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 _____	05/13/2021

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

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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/11/21 through 5/13/21. Avantara Huron was found not in compliance with the following requirements: F565, F641, F676, F755, and F880.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565	F565 1. Call light times for resident 2, and 31 have been monitored and will continue to be monitored for the next 4 months to ensure they are answered within 15 minutes. Resident 367 was discharged on 5/12/2021. Per facility policy all resident council minutes will be addressed with a written notice which will be posted with the resident council minutes within 3 days of the meeting if there are grievances/issues presented at the resident council meetings by the residents. 2. All other residents in the facility are at risk to have their call lights answered in an untimely manner. The IDT will continue to review all call light reports daily and discuss at the morning stand-up meeting with the IDT members. All resident grievances from resident council will be addressed within 3 days of the resident council meeting and a written response will be posted next to the minutes. If necessary, some residents will be given a personal response from a grievance presented at resident council in addition to the posted response. Continued on the next page.....	6-20-2021

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

TITLE
Administrator

(X6) DATE
06/03/2021

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 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 42477 Based on interview, record review, policy review, the provider failed to ensure concerns brought up by the Resident Council were resolved. Findings include: 1. Interview on 5/12/21 at 2:25 p.m. with Resident council members revealed: *They had regular meetings. *Resident 2 was the resident council president. *Residents 367, 32, and 31 were also in attendance. *Residents 2, 31, and 367 felt that it took too long to get their call lights answered. *Resident 32 was hard of hearing and had a difficult time comprehending the questions. *Call lights had been an issue at other resident council meetings. *They had not felt that the issue had improved. *They felt that they had to wait unusually long on weekends and during the nighttime hours. *Resident 367 stated she had been in the facility for three weeks and she had noticed that she had to wait a long time to have her call light answered. *Resident 2 stated she had adjusted her toileting schedule so she would not have to use the bathroom at night as much. *Resident 2 felt that they did not have enough staff to help the residents.	F 565	3. The Administrator will provide education to all staff on 6/9/2021 to ensure that call lights are answered in a timely manner. As part of that education, the use of walkie talkies, and the call light pagers will be addressed. Education will also be provided to Social Services staff during this same education session on the facility policy on addressing resident council grievances timely and that all responses are written and posted within 3 days with the resident council minutes. Education will also be provided to Social Services staff on addressing grievance responses individually with residents as well if necessary. Those staff members not in attendance at the education session due to vacation, sick leave, or casual work status, will be educated prior to their first shift worked following the education session. 4. The Administrator/designee will be responsible for overall compliance and will conduct audits on call lights for residents 2 and 31 and all other residents in the facility 3 times a week for 3 months. These audits will be included in the PIP that has been created for call light monitoring through our QAPI/CQI program. The Administrator/designee will also conduct 5 audits per week for 4 weeks and then 5 audits per month for 3 months to ensure walkie talkies and the call light pagers are being used as directed. These audits will also include battery checks on the equipment. The Administrator/designee will also conduct monthly audits on the resident council minutes and grievance responses for those minutes for the next 3 months. All audit findings listed above will be reviewed by the Administrator at monthly Client Care and QAPI/CQI meetings for 3 months for discussion of the effectiveness of the correction plan and for the recommendation to adjust the correction plan, and/or reduce frequency or discontinue of the audits based on the audit findings.	

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F 565	Continued From page 2 Review of the provider's grievance log revealed: *On 12/16/20 there was a grievance, "Call lights on D wing not answered timely." -The grievance had a resolved date of 1/11/21. *On 2/17/21 there was a grievance, "D wing residents feel it takes too long to get their call lights answered at times." -The grievance had a resolved date of 3/12/21. *On 3/24/21 there was a grievance, "Call lights not answered timely." -The grievance had a resolved date of 3/24/21. *On 4/21/21 there was a grievance, "Call lights not answered timely on occasion and only 1 person in the dining room." -The grievance had a resolved date of 4/21/21. Review of resident council meeting minutes revealed: *December 2020, "...Feel there isn't enough staff to assist to their needs and they have to wait longer than usual. Staff are very respectful and helpful and apologize for keeping them waiting when they arrive. Their needs are met but they feel rushed." *January 2021, "Call lights still seem to be an issue. We did do an audit and the lights did seem to be answered in a timely manner. Another issue that was brought up again was the residents feel staff are not remaining in the dining room while they eat their meals and they want this to happen. This was brought to administrative team and is being handled." *March 2021, "Majority of the residents in attendance still feel that there is a delay in getting call lights answered in a timely manner. Primarily in the late afternoon and evenings. We did advise that there is ongoing training and audits done with staff to utilize pagers and walkie-talkies to alert	F 565	Type text here	

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F 565	Continued From page 3 staff of residents needs and/or assistance." *April 2021, "Majority of the residents in attendance still feel that there is a delay in getting call lights answered in a timely manner. Review of the provider's September 2019 grievance policy revealed: *"5. The grievance official shall confer with persons involved in the incident and other relevant persons within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal party, an oral explanation shall accompany a written one." *"6. During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights." *"8. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance, and the date the written decision was issued" *"To provide a system that allows residents, families, staff and others to bring comments of grievances and satisfaction to the attention of the grievance official which allows the team to investigate and bring resolution in a timely manner." *"Recognize: Recognizing a concern as a grievance early in the process is crucial to an effective and successful resolution. Each grievance must be taken seriously and submitted in a timely manner. Understanding what a	F 565		

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F 565	Continued From page 4 grievance is, where the grievance can come from and who brings grievance to us will help ensure a strong grievance process is in place." *"Action: The way in which the facility carries out the plan of action can have a significant impact on coming to a satisfactory conclusion for the customer. Clear communication between the customer and all involved facility staff is essential. Everyone needs to have a clear understanding of their role in resolving the grievance as well as what steps will be taken to minimize the chance of recurrence." *"Conclusion: Evaluate if the course of action was effective. Keep in mind that the customer's perception of the outcome is how we determine the satisfactory resolution of the grievance. The grievance is not considered resolved until we have documented confirmation from the customer that they are satisfied with the outcome." There was not a grievance departmental response for December 2020 and January 2021. Review of the provider's February 2021 resident council departmental response form revealed: *In response to the 2/17/21 resident council meeting, "Staffing adjusted to have float CNA [certified nursing assistant] stay on D- wing and float to C-wing when needing assistance. Plan to run call lights weekly to monitor for improvement." *February was the only month in the past 6 months that resident council did not voice concerns about staffing and call lights. *Call light logs were looked at from 2/11/21 through 2/18/21. *From 2/11/21 through 2/18/21 there were 61 times call light response was over 10 minutes. -The longest time was 45 minutes.	F 565		

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F 565	Continued From page 5 Review of the provider's March 2021 resident council departmental response form revealed: *"Delay in call lights being answered ([three resident's names mentioned]). Primarily late afternoon & evening." *Explanation or response, "We have been doing audits daily or every 2 days, we have implemented walkie-talkies and call light pagers." *On 4/16/21 visited with [three resident's names] they feel it is better. *The attached call light log was for 3/23/21, the day before the march resident council meeting. *There were 33 times on 3/23/21 that the call light response time was over 10 minutes. Review of provider's April 2021 resident council departmental response form revealed: *"Beds not getting made in a timely manner sometimes it's 2-3 o'clock. Only 1 staff in dining room & on floor-taking long time to get assistance. Call lights not being answered in a timely manner." *Explanation or response, "1. We have made new sign off sheets to ensure bedding is getting made and reinstalled importance of bed making with all staff. 2. There is always the nurse and currently with our census 3 staff between C and D wing. Discussed with residents. 3. We continue to do call light audits daily and with our ever changing resident needs have made adjustments to staffing." *There was a memo on 4/21/21 attached to the grievance that stated: -"Attention CNAs and Nurses: We are going to have walkie talkies and pagers become a part of your uniform to ensure our residents are getting the most timely care possible. When we are carrying the walkie talkies we must make sure	F 565		

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that we are not using resident names and leaving general statements. We must make sure we are receiving notifications [sp] immediately that a resident needs assistance. The nurses pagers go off after 5 minutes and then they should be investigation [investigating] and/or assisting with call lights. C and D wing nurse CAN [CNA] especially need to wear their walkie talkies and pagers as they are spready [sp] out between two hallways..."

Observations made by all onsite surveyors did not reveal any staff using walkie-talkies:
*On 5/11/21:
-From 8:00 a.m. through 12:30 p.m.
-From 2:30 p.m. through 5:30 p.m.
*On 5/12/21:
-From 8:00 a.m. through 12:00 p.m.
-From 2:00 p.m. through 5:30 p.m.
*On 5/13/21:
-From 8:00 a.m. through 12:00 p.m.

Further interview on 5/12/21 at 3:00 p.m. with resident council revealed:
*They all agreed that call lights were still an issue.
*They did not feel that the facility had worked quickly to address the call light grievances.

Interview on 5/12/21 at 3:30 p.m. with anonymous CNA in the hallway of D wing revealed:
*She had a walkie-talkie in her pocket.
*She often leaves it at home or forgets to charge it.
*They use them sometimes.

Interview 5/12/21 at 4:50 p.m. with ombudsman T regarding resident council concerns revealed:
*She agreed that staffing/call lights were a concern.

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F 565	Continued From page 7 *This had been an ongoing issue for the resident council. Interview on 5/13/21 at 10:57 a.m. with director of nursing (DON) C and regional nurse consultant B about call light times revealed: *They try to have call lights answered within 5 to 7 minutes. *DON C would consider 10 minutes to be an excessive wait time. Interview on 5/13/21 at 12:50 p.m. with administrator A regarding resident council revealed: *They try to answer call lights within 5 minutes. *She was aware of the resident council's concerns.	F 565		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review and policy review, the provider failed to ensure two of two sampled residents (7 and 35) had been accurately recorded on the Minimum Data Set (MDS) assessment. Findings include: 1. Observation and interview on 5/12/21 at 10:25 a.m. with resident 35 revealed: *She had broken and decayed lower teeth which were noticeable when she spoke. *She had no upper teeth and chose not to wear	F 641	F 641 1. Resident's 35, and 7's MDS's have been reviewed and modified to ensure they reflect the most current and accurate assessment of those residents. 2. All other residents in the facility are at risk. The most current MDS for each resident will be reviewed by the Director of Nursing & MDS/RN Coordinators by 6/20/2021, to Ensure they reflect the most current and accurate assessment of each resident. 3. The Regional MDS Consultant will be educating RN/MDS Coordinators E & Q, the Director of Nursing, and Social Service Director F and Social Services Assistant L, on the importance of completing MDS assessments accurately on June 4, 2021. The Regional Social Worker Consultant will be conducting additional education for Social Services Director F and Social Services Assistant L on the importance of completing section PQH-9 correctly as well on June 7, 2021. Type text here Continued on next page.....	6-20-2021

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F 641	Continued From page 8 her upper denture. -Her upper denture did not fit correctly because her gums had receded. -She preferred to not get a new denture because she was used to being without one. *She saw her dentist last on 7/10/17 after she had been admitted to the facility. *The dentist had recommended extraction of her lower teeth. *She was self-conscious of the way she looked but chose to keep her remaining teeth as they were. *She refused to have her teeth pulled because she was able to eat okay with them. *Her teeth did not hurt. *She ate a regular diet and preferred this rather than have foods ground. *If there was something on the menu that was difficult to eat, she ordered a substitute food. *She could not remember staff examining her teeth. Review of resident 35's 12/20/20 and 3/9/21 MDS assessment revealed: *Those assessments had not been coded to reflect the current status of her oral health. *No natural teeth or tooth fragments were marked no. *Obvious or likely cavity or broken natural teeth was marked no. Interview on 5/13/21 at 11:29 a.m. with RN/MDS Coordinator/Resident Care Coordinator E regarding resident 35 revealed she: *Had worked in this position for 5 years. *Worked as the director of nursing before her current position. *She was responsible to complete resident 35's MDS assessments.	F 641	4. The Director of Nursing/designee will audit 3 current MDS's that will be completed by RN/MDS Coordinator E & Q, and Social services Assistant L weekly for 4 weeks and monthly for 3 months to ensure the most current and accurate assessment of each resident. Results of audits will be discussed by the Director of Nursing/designee at the monthly Client Care and QAPI/CQI meetings for discussion of the effectiveness of the correction measures and recommendation to adjust correction plan, reduce frequency of audits or discontinue audits based on the findings.	

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F 641	Continued From page 9 *Had last assessed resident 35's teeth on 3/23/21. *Stated she had at times done a record review rather than assessing the resident in person. *Reviewed the RN notes of the resident for how to code the MDS. *Agreed that the assessments should be done in person to ensure their accuracy. Observation and further interview on 5/13/21 at 11:39 a.m. with RN/MDS Coordinator/Resident Care Coordinator E completing an oral examination of resident 35 revealed: *Confirmation resident 35 had broken and decayed lower teeth and no upper teeth. *The MDS assessments she had completed on 12/20/20 and 3/9/21 were incorrect. *Confirmed it was a mistake not to assess resident 35 in person and the MDS assessments were coded incorrectly. Interview on 5/13/21 at 12:06 p.m. with administrator A revealed: *She was unaware resident 35's MDS assessments had been coded incorrectly. *The MDS assessments should have been completed in person and not done by record review. *She would expect staff to follow their policy to do the assessments timely, in person, and the assessments coded accurately to reflect the current status of the resident when completing initial, quarterly, annually and for significant changes. Review of the provider's 10/2/19 Resident Assessment Instrument policy revealed: *..."The purpose of the assessment is to describe the resident's capability to perform daily life	F 641		

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F 641	Continued From page 10 function and to identify significant impairments in functional capacity." *..."All persons who have completed any portion of the MDS Resident Assessment Form must sign such document attesting to the accuracy of such information." Surveyor: 42477 2. Observation on 5/11/21 at 9:01 a.m. of resident 7 revealed: *She was sitting in a wheelchair with her back to the door. *She had ointment in her eyes so she did not open them. *She was making a whimpering noise. *Her speech was not understood by this surveyor. Review of resident 7's electronic medical record (EHR) revealed: *She had frequent episodes of crying and yelling. *Her diagnoses included: -Alzheimer's disease. -Major depressive disorder. -Anxiety disorder. Review of resident 7's most recent quarterly 5/4/21 MDS revealed: *Her brief interview for mental status (BIMS) was listed as a 4. -Meaning severe cognitive impairment. *Over the roughly two week look back period she was: -Never felt down or depressed. -Never tired or had a lack of energy. -Never had trouble concentrating. -Never felt bad about herself. *She received a total severity score of her patient health questionnaire-9 (PHQ-9) of "00."	F 641		

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F 641	Continued From page 11 *For section E behavior- "She had no rejection of care, she had no wandering, she had no change in behaviors, She had exhibited no physical behaviors, exhibited 1-3 days of verbal behaviors. and there had been no other behavioral symptoms exhibited." Review of resident 7's current 5/11/21 care plan revealed: *She had a focus of: -"[resident's name] takes Psychoactive medications R/T Anxiety disorder." *She had a goal of: -"[resident's name] will have intended effect of the medication through next review." *Her interventions included: -"Monitor behavior while on medication." -"Monitor for any ill effects related to medication." *She had a focus of: -"[resident's name] has impaired cognitive function/dementia or impaired thought processes related to diagnosis of Alzheimer's." *She had a focus of: -"[resident's name] has a mood/behavior problem R/T [related to] Alzheimer, anxiety disorder, frequent crying episodes, and resistance of cares at times." *She had a goal of: -"[resident's name] will have fewer episodes of crying out, and resisting of care behaviors through next review." -"Document behaviors, and [resident's name] response to interventions." Review of resident 7's electronic progress notes revealed: *"Note regarding a quarterly assessment with an ARD [assessment reference date] of 2/2/2021. [resident's name] was initially admitted to the	F 641		

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F 641	Continued From page 12 facility from the community. Her primary diagnosis remains Alzheimer's disease. She is alert but only oriented to self..." "...She exhibited frequent crying twice during the look back period. Staff offers comfort during these times and often calls her husband in hopes of improving her spirits. She had no other inappropriate or abnormal behaviors noted during the review period." Review of resident 7's documented behaviors revealed: *On 5/11/21 at 4:59 a.m. she was, "yelling/screaming" *On 4/28/21 at 3:30 p.m. she was, "Behavior - Yelling/Screaming" -"Res [resident] yelling and screaming during cares, unable to redirect, resolved once res is left at rest, will continue to monitor." *On 4/25/21 at 2:17 p.m., "Behavior - Frequent Crying." -"res was calm during breakfast and ate well and took medication really well, did well this afternoon during cares after lunch, will continue to monitor." *On 4/23/21, "She spit out her medications." *From 4/3/21 through 2/22/21 she had 7 episodes of crying or behaviors. Interview on 5/13/21 at 12:30 p.m. with social services designee (SSD) F and social services assistant L regarding resident 7's depression screening revealed: *Social services assistant L completed resident 7's depression screening. *Social services assistant L stated: -She had not had more than 5 minutes of MDS training. -She was under the assumption that her MDS assessment had to match the nurse's	F 641		

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F 641	Continued From page 13 documentation. -She acknowledged resident 7 exhibited behaviors. Review of the provider's October 2019 resident assessment policy revealed, "Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning."	F 641		
F 676 SS=E	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,	F 676	F 676 1. Restorative Plans for residents 18, 7, 11, 16, 30, 58, have been reviewed and revised as necessary to ensure that they have the appropriate restorative plan in place and that they are implemented and documented appropriately. The facility has implemented a plan for designated Restorative Therapy staff that will not be pulled to the floor to do C.N.A. work. 2. All other residents in the facility on restorative therapy are at risk for not having appropriate restorative plans in place and are at risk for those plans not being implemented or documented appropriately. All residents with restorative plans in the facility will have their rest-orative plans reviewed by 6/20/2021 by the Director of Nursing and Clinical Care Coordinators to ensure their restorative plans can be implemented and documented appropriately. 3. The Administrator, Director of Nursing, and Clinical Care Coordinators reviewed the policy on Rehabilitative Nursing and Education will be provided to all staff including the restorative aides by the Director of Nursing on 6/9/2021 to ensure that restorative plans for all residents are implemented and documented appropriately and according to the facility policy. Those staff members not in attendance at the education session due to vacation, sick leave, or casual work status, will be educated prior to their first shift worked following the education session. Continued on next page.....	06/20/2021

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F 676	Continued From page 14 §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §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 observation, interview, record review, and policy review, the provider failed to adequately implement and document a restorative plan for six of 18 sampled residents (7, 11, 16, 18, 30, and 58). Findings include: 1. Observation on 5/11/21 at 8:45 a.m. of resident 18's room revealed a right hand splint had been placed on her recliner. Interview on 5/11/21 at 10:30 a.m. with resident care coordinator A regarding resident 18's hand splint revealed she wore the hand brace during the night to prevent further contractures. Interview on 5/12/21 at 9:35 a.m. with Resident 18 regarding her right hand revealed she had some pain in her hand when she moved it. Review of resident 18's medical record revealed 5/4/21 physician's orders for: -"Restorative nursing as indicated by assessment" with an order date of 3/23/21. -A splint to her right hand during the night with an order date of 4/1/21.	F 676	4. The Director of Nursing/designee will be responsible for overall compliance and will conduct audits on restorative plans, implementation, and documentation of those plans for residents 18, 7, 11, 16, 30, 58 along with 4 random residents weekly for 4 weeks, 2 times a month for 4 weeks, and monthly for 3 months. These audits are part of a PIP created for the QAPI/CQI process. All audit findings listed above will be reviewed by the Director of Nursing at monthly Client Care and QAPI/CQI meetings for 3 months for discussion of the effectiveness of the correction plan and for the recommendation to adjust the correction plan, and/or reduce frequency or discontinue of the audits based on the audit findings.	

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F 676	Continued From page 15 Review of resident 18's Occupational Evaluation and Plan of Treatment notes revealed she received occupational therapy from 3/17/21 through 4/9/21. Review of resident 18's revised care plan revealed: *She was at risk for contractures related due to the non-use of her right hand. *The goal had been to prevent further contractures through the next review period. *She had received occupational therapy from 3/17/21 through 4/9/21 for her right hand contractures. *A 4/9/21 intervention for restorative therapy to assist with passive range of motion (PROM) to the right upper extremity. *A 4/1/21 intervention for a splint to her right hand overnight. Review of resident 18's March 2021 restorative program documentation sheet revealed: *Her undated active range of motion plan using Theraputty had been discontinued on 3/17/21. *Her undated passive range of motion (PROM) program to "Both hands and lower extremities stretching Right upper extremity-proximal to distal (shoulder to digits [fingers]) was to have been started on 3/17/21 and done "Q [every] shift, Day 6-2." *From 3/17/21 through 3/31/21 (fifteen days) the PROM program had been marked as: -Blank ten of fifteen days (3/17, 3/18, 3/19, 3/20, 3/21, 3/23, 3/35, 3/27, 3/28, and 3/30). -"NA" three of fifteen days (3/22, 3/26, and 3/29). -"RR" one of fifteen days (3/31). -Marked 15 minutes one of fifteen possible days (3/24).	F 676		

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F 676	Continued From page 16 Review of resident 18's April 2021 restorative program documentation sheet revealed: *From 4/1/21 through 4/30/21: -Her undated active range of motion plan using Theraputty (putty used by therapists for hand therapy) had been restarted on 4/10/21. Of the 4/10/21 through 4/30/21 (twenty-one days) Theraputty active range of motion (AROM) had been marked as: -Blank ten of twenty-one days (4/11, 4/12, 4/16, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24, and 4/27). -"NA" for eleven of twenty-one days (4/10, 4/13, 4/14, 4/15, 4/17, 4/18, 4/26, 4/27, 4/28, 4/29, and 4/30). -No AROM had been completed in April. *From 4/1/21 through 4/30/21 (thirty days) the PROM program had been marked as: -Blank fourteen of thirty days (4/1, 4/3, 4/5, 4/6, 4/8, 4/9, 4/11, 4/12, 4/16, 4/19, 4/21, 4/22, 4/23, and 4/27). -"NA" fourteen of thirty days (4/2, 4/4, 4/7, 4/10, 4/13, 4/14, 4/15, 4/17, 4/18, 4/25, 4/26, 4/28, 4/29, and 4/30). -Ten minutes one day (4/20). -Fifteen minutes one day (4/24). Review of resident 18's May 2021 restorative program documentation sheet revealed: *From 5/1/21 through 5/12/21 (twelve days) therapeutic AROM had been marked as: -Blank for seven of twelve days (5/5, 5/6, 5/7, 5/9, 5/10, 5/11, and 5/12). -"NA" five of twelve days (5/1, 5/2, 5/3, 5/4, and 5/8). -No AROM had been completed in May. *From 5/1/21 through 5/12/21 (twelve days) therapeutic PROM had been marked as: -Blank for seven of twelve days (5/5, 5/6, 5/7, 5/9,	F 676		

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F 676	Continued From page 17 5/10, 5/11, and 5/12). -"NA" five of twelve days (5/1, 5/2, 5/3, 5/4, and 5/8). -No PROM had been completed in May. Of thirty-three opportunities for AROM in the combined April 10, 2021 through May 12, 2021, resident 18 received zero days of therapy. Of fifty-seven opportunities for PROM in the combined March 17, 2021 through May 12, 2021 resident 18 received three days of therapy. Interview on 5/13/21 at 9:45 a.m. with the certified nursing assistant (CNA) K stated: *She worked as a restorative aide, bath aide, and CNA. *The director of nursing (DON) C was the restorative nurse. -DON C put the restorative programs that the therapists had recommended into the restorative program when their physical or occupational therapy was done. *Clinical care coordinators (CCC) E and Q were to have been notified if there were problems. *Staff were pulled out of the restorative role if there was a call-in from another CNA. *The restorative aides were to have documented daily on the residents who were part of the restorative program. *When asked what the initials placed in the documentation boxes stood for she stated the: -RR meant the resident had refused restorative therapy. -She was not sure what the N/A stood for; sometimes it meant the resident refused, other times it could have meant not applicable, "Or something else, like it wasn't done." -When CNA K was on the restorative shift she	F 676		

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F 676	Continued From page 18 was responsible for the whole building. -Group exercises were done by the activity staff. -The restorative aides tried to invite the residents twice if they had refused it the first time. -The restorative aides turned their paperwork in daily to the DON. Interview on 5/13/21 at 10:10 a.m. with the director of nursing regarding the restorative program revealed: *Each restorative aide (RA) was given a packet with all the new restorative changes before they began their shift. *Each RA was responsible for documenting in the electronic medical record at the end of their shift. *If another CNA calls in the RA could get pulled away from the restorative therapy to help on the floor. *There is a restorative aide every day and the restorative program is seven days a week. *There was no certain day the resident was to be attending restorative therapy unless the therapists state specifically. Surveyor: 42477 2. Review of resident 7's electronic medical record (EHR) revealed: *She had an order of, "Restorative nursing as indicated by assessment." *She was to have: -"Nursing rehab: Passive ROM [range of motion], and stretching exercises..." -This was to be done day shift and as needed (prn). Review of resident 7's restorative records revealed: *In December 2020:	F 676		

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F 676	Continued From page 19 -She had received nursing rehab 14 out of 31 opportunities. -She had 17 missed opportunities to receive ROM exercises. *In January 2021: -She had received nursing rehab 17 out of 31 opportunities. -She had one documented refusal. -She had 13 missed opportunities to receive ROM exercises. *In February 2021: -She had received nursing rehab 13 out of 28 opportunities. -She had 15 missed opportunities to receive ROM exercises. *In March 2021: -She had received nursing rehab 10 out of 31 opportunities. -She had one documented refusal. -She had 20 missed opportunities to receive ROM exercises. *In April 2021: -She had received nursing rehab 5 out of 30 opportunities. -She had one documented refusal. -She had 24 missed opportunities to receive ROM exercises. *In May 2021: -She had not received any ROM exercises. Review of resident 11's EHR revealed: *She had an order of, "Restorative nursing as indicated by assessment." *She was to have: - Three times per day, "Nursing rehab: Active ROM: Can ride nu step on level 3, or do fine motor tasks, or seated LE/UE exercises." -Three times per day, "Nursing rehab: Walking program: Use assist of 1, walker and gait belt,	F 676		

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F 676	Continued From page 20 Encourage to ambulate in hallways." Review of resident 11's restorative records revealed: *In December 2020: -She had received nursing rehab 9 out of 124 opportunities. -She had five documented refusals. -She had missed 110 missed opportunities to receive ROM exercises. *In January 2021: -She had received nursing rehab 9 out of 124 opportunities. -She had six documented refusals. -She had 109 missed opportunities to receive ROM exercises. *In February 2021: -She had received nursing rehab three out of 112 opportunities. -She had eight documented refusals. -She had 101 missed opportunities to receive ROM exercises. *In March 2021: -She had received nursing rehab three out of 124 opportunities. -She had 11 documented refusals. -She had 113 missed opportunities to receive ROM exercises. *In April 2021: -She had received nursing rehab three out of 120 opportunities. -She had two documented refusals. -She had 115 missed opportunities to receive ROM exercises. *In May 2021: -She had not received any ROM exercises. Review of resident 16's EHR revealed: *She had an order of, "Restorative nursing as	F 676		

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F 676	Continued From page 21 indicated by assessment." *She was to have: -Daily, "Nursing Rehab: Active ROM" -Day and Evening shift, "Nursing rehab: walking" Review of resident 16's restorative notes revealed: *In December 2020: -She had received nursing rehab eight out of 93 opportunities. -She had one documented refusal. -She had 84 missed opportunities to receive ROM exercises. *In January 2021: -She had received nursing rehab eight out of 93 opportunities. -She had one documented refusal. -She had 84 missed opportunities to receive ROM exercises. *In February 2021: -She had received nursing rehab six out of 84 opportunities. -She had five documented refusal. -She had 73 missed opportunities to receive ROM exercises. *In March 2021: -She had received nursing rehab one out of 51 opportunities. -She had no documented refusals. -She had 50 missed opportunities to receive ROM exercises. -She went on comfort cares 3/17/21. Review of resident 30's EHR revealed: *She had an order of, "Restorative nursing as indicated by assessment." *She was to have: -One time per day, "Nursing rehab: Active ROM may use ace wrap (in therapy room) to tie legs	F 676		

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F 676	Continued From page 22	F 676		

together and prevent her left leg from falling outward. May perform seated upper extremities on pulleys. May perform Nustep level 4 for 10-15 minutes 3-4x per week.:
-Daily and prn, "Nursing rehab: Walking-ambulate 15 minutes 3-5x per week with RT [restorative] staff."

Review of resident 30's restorative records revealed:
*In December 2020:
-She had received nursing rehab twice out of 62 opportunities.
-She had four documented refusals.
-She had 56 missed opportunities to receive ROM exercises.
*In January 2021:
-She had 12 documented refusals.
-She had 50 missed opportunities to receive ROM exercises.
*In February 2021:
-She had received nursing rehab once in 55 opportunities.
-She had two documented refusals.
-She had 52 missed opportunities to receive ROM exercises.
*In March 2021:
-She had 62 missed opportunities to receive ROM exercises.
-She did not have any documented refusals.
*In April 2021:
-She had 27 missed opportunities to receive ROM exercises.
-She had two documented refusals.
*In May 2021:
-She had not received any ROM exercises.

Observation on 5/11/21 at 9:29 a.m. of resident 58 revealed:

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F 676	Continued From page 23 *She was sitting in her room in a Gerri chair. *Her legs and arms appeared to be very contracted. *She had gauze in between her fingers in her left hand. Review of resident 58's EHR revealed: *She was admitted to the facility on 6/13/13. *Her brief interview for mental status (BIMS) was not listed. -Her most recent 4/20/21 quarterly MDS stated she was never or rarely understood. *Her diagnoses included: -Alzheimer's Disease. -Other specified disorders of bone density and structure. -Contractures. *She had pressure ulcers in between her fingers due to her contractures. Review of resident 58's progress notes revealed: *On 4/3/20, "...[resident's name] is having a difficult time opening hand to participate in stand up lift transfers..." *On 12/4/20, "1. Provide progressive PROM to bilateral arms while laying down. 2. Position orthodic carrots in both hands to promote extension and prevent further deformities. 3. Apply sleeve protector to left forearm into elbow 4. Assess skin daily for breakdown/redness in the morning..." *On 1/14/21, "...Updated POA [power of attorney] in regards to resident's left arm being contracted. OT to eval and treat per standing orders. POA agreeable to POC [point of contact]..." *On 4/19/21, "Arms and hands noted to increase with contractors. RT doing PROM but continues to worsen. Orders obtained for OT to eval and treat. Res daughter [name] updated and	F 676		

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F 676	Continued From page 24 agreeable to POC." *On 4/19/21, "Res noted to have small open area (4mmw x6mmh) between lt[left] middle and ring finger along knuckle area of inner middle finger. Res lt hand is contractured with fingers tightly closed. Staff do use carrots for hands. Dry gauze applied to area to dry and reduce friction/pressure." *On 4/28/21, she was noted to be receiving restorative therapy with PROM to maintain her current functional status. Review of resident 58's restorative records revealed: *She had 29 missed opportunities to receive ROM exercises in November 2020. *She had 18 missed opportunities to receive ROM exercises in December 2020. *She had 12 missed opportunities to receive ROM exercises in January 2021. *She had eight missed opportunities to receive ROM exercises in February 2021. *She had 17 missed opportunities to receive ROM exercises in March 2021. *She had 17 missed opportunities to receive ROM exercises in April of 2021. *She had not received any ROM exercises for May 2021. Review of resident 58's April 2021 care plan revealed: *She had a focus of: -"[resident's name] receiving Occupational Therapy related to Decreased ROM on bilateral arms and hand. Risk for Contractures." *She had a goal of: -"Improve ROM to arms and hands." *Her interventions included: -"[Resident's name] uses Carrots in bilateral	F 676	h	

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F 676	Continued From page 25	F 676		

hands to keep ROM."
-"PROM[passive range of motion] to upper extremities for contractor management and prevention."
*She also had a focus of:
-"[Resident's name] has extensive care needs and required the support/services of the LTC [long term care] setting. The stay is presently identified as Long-Term."

Interview on 5/13/21 at 9:38 a.m. with certified nursing assistant (CNA) K revealed:
*She has worked in the facility for about 30 years.
*She helps residents with restorative, baths, and other CNA duties.
*Usually a CNA is listed on the schedule for the restorative task each day.
-There are days where the CNA is pulled from the restorative role to do other tasks.
*They document the completed restorative tasks on the computer.
*They document not applicable if it was not done.
*They document resident unavailable if the resident was not available for some reason.
*They document resident refused if the resident refused the exercises.

Interview on 5/13/21 at 10:11 a.m. with director of nursing C and regional nurse consultant B revealed:
*She oversees the restorative program.
-Each resident's restorative program is based on therapy's recommendations.
*Aides document in the EHR if the task was completed.
*She agreed that the restorative aides sometimes get pulled for other tasks.
*She agrees that their restorative program is not where it should be and they are working on it.

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F 676	Continued From page 26 *Resident 58 has had contractures since 2020. *Resident 58 has had PT and OT involved with her care. Interview on 5/13/21 at 12:15 p.m. with the director of therapy H revealed: *Resident 58 started therapy again in April 2021. *Resident 58's contractures have been getting worse. *The nursing staff should be implementing therapy's recommendations and orders. *Therapy recommendations are not always implemented by the nursing staff. *Agreed that restorative was not being completed for residents, otherwise they would not keep getting repeated orders to see the same residents. Review of the provider's October 2019 rehabilitative nursing care policy revealed: *"Rehabilitative nursing care is provided for each resident admitted." *"Nursing personnel are trained in rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan." *"The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence.	F 676		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755	Plan of correction on following page	

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F 755	Continued From page 27 personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, document review, and policy review, the provider failed to ensure one of one emergency kit (E-kit) and one of one emergency controlled medication E-kit was secured and medication accountability occurred in one of two medication rooms and one of three medication carts. Findings include: 1. Observation 5/12/21 at 4:20 p.m. of the medication emergency kit located on the C wing	F 755	F 755 1. The facility "Emergency Drug Kit" found to be deficient during the survey has been locked with a numbered break-away tag which will be replaced with new numbered break-away tags any time the kit is opened for any reason. The "Emergency Drug Kit Log" has also been placed with the "Emergency Drug Kit." The one missing dose of Solu-Medrol 125mg (vial) was at the pharmacy. (The pharmacist neglected to put it in the box. Moving forward, the Pharmacy will use a second person to double check the "Emergency Drug Kits" at the pharmacy to prevent that from happening again.) Audits will be conducted by the Director of Nursing/designee when the Emergency Kits are replaced by Pharmacy each month when the Emergency Kits arrive at the facility. The DON/designee will also do audits weekly after they arrive to ensure the Emergency Kit drugs are all accounted for. If a drug is found missing, the DON/ designee will conduct an investigation on the missing drug. 2. Both "Emergency Drug Kits" in the facility are at risk. Both kits have been equipped with the necessary numbered break-away tags and the "Emergency Drug Kit Log". 3. The Pharmacy Consultant will provide education to all nursing staff and the consulting pharmacists on June 9, 2021, on the proper use of the numbered, break-away tags and the "Emergency Drug Kit Log", to ensure that the two Facility "Emergency Drug Kits" are secured appropriately and the "Emergency Drug Kit Logs" are completed in their entirety. Those staff members not in attendance at the education session due to vacation, sick leave, or casual work status, will be educated prior to their first shift worked following the education session. Continued on next page.....	6-15-2021

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F 755	Continued From page 28 medication room revealed: *The kit sat on a counter. *There was no seal or numbered breakaway tag securing the medication in the emergency kit. *Review of all medications in the unsealed kit using the attached provider's E-kit drug list with registered nurse (RN) R revealed one missing dose of Solu-Medrol 125 milligrams (mg.) vial. Review of the provider's pharmacy Emergency Kit Replacement Sign-Out Book used to obtain a replacement medication if a drug was removed from the kit revealed: *The book had previous replacement forms from 10/5/2020 through 5/10/21. *There was no form to indicate when the Solu-Medrol had been removed. *Further review of the E-kit replacement sheets revealed the nurse was to have filled out the form with the: -Resident's name and date of birth. -Medication and dose removed. -Prescriber. -Nurse's name and date the medication was removed. *Below this information the nurse was to have written: -The number on the tag that had been removed from the kit. -The number on the new tag that had been placed on the kit. *The replacement sheets were to have been retained in the book for six months. Review on 5/12/21 at 4:45 p.m. of the narcotic E-kit stored in the narcotic box in the A-Wing medication cart revealed the E-kit box was not secured by a lock or breakaway tag. There was no system of securing the E-kit with a numbered	F 755	4. The Director of Nursing/Designee will conduct weekly audits for four weeks and monthly audits for 3 months, on the two emergency drug kits in the facility which will include ensuring the emergency drug kits logs are completed in their entirety. The Director of Nursing/designee will report on the audit findings at monthly Client Care and QAPI/CQI meetings for discussion of the effectiveness of the correction measures and recommendation to adjust correction plan, reduce frequency of audits or discontinue audits based on the findings.	

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F 755	Continued From page 29 tag. Review of the E-kit controlled drug record revealed: *Each medication was on a separate sheet of paper and not attached to a bound book with numbered pages. *The directions on each of the E-kit Controlled Drug Records stated: -"Document when the dose is removed from the E-kit and order replacement." -"Document when the replacement is returned to the E-kit." *A controlled drug record for Ativan 0.5 mg.: -Had no date to indicate when it had been added to the E-kit. *Ativan 2 mg./milliliter (ml.) 2 vials. -"In med room fridge lock box." -Had no date to indicate when it had been added to the E-kit. *Hydrocodone 5/325 mg., 6 tablets. -Had a written message at the top of the page indicating "Tag # [number] 101119." -A note on 7/2/20 "Opened to check expires." "Tag 5661867." -On 12/26/20 one tablet had been removed. --The nurse signed the entry but left a dash where the tag number was to have been. --There was no further entry to identify when the medication had been replaced. *Morphine Sulfate Solution 10 mg./0.5 ml, six prefilled oral syringes." -The solution amount had been crossed off and above it was written "Concentrate 20 mg./ml., 1 bottle." --There were no initials to identify who made those changes. --On 1/15/21 at 7:10 a.m. "1" had been removed, and the total stock was 0.	F 755		

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F 755	Continued From page 30 --On 1/15/21 at 6:00 p.m. "1" had been replaced, and the total stock was 1. Interview at the above time with RN E revealed: *The E-kit box was not supposed to be sealed. *The box was stored in a locked medication cart. *The oncoming staff and outgoing staff opened the box each shift to count the medications. *The previous director of nursing (DON) told the staff they had not required a numbered tag to monitor who had been in the E-kit. *The numbered tags were not necessary because the meds had been counted each shift. Interview on 05/13/21 9:00 AM with the consultant registered pharmacist revealed: *She was aware the emergency kit and emergency controlled medication kit did not have numbered breakaway locks. *She thought the meds should have been sealed with a numbered breakaway lock so that they could identify the last person that had opened the medication kit and identified what had been removed and when. *The provider stopped using the numbered locks approximately one to two years ago. Interview on 5/13/21 12:40 p.m. with the DON confirmed the e-kits should have been sealed with a numbered lock to identify who had been in the E-kit and when the E-kit had been opened. Review of the provider's 11/21/18 Emergency Pharmacy Service and Emergency Kits policy revealed: *The provider's emergency pharmacy service was available on a twenty-four-hour basis. *Emergency medication supplies are provided by the pharmacy.	F 755		

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F 755	Continued From page 31 *The ordered medication was to have been obtained either from the emergency box, the pharmacy, or a backup pharmacy determined by the provider's pharmacy. *Emergency non-parenteral medications were to have been kept in two medication rooms with other emergency medications in a sealed, portable container, locked drawer, or cabinet. *Emergency controlled substances were to have been kept on one unit with other emergency medications in a sealed, portable container, locked drawer, or cabinet. *For controlled medications the inventory count sheet was to have been updated. *If exchanging kits, when the replacement arrived the receiving nurse was to give the used kit to the pharmacy personnel. *If replacing used doses of medication, the nurse was to have replaced the medication in the appropriate area of the kit. *A new seal was to have been placed on the kit after the replacement medication had been added. *The kits were to have been monitored/inventoried by the consultant pharmacist at least every thirty days for completeness and expiration dating of the contents. The date of inventory was to have been noted outside the kit. *"Accountability for controlled substances stored in the emergency kit is maintained as follows: 1. A perpetual inventory system is used with a separate sheet or a bound book with numbered pages for each individual medication in the kit. 2. Each dose given and all replacement doses received from the pharmacy are entered on the appropriate inventory sheet with the 'amount remaining' adjusted accordingly. 3. The incoming and outgoing nurses verify the	F 755		

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F 755	Continued From page 32 inventory of controlled substances in each change of shift or exchange of keys. 4. When a controlled substance medication expired or was removed from the contents list, it was destroyed at the facility by a representative of the DEA, the DEA is informed, or other procedures are followed as required by state law."	F 755		
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	1. At this point, we can only look forward in improving our infection control policies and procedures. The Director of nursing, maintenance supervisor, housekeeping supervisor, clinical care coordinators, infection preventionist, and administrator will be provided re-education about appropriate and necessary changes to the facility infection control and prevention plan no later than June 8, 2021 by the Regional Nurse Consultant (RNC) or designee. The medical director was able to review the plan of correction and approved infection prevention and infection control policies prior to and following the survey. No revisions to policies and procedures were necessary as they are in line with CDC and CMS recommendations about: *Appropriate hand hygiene and glove use during resident cares. *Appropriate cleaning and disinfection of resident rooms. *Appropriate cleaning and maintenance of tub rooms. *Appropriate cleaning of resident equipment. *Proper inspection of equipment to ensure cleanable surfaces are present on all. *Previously distributed resident incontinent products were removed from a resident room and returned to a clean area without being disinfected properly. *Resident clean laundry was not covered while being distributed to resident room and hangers removed from resident rooms were placed back on the clean linen cart with clean clothes present. Continued on next page.....	6/20/2021

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F 880	Continued From page 33 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: 43844	F 880	*Paper towels were stored on the back of a toilet where they could be splashed by toilet water. * Paper towel dispenser was broken in one resident bathing area bathroom. *Necessary infection control and prevention plan that includes effective antibiotic stewardship. All staff licensed and unlicensed who provide above services to residents will be educated by the Administrator, DON, RNC or designee on June 9, 2021. Those staff members not in attendance at the education session on June 9, 2021, due to vacation, sick leave, or casual work status, will be educated prior to their first shift worked following the education session. Education was put out per flyers, and paper document to all staff on 6/1/2021 '2. Identification of Others: *ALL residents have the potential to be affected when hand hygiene and glove use is not done as trained. *ALL residents who have their room space cleaned and disinfected have the potential to be affected. *All residents who receive whirlpool tub bathing have the potential to be affected if the tubs and surrounding area is not maintained in a clean and kept manner. *ALL staff completing the assigned tasks have potential to be affected. *All residents are at risk to be affected by contaminated clothing. *All residents are at risk when equipment/furniture is deemed an uncleanable surface. *All residents are at risk of being affected by an un-sanitized incontinent package. Policy education/ re-education about roles and responsibilities for the above identified assigned task(s) will be provided by the Administrator, DON, RNC or designee no later than June 20, 2021. System Changes: Root cause analysis was conducted on 6/2/21 by the DON, using the 5 Why's system: Hand hygiene, PPE use, resident room and tub room cleaning was not being done properly. *Why? Staff were not following Infection prevention and infection control policies. *Why? Staff were not consistently monitored for proper hand hygiene, PPE use, resident room, and tub cleaning. *Why? Improper observation and audits of all staff by administrator, DON, clinical care coordinators, infection preventionist, and housekeeping supervisor *Why? Not enough time was scheduled to effectively monitor all shifts and staff for observation and auditing infection control procedures and policies. Continued on next page.....	

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F 880	Continued From page 34 Surveyor: 42477 Based on observation, interview, and policy review, the provider failed to follow appropriate infection control practices in multiple areas to ensure: *Mechanical lift cleaning was done in a sanitary manner. *Staff performed hand hygiene before, during, and after care tasks with residents in the dining room and resident room. *Previously distributed incontinent care products were not removed from resident room and returned to a clean area. *Resident clean laundry was covered while be transported and distributed throughout the facility. *Three of three facility tub rooms were cleaned and maintained with resident personal hygiene items stored per facility policy. *Functional paper towel dispensers in one communal bathroom and one shared toilet room on the 300/400 wing. *Resident room cleaning was done in a sanitary manner. *Dining room chairs were maintained with a cleanable surface. Findings include: 1. Observation and interview on 5/11/21 at 8:32 a.m. with nursing clerical support assistant J revealed she: *Had been cleaning a mechanical lift in the hallway. *Stated she cleaned the mechanical lifts every day with soapy water. *Had been using a bucket with brown colored soapy water. *Had used the same cleaning cloth for the entire lift even after it had been on the floor.	F 880	*Why? Unfortunately, we have had to spend a lot of time on staffing recently. Times will be scheduled for monitoring from management staff. There will be no excuses for it to be completed. All staff that were observed to not be in compliance with infection prevention and control polices has completed the CMS Nursing Home Infection Preventionist Training modules. The Administrator, IP, DON, maintenance housekeeping supervisor, and any others identified as necessary, will ensure ALL facility staff are responsible for following infection prevention and infection control policies. The Administrator and Director of Nursing contacted the South Dakota Quality Improvement Organization (QIN) on 6/2/21. The 2567, the root cause analysis and this plan of correction were discussed, and the QIN agreed with this plan of correction and provided links for tools that may be used in continued staff education. '3. Monitoring: Administrator, DON, maintenance supervisor, housekeeping supervisor, clinical care coordinators, and infection preventionist and any others identified as necessary will conduct auditing and monitoring for areas identified as well as any items identified through Root Cause Analysis. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 4 weeks then monthly for 3 months. The DON/designee will be making observations across all shifts to ensure staff compliance with: *Appropriate hand hygiene and glove use. *Appropriate cleaning and disinfection of resident rooms. *Appropriate cleaning of whirlpool tubs and maintenance of surrounding area. *Any other areas identified thru the Root Cause Analysis. After monitoring weekly for 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly for 3 months. Monitoring results will be reported by administrator, DON, and/or maintenance housekeeping supervisor to the QAPI committee and continued for no less than 3 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.	

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F 880	Continued From page 35 *Stated they changed the soapy water once per day at the end of the day. Surveyor: 43844 2a.Observation on 5/11/21 at 8:55 a.m. of certified nurse assistant (CNA) I as he responded to resident 59's call light revealed he: *Touched the call light turning it off. *Touched the divider curtain. *Did not perform hand hygiene. *Exited the room. *Did not perform hand hygiene. *Again, responded to the resident call light. *Touched the call light turning it off. *Touched the wheelchair the resident was sitting in. *Removed the call light cord from resident 59's hand. -Placed it on the bed. *Moved the resident in the wheelchair next to the bed. *Left the room *Did not perform hand hygiene. *Entered the dining room. *Did not perform hand hygiene. *Assisted another resident with the meal. Surveyor: 42477 2b. Observation on 5/11/21 at 11:43 a.m. of CNA G and CNA I in the 300/500 wing dining room revealed: *CNA G was assisting resident 58 and another resident with their meals. *CNA G was seated between the two residents. *From 11:43 a.m. through 12:22 p.m. CNA G touched the following areas and items and did not perform hand hygiene: -Wiped both the residents' mouths multiple times. -Touched his face shield.	F 880		

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	435020	A. BUILDING _____ B. WING _____	05/13/2021

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F 880	Continued From page 36 -Touched his surgical mask. -Touched CNA P's scrub to get her attention. -Adjusted resident 58's eyeglasses. -Touched resident 58's shoulder. -Touched resident 58's wheelchair. -Assisted them in positioning/propping up an unidentified resident's head. *CNA I had been assisting and feeding two other residents, he did not perform hand hygiene when moving back and forth between the two residents. Surveyor: 43844 2c.Observation on 5/12/21 at 8:24 a.m. of CNA P assisting resident 16 revealed: *CNA P: -Emptied the trash can. -Placed the trash bag on the floor. -Did not perform hand hygiene. *Made the bed. *Moved the walker to the side of the bed. *Wrapped the resident gait belt into a circle and placed it on the dresser. -Opened the dresser drawer. -Moved items around in the drawer. *Walked to the roommate's side of the room then returned to resident 16's side. *Did not perform hand hygiene. *Brushed resident 16's hair. *Picked up the trash bag from the floor. -Took it to the soiled utility room. -Did not perform hand hygiene. *Returned to resident 16's room. *Folded up the walker. *Wrapped oxygen tubing around her hand. -Pulled up her pants with her hand holding the oxygen tubing. -Did not perform hand hygiene. *Took resident and their oxygen concentrator to the dining room.	F 880		

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F 880	Continued From page 37 3.Observation on 5/11/21 at 9:33 a.m. of social service assistant L revealed: *She had a clean linen cart. -She removed two packages of incontinent pads from a resident room. -She placed those same pads on that clean linen cart. Surveyor: 42477 4. Observation on 5/12/21 at 7:51 a.m. of laundry aide O distributing clean laundry on the 300 and 400 wing revealed: *She had a transport cart that remained uncovered the entire time. *She had gone into a resident room to place clean clothes. *When she returned to the cart she had brought hangers from the resident room and placed them on the cart. *She performed hand hygiene after reaching into the clean cart to place the hangers. Surveyor: 43844 5a.Observation on 5/11/21 at 9:07 a.m. of the 300 wing shower room revealed: *The door was not locked. *There was a white cabinet next to the whirlpool *Cabinet door was not locked. -Sign on white cabinet door revealed "We CANNOT use communal wipes, deodorant, barrier cream, combs, etc. in the bath area" -Contents of the cabinet included: --Suave deodorant, Avon Senses, and Aveeno lotion. --They did not have individual resident name to identify. --There was a nail clipper with a fingernail remanent in them.	F 880		

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F 880	Continued From page 38 5b.Observation on 5/12/21 at 7:59 a.m. of the 400 wing shower room revealed: *A wet washcloth on the floor. *Used facial tissue on the floor. *The whirlpool surface was cracked in 6 areas at the drain level. *There was loose contact paper on shelf edging. *There were several unidentified resident personal items. *There was a bag of non-sterile cotton tipped applicators containing one applicator with what appeared to be ear wax on it and 11 clean applicators. *A pink bin contained a purple razor with no name on it but had hair on the blade. 5c.Observation on 5/12/21 at 8:36 a.m. of the 500 wing shower room revealed: *White cabinet next to the whirlpool with stored items. -There was a clear basket labeled 'please clean clippers with these alcohol wipes. --The alcohol wipes were there as was a visibly soiled nail clipper. -There were several personal care items with no resident identification. *White shelf below the cabinet had orange colored residue on the shelf and next to the shampoo bottle. 6a.Observation on 5/11/21 at 9:13 a.m. of the 300/400 communal bathroom revealed: *Paper towels stored on the back of the toilet exposing them to any splash or spray when the toilet is flushed. *Paper towel dispenser was broken. 6b.Observation on 5/12/21 at 8:07 of the 300/400	F 880		

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F 880	Continued From page 39 wing shared toilet room revealed: *Paper towels stored on the back of the toilet. *Paper towel dispenser was broken. *There was tile missing on the edge of the floor adjacent to the toilet. *There was black shower chair visibly soiled being stored. Surveyor: 42477 7. Observation and interview on 5/12/21 at 8:20 a.m. of housekeeping aide N revealed, she: *Had worked in housekeeping for three years. *Went into residents' shared room to grab the trash out of the trash receptacles. *Reached into the cart with the same gloves she had removed the trash with. *Grabbed "Sunburst Sani 2" chemical. *Went back into the shared resident room and sprayed the bedside tables and sink countertop with the chemical. -Had not moved any items on those surfaces before spraying. *Stated the chemical is to sit for ten minutes. -Began wiping the surfaces after only two minutes. -Returned the chemical to the cart. *Sprayed the toilet with Clorox Clean-up. *Touched the shared residents' doorknob with the same soiled gloves. *She changed her gloves and performed hand hygiene after she touched other clean surfaces and reached in her house keeping cart with soiled gloves. Surveyor: 43844 8.Observation on 5/12/21 at 2:56 p.m. of the Nixon dining room revealed dining room chairs had visibly frayed seat edges making them an uncleanable surface.	F 880		

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F 880	Continued From page 40 Surveyor: 42477 9. Interview on 5/13/21 at 11:31 a.m. with registered nurse/infection preventionist R revealed: *She agreed staff should be performing hand hygiene before, during, and after contact with residents or completion of assigned task(s). *She agreed laundry should be covered during transport and distribution throughout the facility. *She also agreed with the identified concerns with the facility tub and toileting rooms. 10. Review of the provider's February 2021 Infection Prevention Program policy revealed: *"The comprehensive infection prevention and control program addresses detection, prevention and control of infections among residents and personnel. It is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." 11. Review of the provider's October 2012 Handwashing/Hand Hygiene policy revealed: *"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." *"Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions." -"a. When coming on duty;" -"c. Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice);" -"f. Before and after eating or handling food (hand washing with soap and water);"	F 880		

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F 880	Continued From page 41 -"g. Before and after assisting a resident with meals;" -"s. After handling soiled equipment or utensils;" *"6. In most situations, the preferred method of hand hygiene is with an alcohol- based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all of the following situations:" -"a. Before and after direct contact with residents." -"b. Before donning sterile gloves." -"c. Before performing any non surgical invasive procedures." -"d. Before preparing or handling medications." -"e. Before handling clean or soiled dressings, gauze pads, etc.;" -"f. Before moving from a contaminated body site to a clean body site during resident care." -"g. After contact with a resident's intact skin." -"h. After handling used dressings, contaminated equipment, etc.;" -"i. After contact with objects (e.g., [for example] medical equipment) in the immediate vicinity of the resident; and" -"j. After removing gloves." 12. Review of the provider's undated daily room cleaning policy revealed: *"To use proper cleaning method with proper equipment to sanitize a resident's room or any area in the nursing facility." *"Use proper hand hygiene before and after task. Use proper PPE." *"1. Empty Trash [.]" -"a. Collect trash first thing when you enter each room[.]" -"b. Sanitize trash can daily using Clorox Hydrogen Peroxide Disinfectant Cleaner[.]" -"c. Replace liner daily[.]"	F 880		

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F 880	Continued From page 42 -"d. Beware of sharps or other potentially hazardous materials that could be in the trash[.]" *"2. Horizontal Surfaces- disinfected:" -"a. Scrub all surfaces with Clorox Hydrogen Peroxide Disinfectant Cleaner[.]" -"b. As you enter the room, work clockwise around the room hitting all surfaces[.]" -"c. All table tops, headboards, window sills, chairs, etc, should be done with Clorox Hydrogen Peroxide Disinfectant Cleaner." *"3. Spot Clean Walls[.]" -"a. Vertical surfaces are not completely wiped down daily- but must be spot cleaned daily using Spray Kleen Multi-Purpose Cleaner[.]" -"b. Walls- especially by trash cans, light switches, and door handles will need special attention." *"5. Bathroom[.]" -"a. Vent- make sure vent is cleaned. Use a bristle brush if necessary." -"b. Mirror- clean mirror, edges of mirror, and shelf with Spray Kleen Glass and Hard Surface Cleaner[.]" -"c. Sink- using Clorox Hydrogen Peroxide Disinfectant Cleaner, clean all porcelain on sink, both top and bottle. Scrub all fixtures and drains. Be sure to scrub the wall under the sink." -"d. Grab Bar & Toilet Paper Holder- clean and disinfect with Clorox Hydrogen Peroxide Disinfectant Cleaner[.]" -"e. Call Switch Plate- clean and disinfect with Clorox Hydrogen Peroxide Disinfectant Cleaner[.]" -"f. Toilet- scrub and disinfect toilet bowl cleaner with Acid Bowl Cleaner. Use Acid Bowl Cleaner on interior of bowl only. Remove all stains and build up on exterior of toilet and tank with Clorox Hydrogen Peroxide Cleaner[.]" -"g. Change gloves and rags often."	F 880		

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F 880	Continued From page 43 13. Review of the provider's Sani-Clean 2 Detergent/Disinfectant/Deodorant manufacturer's recommendations revealed, "Let solution remain on surface for a minimum of 10 minutes..."	F 880		

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E 000	Initial Comments Surveyor: 16385 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 5/11/21 through 5/13/21. Avantara Huron was found in compliance.	E 000		

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

Laurie L. Solem | Administrator | 06/03/2021

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

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/11/21. Avantara Huron 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 deficiencies identified at K321 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321	a.) The bungee cord and sweatshirt holding the boiler room door open at the time of the survey were both removed immediately in the presence of the surveyor. The maintenance director educated the maintenance assistant on 5/11/2021 on the importance of not propping the door to the boiler room or any mechanical room such as this. This door will be added to the preventative maintenance system the facility uses called TELS to assist in monitoring for compliance. Audits will be conducted weekly x four weeks and monthly for 3 months by the maintenance director/ designee to ensure compliance. The maintenance director will report audit findings at the facility monthly Safety and QAPI/CQI meetings for four months. b.) The sheetrock on the ceiling of the mechanical room, including the area under the kitchen, was replaced with new sheetrock by 6/20/2021. The maintenance director educated the maintenance assistant on the importance of ensuring all areas in mechanical areas such as this maintain the required fire separation protection as mentioned in this deficiency. This area and all mechanical areas in the facility will be included in the facility TELS system to assist in monthly monitoring for compliance. Audits will be conducted weekly for four weeks and monthly for 3 months by the maintenance director/ designee to ensure compliance. The maintenance director will report audit findings at monthly Safety and QAPI/CQI meetings for 4 months.	6-20-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem
TITLE: Administrator
(X6) DATE: 06/03/2021

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K 321	Continued From page 1 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain a hazardous area (boiler room) in the lower level as with the required one-hour separation or the required 3/4-hour fire-rated self-closing door. Findings include: 1. Observation on 5/11/21 at 11:30 a.m. revealed the basement boiler room was over 100 square feet, contained fuel fired equipment and did not maintain required fire separation. a. The door leading to the maintenance shop was held open with a bungee cord and a sweatshirt. b. The pan and joist ceiling system was not fire protected or protected by a solid sheetrock ceiling. Much of the sheetrock is currently missing. c. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency affected two of three requirements for hazardous rooms. The location of this deficiency (lower level below the kitchen) has the potential to directly affect all of the residents and staff of the nursing home.	K 321		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		

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K 353	Continued From page 2 Sprinkler System - Maintenance and Testing 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: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done in November, 2019 or February, 2020). Findings include: 1. Record review at on 5/11/21 at 1:15 p.m. revealed the required quarterly flow tests had not been performed since the last survey. Flow tests since the last survey (5/9/19) were performed on 8/12/19, 9/24/20, and 4/20/21. There was a waiver present during the pandemic, but the tests required in November, 2019 and February, 2020 would not have been covered by the waiver. Interview with maintenance director at the time of	K 353	The quarterly flow test for the sprinkler system was performed on 4/20/2021. It is due to be performed again by 7/20/2021. The quarterly flow tests are currently included in the facility TELS system in order to track compliance and will alert the maintenance director when the quarterly flow tests are due. Both the maintenance director and the assistance maintenance assistant were educated on how to conduct these quarterly flow tests on 4/20/2021 by a Building Sprinkler System technician. They were both educated on how to enter and track these quarterly flow tests in the TELS system on 4/20/2021 by the facility's Regional Maintenance Director on 4/20/201. The maintenace director/designee will conduct monthly audits through the facility TELS system to ensure compliance. The maintenance director/designee will report audit findings at monthly Safety and QAPI/CQI meetings for one year to ensure compliance.	5-11-2021

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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 the record review confirmed that condition.	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 _____	05/13/2021

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 Surveyor: 40506 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted 5/11/21 through 5/13/2021. Avantara Huron was found not in compliance with the following requirement(s):0121, and 0157.	S 000		
S 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain cleanable surfaces in the tub room on E wing (tile floor breaking up, and exposed particle board on the cabinetry). Findings include: 1. Observation on 5/11/2021 at 10:20 a.m. revealed the floor tiles at the entrance to the tub room, as well as several within the tub room were broken and cannot be cleaned sufficiently. 2. Observation on 5/11/2021 at 10:25 a.m. revealed the laminate cabinetry in the tub room has exposed particle board at the door edges due to laminate wear and cannot be cleaned	S 121	S 121 1. The broken missing tiles in the E Wing tub room and the Cabinetry with the exposed particle board will be repaired or replaced by 6/20/2021 by the maintenance director and maintenance assistant. 2. All other tub rooms in the facility are at risk to have uncleanable surfaces. All other tub rooms were audited by the maintenance director and assistant on 6/1/2021 to ensure all areas are deemed cleanable surfaces and to ensure that all cabinetry, tiles, walls, etc., are in good repair. Any repairs needed will be completed by 6/20/2021. 3. All tub areas in t he facility have been included in the facility preventative maint-enance system called TELS and will be checked monthly by the maintenance director/designee to ensure they all maintain cleanable surfaces, and that the cabinetry, tiles, walls, etc., are in good repair. 4. The maintenance director/designee will be responsible for overall compliance and will conduct weekly audits on all bath areas for 4 weeks and monthly audits for 3 months to ensure compliance. Audits will be conducted by the maintenance director/designee. Audit findings will be reported by the maintenance director at monthly Safety and QAPI/CQI meetings for discussion of the effectiveness of the correction plan and recommendation to adjust correction plan, reduce frequency of audits or discontinue audits based on findings.	06/20/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem | TITLE: Administrator | (X6) DATE: 06/03/2021

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
	10633	A. BUILDING: _____ B. WING _____	05/13/2021

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AVANTARA HURON	1345 MICHIGAN AVE SW HURON, SD 57350

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S 121	Continued From page 1 sufficiently.	S 121		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to maintain exhaust ventilation in soiled utility rooms and soiled laundry closets. Findings include: 1. Observation on 5/11/2021 at 10:10 a.m. revealed the beauty shop had no exhaust ventilation. Interview with the environmental services manager at the time of the observation confirmed that finding. 2. Observation on 5/11/2021 at 10:30 a.m. revealed the soiled utility room on E wing had no exhaust ventilation. Interview with the environmental services manager at the time of the observation confirmed that finding. 3. Observation on 5/11/2021 at 10:30 a.m. revealed the soiled utility room/biohazard room outside of the clock-in room on B wing had no exhaust ventilation. Interview with the environmental services manager at the time of the observation confirmed that finding. 4. Observation on 5/11/2021 at 10:45 a.m. revealed the soiled laundry room outside of the housekeeping closet on C wing had no exhaust ventilation. Interview with the environmental services manager at the time of the observation	S 157	1. The ventilation systems for the beauty shop, E Wing dirty utility room, utility/ biohazard room outside the clock-in room on B Wing, and the ventilation system for the soiled laundry room outside the housekeeping closet on C Wing were all repaired by 6/7/2021. 2. All other ventilation systems in the facility were checked by the maintenance director and the maintenance assistant on 5/13/2021 to ensure they were all in good working condition. Needed repairs will all be completed by 6/7/2021. 3. All ventilation systems in the facility have been included in the facility preventative maintenance system called TELS and will be checked monthly by the maintenance director/designee to ensure they are all working properly. 4. The maintenance director/designee will be responsible for overall compliance and will conduct weekly audits for 4 weeks and monthly audits for 3 months to ensure compliance. Audits will be conducted by the maintenance director/designee. Audit findings will be reported by the maintenance director at monthly Safety and QAPI/CQI meetings for discussion of the effectiveness of the correction plan and recommendation to adjust correction plan, reduce frequency of audits or discontinue audits based on findings.	06/20/2021

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
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S 157	Continued From page 2 confirmed that finding.	S 157		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 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 5/11/21 through 5/13/21. Avantara Huron was found in compliance.	S 000		