.m. revealed unoccupied resident rooms 501, 503, 504, 505, and 510 in the E wing were greater than 100 square feet and were being used to store combustible items. The corridor door for each room was not equipped with a closer. 3. Observation on 8/1/23 at 11:30 a.m. revealed the soiled linen holding room door did not close and latch as required. Interview with the maintenance director at the time of the observation confirmed those findings. The deficiencies had the potential to affect 100% of the occupants of those smoke compartments.	K 223		
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of	K 325	1. Two gallons of hand sanitizer was removed from the Central Supply storage room located between rooms 114 and 116 on 8/1/2023. 2. Education was provided to the Central Supply Clerk on 8/10/2023 to ensure that the proper amount of hand sanitizer is stored in the storage room which is 5 gallons in a single smoke compartment. 3. The facility TELS system will be updated to include monitoring for the storage of hand sanitizer in a single smoke compartment to ensure compliance. .....continued on next page	9/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	**1345 MICHIGAN AVENUE SW** **HURON, SD 57350**

(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 325	Continued From page 2 fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to safely store alcohol-based hand rub (ABHR) in one room (storage room between resident rooms 114 and 116). Findings include: 1. Observation on 8/1/23 at 11:00 a.m. revealed the storage room between resident rooms 114 and 116 had a combined total of 6.625 gallons of bottled ABHR stored. The flammable liquid code does not allow over five gallons of alcohol stored in a single smoke compartment. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for ABHR use.	K 325	4. Audits will be conducted weeky for 4 weeks and then monthly for 3 months by the Maintenance Supervisor/designee to ensure that under 5 gallons of hand sanitizer is stored in the Central Supply storage room. 5. Audit findings will be reported at monthly QAPI meetings for 4 months by the Maintenance Supervisor/designee for discussion on the effectiveness of the correction plan, to make recommendations to adjust the correction plan if necessary, to reduce the frequency of the audits or to discontinue the audits based on findings. The Maintenance Supervisor is responsible for overall compliance.	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	See next page.....	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVENUE SW HURON, SD 57350

(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 353	Continued From page 3 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (spare sprinklers). Findings include: 1. Record review on 8/1/23 at 3:55 p.m. revealed the past two quarterly sprinkler company reports noted inadequate numbers of spare sprinklers. Observation on 8/1/23 at 4:15 p.m. in two of three locations found no spare heads for the laundry sprinkler system, and only two sprinkler heads for the remainder of the facility in the main riser room. NFPA 25, chapter 5.1.4 maintains that there should have been spairs for all types of heads used, and should never have less than six spare sprinkler heads. Interview with the maintenance supervisor at the time of the record review confirmed that	K 353	1. Six sprinkler heads of each type used in the facility were ordered and received on 8/10/23. 2. An inventory log for spare sprinkler heads was created and placed in the cabinet where the spare sprinkler heads are being stored to ensure when we use a sprinkler head a replacement is ordered right away. 3. An audit will be conducted weekly for 4 weeks and monthly for 3 months by the Maintenance Supervisor/designee to ensure we have 6 spare sprinkler heads of each type used in the facility at all times. 4. Audit findings will be reported by the Maintenance Supervisor/designee at monthly QAPI meetings for 4 months for discussion on the effectiveness of the correction plan, to make recommendations to adjust the correction plan if necessary, to reduce the frequency of the audits or to discontinue the audits based on the findings. The Maintenance Supervisor is responsible for overall compliance.	9/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/01/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	**1345 MICHIGAN AVENUE SW** **HURON, SD 57350**

(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 353	Continued From page 4 condition. Failure to continuously maintain the automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required maintenance items for the automatic sprinkler system.	K 353		

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
	10633	A. BUILDING: _____ B. WING _____	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA HURON	1345 MICHIGAN AVE SW HURON, SD 57350

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/1/23 through 8/3/23. Avantara Huron was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/1/23 through 8/3/23. Avantara Huron was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem

TITLE: Administrator

(X6) DATE: 08/21/2023