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
	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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: 29354 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/27/21 through 4/29/21. Avantara Redfield was found not in compliance with the following requirements: F658 and F812. A complaint survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/27/21 through 4/29/21. Areas surveyed included skin and wound assessment and treatment, restorative nursing, and resident rights. Avantara Redfield was found not in compliance with the following requirements: F580 and F676.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580	1. Resident 234 has discharged. No immediate correction could be made for omission of documentation of notification to resident 234's representative for prior changes of skin condition and treatment. All residents could potentially be at risk. 2. Policy was reviewed with no revisions needed. The DON or designee will provide education to all nursing staff on policy including notifying the resident's representative, when applicable, of resident changes in skin condition and treatment, and documentation of such. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit 5 random residents' medical records weekly x 3 months for documented notifications to residents' representative, when applicable, of changes in skin condition and treatment. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/21

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

Diane Forgey | Administrator | 5/18/21

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 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on closed record review, interview, and policy review, the provider failed to document notification to family or responsible party for changes in skin for one of one sampled discharged resident (234). Findings include: 1. Review of resident 234's medical record	F 580		

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F 580	Continued From page 2 revealed: *He was admitted to the facility on 12/2/20 for skilled services following a femur fracture. *He had a stage 2 (a superficial area that presents as an abrasion or blister) open area to his buttocks and coccyx (tailbone). -That area had healed on 12/25/20. -Staff had continued the use of Calmoseptine (an ointment applied to protect skin) due to fragile and discolored skin. -There was no documentation his family had been notified the affected area had healed. On 2/18/21 resident 234 was noted to have an area of maceration (skin breakdown from moisture) to his buttocks. *His physician had been notified with orders received to change the treatment to a powder and foam dressing. *Skin evaluation was completed with staff educated about the need to reposition and he was educated about the need to reposition off his buttocks. -There was no documentation at that time his family had been notified about the new skin concern and treatment plan. *On 2/22/21, an abraded area was found on the top of both ankles where the lower leg met the foot. -Nurse assessment indicated the cause as being in the same location as the wrinkles that occurred in his elastic Ted hose (compression stocking). -There was no documentation his family had been notified when the abrasions were discovered. *On 2/26/21, he was discharged to another facility. *On 4/8/21, the South Dakota Department of Health complaint department received a	F 580		

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F 580	Continued From page 3 complaint regarding resident 234. -The complainant indicated resident 234 had been admitted to another facility on 2/26/21 with a deep tissue injury to his left heel. *Review of skin evaluations, alteration in skin integrity evaluations, and interdisciplinary notes from 12/2/20 through 2/26/21 had no documentation of any heel breakdown. *There was no documentation his family had been notified of any heel breakdown. Interview on 4/28/21 at 2:15 p.m. with director of nursing (DON) B and licensed practical nurse (LPN) F who was the wound nurse regarding resident 234 revealed and confirmed: *He had been admitted with a stage 2 ulcer to his buttocks and coccyx. -That area had healed. *On 2/18/21, he had the macerated area to his buttocks identified. -New orders had been initiated. *On 2/25/21, LPN I completed a skin evaluation and addressed his rear lower leg. -His family had been aware of that concern. -LPN I also addressed his macerated coccyx and scabbed areas to his ankles in the skin assessment. *His family had called almost every day to get reports of his condition. *On 2/26/21, at the time of discharge LPN F had identified the abrasions to his ankles and left lower calf. *LPN F stated she had completed a head-to-toe skin assessment on 2/26/21. *DON B and LPN F stated neither LPN I nor LPN F had notified his family of a deep tissue injury to either heel, because there was no skin breakdown identified on his heels during their full skin assessments on 2/25/21 or on 2/26/21.	F 580		

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F 580	Continued From page 4 *There was no documentation of having notified his family members of: -The buttocks/coccyx maceration and new physician's orders at the time it was identified. -The abrasions to his ankles at the time they were identified. Review of the provider's December 2019 Notification of Change in Condition policy revealed: *The facility would provide care to the residents and provide notification of resident change in status. *"The facility must immediately inform the resident; consult with the resident's physician and notify, consistent with his or her authority, the resident representatives when there is a significant change in the resident's physical, mental, or psychosocial status." *A need to alter treatment significantly might include a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment.	F 580		
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: 32332 Based on interview, record review, and policy review, the provider failed to ensure a resident with documentation of a weight loss had been reweighed for accuracy for one of one sampled	F 658		

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F 658	Continued From page 5 resident (25). Findings include: 1. Observation on 4/28/21 at 12:30 p.m. of resident 25 during the noon meal service in the dining room revealed she: *Came to the table for the meal but kept moving in her chair. *Picked at her food and left the meal early. Review of resident 25's medical record revealed: *A 3/18/21 dietary evaluation by dietary manager C indicated a weight loss that was not significant, but staff would be monitoring for further changes. -She began receiving a supplement three times daily between meals. *A 3/26/21 dietary UDA (user defined assessment by the dietitian had indicated: -A nine percent weight loss in the last 180 days. -Her usual oral intake was around twenty-five percent of all meals. -She was offered to have her dentures checked, but she declined. *A physician's order on 3/29/21 for a speech therapy evaluation and treatment for weight loss. Review of resident 25's weights from 10/6/20 through 4/27/21 revealed: *In the month of October (10/6/20) she had one weight documented and she was 165 pounds (lb). *For the month of November 2020 no weights were documented. *For the month of December 2020 her weight was documented two times: *12/16/20: She was 159.0 lb. (a decrease of six pounds.) *12/18/20: 151.0 lb. (an eight pound loss in two days). *In January 2021 her weight was documented one time (1/1/21) and she was 151.0 lb.	F 658	1. No immediate correction could be made for omission of reweighing resident 25 when weight fluctuated. All residents could potentially be at risk. 2. Policy was reviewed with no revisions needed. The DON or designee will provide education to all nursing staff on policy including the need to reweigh residents if new weight does not appear correct and documentation of such. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit 5 random residents' medical records weekly x 3 months to identify any weight fluctuations and that residents were reweighed, when applicable, and documentation of such. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/2021

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F 658	Continued From page 6 *In February 2021 (2/2/21) she weighed 149.0 lb. *In March 2021 (3/8/21) she had a one lb. increase and she weighed 150.0 lb. *In April 2021 she was weighed one time (4/7/21) and her weight was 146.0 lb. *There were no further weights documented. Interview on 4/29/21 at 9:27 a.m. with dietitian E and dietary manager C regarding resident 25's weight changes and the possibility of inaccurate weights revealed: *Dietitian E had been frustrated with the weight fluctuations. *The provider's policy stated the resident was to have been reweighed if there were fluctuations. *Resident 25: -Had not been reweighed at the time the weights had fluctuated. -Had not had a significant weight change (a ten percent change in 180 days) yet. -Was going to be weighed on 5/3/21 so she would have been reweighed again soon. -Was placed on the nutrition at risk list and the dietitian had been seeing her monthly. *The provider's weight policy had recently been updated and no longer contained specific recommendations for how much of a fluctuation was required before reweighing residents. *It was up to the physician to decide how often the resident was weighed. At the same time as the above interview dietary manager C stated: *There was no direction in the weight policy for when to reweigh a resident. *The old rule was to reweigh them if there was a fluctuation of five or more pounds. *Weights were supposed to have been done monthly.	F 658		

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F 658	Continued From page 7 *There were times the resident's weight had fluctuated by five to six pounds between her reweighs. *The resident had only been reweighed once. *The director of nursing (DON) was to have been responsible for ensuring the residents were reweighed. Interview on 4/29/21 at 3:30 p.m. with DON B revealed: *Resident 25 had weight loss. *She was unsure who was responsible for ensuring the residents were reweighed if there were fluctuations. Review of the provider's revised March 2021 Weighing the Resident policy revealed: *The purpose of the procedure was to determine the resident's weight and height, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height to determine the ideal weight of the resident. *The weight was to have been measured upon admission, weekly for four weeks, and then monthly or per physician orders. *The staff were to report significant weight loss or gain to the nurse. *The nurse was to report those changes to the physician. *If the weight did not appear correct the resident was to have been reweighed to ensure the weight was accurate. *The threshold for significant unplanned and undesired weight loss/gain would have been based on the following criteria: -One month: 5% weight loss was considered significant; greater than 5% was severe.	F 658		

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F 658	Continued From page 8 -Three months: 7.5% weight loss was significant; greater than 5% was severe. -Six months: 10% weight loss was significant; greater than 10% was severe.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676	1. Resident 234 has discharged. No immediate correction could be made for lack of implementation and/or documention of a restorative plan for Resident 234. All residents could be potentially at risk. 2. Policy was reviewed with no revisions needed. The DON or designee will provide education to all nursing staff on the restorative nursing program process and documenation. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The DON or designee will audit 5 random residents' medical records weekly x 3 months to ensure that implementation and/or documentation of a restorative plan is in place, if appropriate. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/2021

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F 676	Continued From page 9 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on closed record review, interview, and policy review, the provider failed to adequately implement and document a restorative plan for one of one discharged sampled resident (234). Findings include: 1. Review of resident 234's closed medical record revealed: *He was admitted to the facility on 12/2/20 for skilled services of physical and occupational therapy following a femur fracture. *His therapy was discontinued on 1/28/21 because he was no longer making progress due to the need for a knee immobilizer. *He was placed on a restorative program to prevent him from regressing physically until he could resume his therapy and begin bearing weight again on 2/27/21. *His restorative therapy was started on 2/8/21 for active range of motion and strengthening to his right hip, knee, and ankle. -His care plan indicated restorative therapy was to have occurred four to seven times a week. -That would have allowed him to receive eighteen sessions of restorative exercises in the time before his discharge on 2/26/21. Review of resident 234's February 2021 restorative record documentation revealed he had: *Completed the therapy seven of eighteen	F 676		

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F 676	Continued From page 10 possible days: 2/10, 2/12, 2/16, 2/18, 2/22, 2/24, and 2/25. *Declined therapy four of the eleven remaining days: 2/8, 2/13, 2/14, and 2/23. *Three of the seven remaining days documented as N/A (not applicable): 2/9, 2/11, and 2/21. *The four remaining days were left blank. Interview on 4/28/21 at 2:15 p.m. with director of nursing B and licensed practical nurse F regarding resident 234's restorative program confirmed: *He should have received the restorative exercises four to seven days a week. *The restorative staff were supposed to have marked the restorative record N/A only if he had been out of the building. -He had not been out of the building. -If he had refused the therapy the restorative staff should have marked refused rather than N/A or leaving it blank. *He had not received the restorative exercises as they had been ordered by the restorative nurse. Interview on 4/29/21 at 10:30 a.m. with restorative nurse H regarding the missing entries and N/A documentation in resident 234's restorative record confirmed: *She was not aware he had so many missing entries. *If he had therapy it should have been documented on the restorative record. *N/A was to have been used only if the resident was not in the building. -He had not left the building. *The only place staff were to document his restorative attendance was in the restorative record.	F 676		

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F 676	Continued From page 11 Review of the provider's revised August 2020 Restorative Nursing Program policy and procedure revealed: *"Appropriate nursing and restorative services consistent to the resident's functional needs must be provided." *Nursing and restorative services were to have been reflected in the resident's individualized care plan. *Restorative programs were to have been indicated in the resident's electronic restorative log in order to document the provision of services and the frequency by nurses, certified nursing assistants, and restorative aides.	F 676		
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:	F 812		

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F 812	Continued From page 12 Surveyor: 43021 Surveyor: 42477 Based on observation, interview, and policy review, the provider failed to ensure the kitchen had stored, prepared, and monitored food processes for the thirty-one residents per professional standards that included: *Maintaining a clean and sanitary kitchen. *Implementing and maintaining a sanitary manner to temp food before being served to residents. *Implementing and maintaining a monitoring system for chemicals used for disinfection. *Implementing and maintaining a process for pureeing food to retain and increase nutritional value and palatability. *Implementing and maintaining a process to ensure food was dated, rotated, and stored according to practice standards. *Appropriate manner of thawing frozen foods to prevent food-borne illnesses. Findings include: 1. Observations by surveyors 42477 and 43021 on 4/27/21 from 9:33 a.m. through 10:35 a.m. of the facility kitchen revealed: *A refrigerator/freezer in a backroom by a larger freezer. *The refrigerator had outdated containers of thickened water with use-by dates of 10/26/20, 1/4/21, and 4/23/21. -There was expired apple juice dated 10/20. -One loaf of hardened sliced bread dated 1/3/21. *In the freezer above the refrigerator there were many packages of undated freezer burned lunch meat. *Packages of ham indicated "keep refrigerated" and were expired. -There was no date on any of the freezer meat to	F 812	1. Immediate corrective action was taken on 4/29/21 by Dietary Manager for the following areas: outdated or undated liquids, foods and spices were discarded; freezer burned food was discarded; santizier machine was unclogged and in proper working condition; kitchen food preparation area was cleaned to remove visible dust on walls, ceiling and other areas; and the used can was removed from underneath the three-compartment sink. Cook D was immediately re-educated on the facility's processes for: pureeing food; pot and pan test strip/sanitation bucket log; and food storage and preparation by DM and RD on 4/29/21. 2. Policies were reviewed with no revisions needed. The DM or designee will provide education to all dietary staff on the appropriate processes for storing and preparing foods, including thawing, pureeing and temping food; and maintaining a sanitary kitchen, including monitoring chemicals used for disinfection. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The DM or designee will audit 5 random dining services weekly x 3 months, to ensure policies and processes for food storage and preparation are provided in a sanitary manner. Results of audits will be presented by the DM or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 812	Continued From page 13 show when it had been placed in the freezer. Observation of a sign posted on the refrigerator/freezer stated: *Storing food items: -Supplements only good for 14 days after thawing. -Dairy products only good for twenty-four hours. -Thickened juice good for twenty-four hours. -Ketchup and mustard good for two to six months. -Spices one year. -Dry Jell-O and pudding mixes two to three years. -Dry cake mixes one year, watch manufactured dates. -Dry products need six-month rotation. -If any food item is removed from the original container or box and put in a different container, you need to label and date that item. Observation on 4/27/21 at 10:01 a.m. of the walk-in pantry revealed there were two expired containers of thickened liquid cranberry juice, located behind the non-expired stock. Continued observation on 4/27/21 at 10:15 a.m. of the kitchen revealed: *There were multiple loaves of Texas toast with a date of 3/21/21. *Thickened liquids had an open date of 4/8 and 3/22. -There was no mention of the year. *The freezer was filled with waffles, which had no expiration date or when they were placed in the freezer. -There was no mention of the year and only some items had an opened date listed. *Above the food preparation area there was visible dust on the ceiling and around the air	F 812		

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	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 812	Continued From page 14 vents. -That had been located above the food prep table. *A piece of paper hanging on the bulletin board was completely covered with particles of dust. *A window ledge located in the dishwashing area of the kitchen that: -Had clean dishes lined alongside of it. -Had visible food particles and colored liquid stains dried on the window ledge. *The pipe running underneath the three-compartment sink was propped up by a used large soup can. *The food thermometer was laying on top of a three-shelved paper filer that was visibly soiled and contained some loose change. Observation on 4/27/21 at 10:25 a.m. revealed visible dust and debris on: *The bread storage racks. *Ceiling air vents. *Areas above the steam table. *The pipes above the three-compartment sink. *The outlet box above and by the puree equipment. *The window-sills in the dishwashing area. *The support beam above the stove's cooktop. 2. Observation and interview on 4/27/21 at 10:50 a.m. of cook D pureeing foods revealed: *Cook D had drained cooked cauliflower in the kitchen's three compartment dishwashing sink. *She had scooped the cauliflower into the food puree machine and had added: -A spoonful of butter. -Two cups of water. -A 1/4 cup of food thickener. *She placed ground pork in the food puree machine and added:	F 812		

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	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

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F 812	Continued From page 15 -1/4 cup of apple juice. -A 1/4 cup of food thickener. -An unspecified amount of water, until it reached the consistency that she wanted. *She placed drained sweet potatoes in the food puree machine and added: -A spoonful of butter. -An unspecified amount of water, until it reached the consistency that she wanted. *She had rinsed the puree equipment off in between uses. *She stated that she had already pureed the bread. *Surveyors asked how she made the pureed bread and she replied: -Added butter and water. -Sometimes she used broth but today she added water. *When cook D temped the cooked foods she: -Used the same alcohol pad throughout temping the various foods. -The alcohol pad was visibly soiled. -There was visible food on the thermometer after it had been wiped off with the alcohol pad. 3. Observation and interview on 4/28/21 at 11:30 a.m. with cook D revealed: *There was a clipboard that had a sanitation level tracking form. *They checked the chemical level of their disinfectant "every day." *There were four red buckets in the three-compartment sink with a cleaning solution. *Cook D stated the buckets had detergent and sanitizer in them. *They used the red buckets to clean tables and other surfaces. *Cook D attempted to check the buckets for appropriate disinfection levels.	F 812		

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	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 16 *The red disinfectant buckets showed there was no sanitizer. *She attempted to test with different test strips and received the same 0 parts per million (ppm) result. 4. Observation on 4/28/21 at 11:50 a.m. of the spices revealed there were eleven expired containers of spices with dates that ranged from 2017 through 2019. 5. Review of the provider's Pot and Pan Test Strip/Sanitation Bucket log from December 2020 through April 29, 2021 revealed: *The sanitation buckets should have been checked three times per day. *There were three sections: -One for breakfast. -One for lunch. -One for dinner. *Each mealtime had the following spots to be filled out: -Wash temp. -Rinse temp. -PPM. -INT [initials] *They were to log the ppm required per manufacturer guidelines. *They were to notify their supervisor when ppm was not as specified. *The December 2020 log had no documentation. *There was no log for January 2021. *The February 2021 log had been partially filled out for 10 of 28 times. -Rinse temp and PPM had not been filled out for the entire month. *The March 2021 log had been partially filled out for 10 of 31 times. -Rinse temp and PPM had not been filled out for	F 812		

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	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

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F 812	Continued From page 17 the entire month. *The April 2021 log had been partially filled out for 19 of 28 times. -Rinse temp and PPM had not been filled out for the entire month of April. Review of the provider's undated Kitchen Task list revealed: *There had been multiple cleaning tasks that needed to be completed every day. *There had been 805 opportunities for cleaning/other tasks to be completed. *Out of 805 opportunities, eight had been completed. *The sheets were to be turned in every Saturday to dietary manager C's mailbox. *Some of the tasks included: -"Fridge is clean and organized. Label, date in and date open. Expired out." -"Label and Date everything! Open dates on items. Use by dates." 6. Interview on 4/28/21 at 2:47 p.m. with dietary manager C confirmed: *Dietary cooks should have been monitoring food/product use-by dates on a daily basis. *Recording of open dates on product containers had not been consistent. *The kitchen area cleaning schedule was posted and she tried to monitor the schedule. *Broth or something of nutritional value should have been used to puree foods. *Alcohol wipes should have been changed throughout the process of taking food temperatures. Interview and observation on 4/28/21 at 3:18 p.m. with dietary manager C revealed: *Staff were to check the sanitizer level of the	F 812		

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	435054	A. BUILDING _____ B. WING _____	C 04/29/2021

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F 812	Continued From page 18 disinfectant. *The logs had not been filled out. *The chemical gets "stopped up" and sometimes had not dispensed out of the wall unit. *The soup can should not have been used to prop up the pipe. -Agreed some cleaning needed to be done. *The food should have been rotated. *Freezer burned items should have been discarded. *Cook D was thawing two packages of the freezer burned ham in a plastic pitcher of water. *Items needed to have an open date and date when placed in the freezer. *The back refrigerator/freezer was considered the "nurse's fridge." -It had supplements and thickened liquid that were given to the residents. *She was responsible for monitoring expiration dates. *She could not reach the dusty items over the food preparation area. *She had not asked maintenance to address the dusty areas. 7. Interview on 4/28/21 at 3:45 p.m. with cook D revealed she was: *Thawing the freezer burned ham to give the residents another option since they were serving fish for dinner. *Not aware that food should have been thawed under running water or the water should have been changed periodically. Review of the provider's undated Food Preparation policy revealed: *"The Dining Services Director or Cook(s) is responsible to ensure that all utensils, food contact equipment, and food contact surfaces are	F 812		

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F 812	Continued From page 19	F 812		

cleaned and sanitized after every use."
*Thawing of frozen foods, "Completely submerged under cold water (70 [degrees] or below) that is running fast enough to agitate and float off loose ice particles."

Review of the provider's October 2019 Food Storage policy for cold foods revealed "The Dining Services Director/Cook(s) insures [ensures] that all food items are stored properly in covered containers, labeled and dated and arranged in a manner to prevent cross contamination."

Review of the provider's undated Pureed Foods policy revealed dietary staff should have added milk, juice, broth, or liquid that was most appropriate for pureed food.

8. Review of dietary manager C's 12/1/19 job description revealed:
*"In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Dietary Services position is responsible for providing nourishing food to Guests, guests and employees Director manages the day-to-day operations of the dietary department by ordering food supplies, providing supervision of staff and working with the interdisciplinary team to ensure quality nutritional meals are delivered on-time."
*"Operates the dietary department in a safe and sanitary manner by ensuring compliance with Federal, State, and local regulations and following established policies and procedures."
*"Responsible for training and educating staff members."
*"Assure that established infection control and prevention practices and standard precautions

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F 812	Continued From page 20 are maintained at all times." 9. Interview on 4/29/21 at 11:42 a.m. with maintenance supervisor G regarding the kitchen revealed: *He changed the kitchen air filters every month. *He had been the maintenance supervisor for the past five months. *The dust on the ceiling was hard to remove due to the texture. *There was dust on non-textured surfaces. *He would have cleaned the surfaces if he was asked, but he could have been more observant. 10. Interview on 4/29/21 at 3:27 p.m. with registered dietitian E regarding concerns with the kitchen revealed: *Staff should have added something with nutritional value to pureed foods, and not water. *Staff should have been monitoring expiration dates. *Monitoring of expiration dates could be improved.	F 812		

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
	435054	A. BUILDING _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

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E 000	Initial Comments Surveyor: 29354 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 4/27/21 through 4/29/21. Avantara Redfield was found in compliance.	E 000		

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

Diane Forgey | Administrator | 5/18/21

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.

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
	435054	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 04/27/21. Avantara Redfield (Bldg. 01) was found not in compliance with 42 CFR 483.70 (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 deficiency identified at K741 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 741 SS=D	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where	K 741	1. Smoking area was provided with a metal container with self-closing cover on 5/3/21. 2. The Maintenance Supervisor or designee will provide education to all staff on the Smoking Regulation requirements, which includes that a metal container with self-closing cover be readily available to all areas where smoking is permitted. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Supervisor or designee will audit the 2 designated smoking areas for a readily available metal container with self-closing cover daily x 1 week then weekly x 3 months. Results of audits will be presented by the Maintenance Supervisor or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/2021

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

TITLE
Administrator

(X6) DATE
5/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/27/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

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K 741	Continued From page 1 smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to furnish designated smoking areas with a metal container with a self-closing device for emptying ashtrays at one randomly observed designated smoking area. Findings include: 1. Observation on 4/27/21 at 3:10 p.m. at the designated smoking area outside the kitchen revealed several large black marks along the side of the building where staff had been extinguishing their cigarettes. Further observation at that same time revealed that area was provided with metal cans to be used as ash trays. Those metal containers were not equipped with the required self-closing covers. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was not aware of the requirement to provide a container with a self-closing cover in designated smoking areas. Ref: 2012 NFPA 101 Section NFPA 101 19.7.4 (6).	K 741		

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
	435054	A. BUILDING **02 - BUILDING 02** B. WING _____	**04/27/2021**

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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 4/27/21. Avantara Redfield (Bldg 02) was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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

Diane Forgey | Administrator | 5/18/21

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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
	10671	A. BUILDING: _____ B. WING _____	04/29/2021

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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) COMPLETE DATE
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 4/27/21 through 4/29/21. Avantara Redfield was found not in compliance with the following requirement: S195.	S 000		
S 195	44:73:03:02 General Fire Safety Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to arrange designated smoking areas with a metal container with a self-closing device for emptying ashtrays at one randomly observed designated smoking area. Findings include: 1. Observation on 4/27/21 at 3:10 p.m. at the designated smoking area outside the kitchen revealed several large black marks along the side of the building where staff had been extinguishing their cigarettes. Further observation at that same time revealed that area was provided with metal cans to be used as ash trays. Those metal containers were not equipped with the required self-closing covers.	S 195	1. Smoking area was provided with a metal container with self-closing cover on 5/3/2021. 2. The Maintenance Supervisor or designee will provide education to all staff on the Smoking Regulation requirement, which includes that a metal container with self-closing cover be readily available to all areas where smoking is permitted. Education will occur no later than June 18, 2021. Those not in attendance will be educated prior to their first shift worked. 3. The Maintenance Supervisor or designee will audit the 2 designated smoking areas for a readily available metal container with self-closing cover daily x 1 week then weekly x 3 months. Results of audits will be presented by the Maintenance Supervisor or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	6/18/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Forgey

TITLE: Administrator

(X6) DATE: 5/18/2021

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
	10671	A. BUILDING: _____ B. WING _____	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 195	Continued From page 1 Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was not aware of the requirement to provide a container with a self-closing cover in designated smoking areas. Ref: 2012 NFPA 101 Section NFPA 101 19.7.4 (6).	S 195		
S 000	Compliance/Noncompliance Statement Surveyor: 29354 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 4/27/21 through 4/29/21. Avantara Redfield was found in compliance.	S 000		