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
	435058	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CLARK CITY	201 8TH AVENUE NW CLARK, SD 57225

(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: 41088 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/15/22 through 2/17/22. Avantara Clark City was found not in compliance with the following requirement: F880.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	F880 – infection control directed POC (Clark): Corrective Action: 1. For the identification of inappropriate hand hygiene and/or glove use during: *Personal cares, *Wound care and *Medication administration via feeding tube. Time cannot be turned back to correct the past identified breaks in infection control practices observed during the survey involving residents 14, 20 and 28. The administrator, DON/ infection control nurse and/or designee reviewed the policies for the above identified areas. No revisions were necessary as they are in line with CDC and CMS recommendations for the above identified areas. All nursing and direct care staff, including RN C and LPN D, will be re-educated by the DON or designee by 3/13/22. CNA E is no longer employed at this facility. Trays such as the one used by LPN D have been discarded. All nursing staff will be educated that discarding remaining water after medication administration via feeding tube is best practice by 3/13/22. Those not in attendance will be educated prior to their next shift worked. Identification of Others: 2. ALL residents and staff have the potential to be affected if staff do not adhere to identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the administrator, DON or designee by 3/13/22.	3/13/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ethan Carter	Administrator	3/11/22

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 880	Continued From page 1 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 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: 45383	F 880	System Changes: 3. A root cause analysis was conducted using the 5 Why s method. Staff being nervous during surveyor observations was the identified Root Cause for the observed lapses in infection control practices at time of survey. The Administrator, DON/infection control nurse, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The Administration and DON/infection control nurse consulted with the South Dakota Quality Improvement Organization (QIN) on 3/8/22. The root cause analysis and this plan of correction were discussed. The QIN agreed with this plan of correction and provided links for tools that may be used in continued staff education. Monitoring: 4. The administrator, DON/infection control nurse, and/o r designee will conduct auditing and monitoring for areas identified above to ensure corrective actions and identified solutions are sustained until discontinuation is approved by the QAPI committee and the medical director. The Audits will be conducted 2-3 times weekly across all shifts for 4 weeks to ensure staff compliance with: *Appropriate hand hygiene and/or glove use during personal cares. *Appropriate hand hygiene between glove use during care. *Appropriate hand hygiene during and discarding remaining water after medication administration via feeding tube. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to weekly for at least 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 2 Based on observation, interview, record review, and policy review, the provider failed to ensure proper hand hygiene had been performed by three of five observed staff (C,D, and E) while providing care for three of five sampled residents' (14, 20, and 28) as evidenced by: *One of one sampled resident (28) during observed personal care performed by certified nursing assistant (CNA) E. *One of one sampled resident (20) during observed wound care performed by registered nurse (RN) C and licensed practical nurse (LPN) D. *One of one sampled resident (28) observed medication administration via feeding tube performed by LPN D. Findings include: 1. Observation on 2/15/22 at 3:44 p.m. of CNA E who assisted resident 28 with personal care revealed: *She was lying in bed with her brief pulled down. *CNA E: -Pulled up her pants and brief while wearing gloves. -Assisted her to a seated position on her bed. -Applied a gait belt. -Transferred her to her wheelchair. -Removed her gloves and put on a new pair. -Transferred her from her wheelchair to the toilet. -Provided peri care and pulled up her clean brief and pants with her contaminated gloves. -Repositioned her in her wheelchair with the same contaminated gloved hands. -Removed her contaminated gloves and without performing hand hygiene put on a new pair. -Assisted her with oral care. -Removed her gloves and washed her hands. Interview on 2/15/22 following the observation	F 880		

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F 880	Continued From page 3 with CNA E revealed: *She had not been aware that hand hygiene needed to be completed after changing gloves. Review of the provider's October 2019 Hand Hygiene policy revealed: *"All personnel shall be trained and regularly educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections." *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. *"Before putting on and removing gloves hand hygiene shall be performed." 2. Observation on 2/16/22 at 10:44 a.m. with RN C and LPN D who completed wound care for resident 20 revealed: *RN C removed the dressing from his right knee and turned off the wound vac. *LPN D grabbed gauze with her gloved hand and turned the faucet handle on. -Using her gloved hands, she soaked that same gauze with water from the faucet, then dabbed the wound. -Moistened more gauze with tap water and cleaned his pinhole sites. *RN C applied Santyl ointment to the wound bed using a sterile Q-tip applicator. -Removed her gloves without performing hand hygiene and applied a new pair. *LPN D opened a Xeroform gauze package and applied gauze to the pinhole sites. -Removed her gloves and performed hand hygiene. Interview on 2/16/22 at 11:42 a.m. with RN C	F 880		

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F 880	Continued From page 4 regarding the above observation revealed: *She had followed the physician's orders for wound cleansing. *The 1/11/22 physician's order instructed to clean the pinhole sites with soap and water. Interview on 2/16/22 at 11:43 a.m. with DON B regarding the above observation revealed: *She would expect staff to use wound cleanser if not cleansing with soap and water. *"Staff should use sterile water or sterile saline when cleaning wounds with soap." Review of the provider's undated Dressing Change Competency-Aseptic Technique procedure revealed: *"Cleanse wound with prescribed solution." 3. Observation on 2/17/22 at 7:55 a.m. with LPN D administering medication via a feeding tube for resident 14 revealed: *LPN D: -Prepared the medications and placed them on a tray. -Applied a pair of gloves. -Removed the old dressing from around the feeding tube site. -Instilled air into the tube and listened for air to check tube placement. -Removed her gloves to fill the graduate container with water for flushes. -Put on a new pair of gloves without performing hand hygiene. -Flushed the feeding tube with 60 milliliters of water before and after medication administration. -Removed her gloves. -Left the graduate container with water remaining in it on the nightstand next to resident's bed.	F 880		

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F 880	Continued From page 5 Interview on 2/17/22 with LPN D following the above medication administration revealed she: *Had followed the physician's order to instill air and listen for tube placement before administering medication and the water bolus. * Stated, "She normally would have removed the remaining water from the graduate when done but did not do that this time." *Cleaned the inside of the medication tray with an alcohol prep pad, but not the outside of the tray before placing it back in the med cart. *Stated, "She did not think about that." *Agreed she had not performed hand hygiene between glove changes. Interview on 2/17/22 at 8:30 a.m. with DON B regarding the above medication administration observation revealed: *She would expect staff to remove any remaining water from the graduate. *She would expect staff to perform proper hand hygiene according to their policy.	F 880		

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E 000	Initial Comments Surveyor: 41088 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 2/15/22 through 2/17/22. Avantara Clark City was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ethan Carter
TITLE: Administrator
(X6) DATE: 3/11/22

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	435058	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2022**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/17/22. Avantara Clark City 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 the deficiency at K222 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	K222- - The delayed egress magnetic lock hardware on the main entrance inner door was repaired and reset. The delayed egress in working in line with requirements for Egress Doors NFPA 101. - Administrator reviewed facility's policies for Life Safety Code no updates or adjustments needed. Maintenance Director was re-educated regarding Egress Doors, and facility's policy of weekly testing by the Administrator 3/10/22. - Administrator or Designee will audit weekly testing for 4 weeks to ensure compliance with NFPA 101, Egress Doors. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly for at least 2 months. Monitoring results will be reported by administrator or a designee to the QAPI committee and continued until the demonstrates sustained compliance as determined by committee. - Completion- 3/13/22	3/13/22

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

TITLE
Administrator

(X6) DATE
3/11/22

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	435058	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/17/2022**

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 2 Surveyor: 18087 Based on observation, testing, and interview the provider failed to provide egress doors as required at one of five locations (main entrance). Findings include: 1. Observation on 2/17/22 at 2:40 p.m. revealed the main entrance inner door for the vestibule was equipped with magnetic lock hardware that delayed egress. The door was labeled as a delayed egress locked door. Testing of the door with the administrator by applying force in the direction of the path of egress revealed the audible signal would not sound. The required irreversible process of unlocking the door did not initiate. Interview at the time of the observation with the administrator confirmed that condition. He stated it appeared the magnetic lock computer program might need to be rebooted. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one of five exit doors. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		

South Dakota Department of Health

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	10607	A. BUILDING: _____ B. WING _____	02/17/2022

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S 000	Compliance/Noncompliance Statement Surveyor: 41088 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/15/22 through 2/17/22. Avantara Clark City was found not in compliance with the following requirements: S206 and S236.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206		

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

Than Carter

TITLE: Administrator

(X6) DATE: 3/11/22

South Dakota Department of Health

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on personnel file review and interview, the provider failed to ensure one of five sampled recently hired employees (G) had completed all eleven required orientation training programs within 30 days of hire. Findings include: 1. Review of nursing assistant G's personnel file revealed: *He had been hired on 12/30/21. *There was no evidence to support he had completed the following required training topics: -Proper use of restraints. -Resident rights. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting. -Dining assistance, nutritional risks, and hydration. Interview on 2/17/22 at 3:05 p.m. with administrator A confirmed the above training had not been completed and should have been.	S 206	206 - Employee G completed the required trainings for: proper use of restraints, resident rights, confidentiality of resident information, incidents and diseases subject to mandatory reporting, dining assistance, nutritional risks and hydration by Human Resources Director on 3/7/22. - Policies were reviewed with no revisions needed. The Human Resources Director (HRD) was re-educated on the required trainings for new employees by the Administrator on 3/7/22 - All newly hired employees will complete the required trainings within 30 days of being hired. The HRD or designee will utilize a tracking log to ensure all newly hired employees complete the required training within 30 days of being hired. - The Administrator or designee will audit all newly hired employee training records weekly for 4 weeks, then monthly for at least 2 months to ensure all required training is completed within 30 days of being hired. The Administrator or designee will report audit findings monthly to the QAPI committee for review and recommendations for at least 3 months.	3/13/22
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented	S 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10607	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CLARK CITY	201 8TH AVENUE NW CLARK, SD 57225

(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 236	Continued From page 2 tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 41088 Based on personnel file review and interview, the provider failed to ensure one of five sampled employees (nursing assistant (NA) G) had been given a two-step Mantoux tuberculin (TB) skin test within fourteen days of being hired. Findings include: 1. Review of NA G's personnel file revealed: *He had been hired on 12/30/21. *There was a note in his file that stated he needed to have a TB screening asap (as soon as possible). *There was no record of a TB skin test being given. Interview on 2/17/22 at 3:06 p.m. with	S 236	S 236 - Employee G completed the two-step method of the tuberculin (TB) skin test 3/9/22. Policies were reviewed with no revisions needed. The Human Resources Director (HRD) was re-educated on the required TB testing by the Administrator on 3/7/22. - All new hires will receive a two-step method TB skin test within 14 days of being hired and it will be documented. The HRD or designee will utilize a TB testing tracking log to ensure new hires have completed the TB testing within 14 days of being hired and that it is documented. - The Administrator or designee will audit al l newly hired employees' TB records weekly for 4 weeks then monthly for at least 2 months to ensure they have received a two-step TB skin test within 14 days of being hired and that it is documented. The Administrator or designee will report audit findings monthly to the QAPI committee for review and recommendations for at least 3 months. - Completion date: 3/13/22	3/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10607	A. BUILDING: _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CLARK CITY	201 8TH AVENUE NW CLARK, SD 57225

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S 236	Continued From page 3 administrator A confirmed NA G had not received a two-step TB skin test and should have.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 41088 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 2/15/22 through 2/17/22. Avantara Clark City was found in compliance.	S 000		