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
	435047	A. BUILDING _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 EAST PARK STREET PIERRE, SD 57501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/10/23 through 1/13/23. Avantara Pierre was found not in compliance with the following requirements: F657, F658, F675, F686, F692, F802, F809, F812, and F865.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	1. Resident 20 and husband have been invited to attend her care conference scheduled for February 7, 2023. Resident 37 and his wife have been invited to attend his care conference scheduled for February 7, 2023. 2. All residents and their families/ resident representative are risk for not having the opportunity to participate in the plan of care process. All residents' medical records will be reviewed for the past 3 months to ensure residents and families/resident representatives have been provided the opportunity to participate in their plan of care. 3. The Administrator or designee will educate the Interdisciplinary Team (IDT) on the Care Planning policy to include ensuring that the resident and families/ resident representatives are invited to scheduled care conferences and provided the opportunity to participate in the resident's plan of care. Education will occur no later than February 11, 2023. Those 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.	02/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/09/23

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 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure two of two sampled residents (20 and 37) and their families had the opportunity to participate in the plan of care process. Findings include: 1. Interview on 1/10/23 at 11:40 a.m. with resident 20 revealed she did not know what a care conference was and had never been to a meeting that discussed her plan of care. Review of resident 20's medical record revealed: *She was admitted on 3/2/21 and had diagnoses that included: breast cancer, heart failure, osteomyelitis of the vertebra, anemia, type 2 diabetes, glaucoma, malnutrition, bipolar disorder, peripheral vascular disease, left leg below the knee amputation, right leg above the knee amputation, and chronic kidney disease. *A 11/18/22 Brief Interview for Mental Status (BIMS), which is a screen used to assist with identifying a resident's current cognition, had a score of 13 meaning she was cognitively intact. *There was no documentation that the resident or her husband had attended a care planning meeting in the last six months. *There was no documentation the resident or her husband had refused to attend a care planning meeting in the last six months. *Her care plan indicated that her significant other should have been involved in her care conferences. Interview on 1/13/23 at 9:05 a.m. with director of nursing (DON) B regarding resident care conferences revealed: *Care conference members included the	F 657	4. The Administrator or designee will audit 5 residents' medical records to scheduled care conferences and provided the opportunity to participate in the resident's care plan of care. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendations for continuation/ discontinuation/revision of audits based on audit findings.	

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F 657	Continued From page 2 interdisciplinary team (IDT) which was: -Therapist, dietary manager, nursing management, and social worker. -Occasionally a nurse who worked a charge position would attend. -There was no certified nursing assistant (CNA) involvement in the care conferences. -Families were to be invited by the social service director. -When residents and families were invited and declined to attend the care conference there should have been documentation in the residents medical record. -The care conference would be documented in an IDT progress note in the electronic medical record. *She thought they had been having care conferences unless they had a COVID-19 outbreak. -The last COVID-19 outbreak at the facility was in June or July 2022. -She confirmed that the last six months there were no concerns of a COVID-19 outbreak. *Minimum Data Set (MDS) coordinator/registered nurse (RN) N would have attended the care conference as the clinical nurse. --If the MDS coordinator/RN N was not available then she would attend the meeting. *There should have been documentation of those who attended the care conference meetings. Interview on 1/11/23 at 9:50 a.m. with MDS coordinator/RN N and admission coordinator P revealed: *MDS coordinator/RN N had been updating the care plans with each MDS assessment that had been completed. -She did not attend the care conference as part of the interdisciplinary team.	F 657		

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F 657	Continued From page 3 *MDS coordinator/RN N stated, "We just recently started doing care plan meetings again." -They had done two the week of 1/2/22 and one the week of 1/9/22. -RN N was not sure how long they had not been completing them, she thought at least 6 months. Interview on 1/13/23 at 9:19 a.m. with MDS coordinator/RN N revealed the social service director was responsible for notifying and inviting residents, their family and/or their representative when a care conference was scheduled. 2. Interview on 1/10/23 at 10:44 am with resident 37 regarding care conferences revealed: *He used to attend care conferences but had not been invited for a while. *His wife received a letter to attend but she did not drive. *The social worker would come to his room and talk to him after the meetings about therapy concerns or progress. Review of resident 37's medical record revealed: *He was admitted on 1/24/20 and had a BIMS score of 14 indicating his cognition was intact. *There was no documentation the resident or his wife had attended any care planning meeting. *There was no documentation the resident or his wife had refused to attend any care planning meeting. *His care plan included having family or close friend involved in care discussions. Phone interview on 1/12/23 at 9:42 am with resident 37's wife revealed she: *Wanted to be involved in the care conferences for her husband. *Had not been offered any alternatives to be able	F 657		

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F 657	Continued From page 4 to attend care conferences. Interview on 1/13/23 at 10:44 a.m. with administrator A regarding care conferences revealed: *Members of IDT should attend, if not able to, they document their information in the electronic medical record (EMR) prior to the conference and it would be there to review during the conference. *Family and residents were invited by the social worker. *The social worker was to document in the residents EMR interdisciplinary (IDT) Progress Note if the resident refused to attend. *If family could not make it to the care plan meeting, the facility was supposed to call the family for a phone care conference. *After the care conference was held a note would have been entered into the resident's medical record to document the meeting. Review of the provider's September 2019 Care Planning policy revealed: *Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. -4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. *Residents and their representatives were to be invited to care conferences within seventy-two hours of admission, after completion of the comprehensive care plan, and at least quarterly. *Care conferences were meant to be interactive and allow the resident and their representative participate in the plan of care.	F 657		

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F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to: *Ensure two of two licensed practical nurses (LPN) (C and F) had followed professional standards of practice administering insulin for 3 of 4 (2, 9, and 20) residents. *Follow-up for one of one sampled resident (20) who needed her glasses adjusted and missed a scheduled comprehensive eye exam. *Notify the physician for one of one sampled resident (36) who had complaints of dizziness. Findings include: 1. Observation and interview on 1/12/23 at 7:56 a.m. of LPN F administering Novolog insulin to resident 20 revealed she had: *Administered the insulin into the residents abdomen using an insulin pen and then immediately removed the needle from her abdomen. *Not held the needle in place long enough to count to ten. *known she should have held the insulin pen in place for ten seconds after administering the dose of insulin to ensure the resident received the full dose. 2. Observation on 1/12/23 at 8:20 a.m. of LPN C administering Novolog 70/30 insulin to resident 2 revealed:	F 658	1. No immediate correction action could be taken for LPN F's failure to follow professional standards of practice administrating insulin to residents 2,9 and 20. A comprehensive eye exam for resident 20 has been scheduled for February 27, 2023. Central Dakota Eye Care is scheduled to adjust resident 20's glasses on February 3, 2023. Resident 36's provider was notified of his complaints of dizziness on January 12, 2023. Provider spoke with neurologist in Sioux Falls and resident has follow up with primary care provider. Eliqius 5 mg BID was re-started. Resident discharged from facility on January 13, 2023. 2. All diabetic residents are at a risk for adverse effects from the failure to follow professional standards of practice administrating insulin. All residents that utilize glasses to improve their vision are at risk of improper fitting glasses. All residents are risk for missing scheduled appointments. All residents are at risk for adverse effects from the failure to notify the physician of change in conditions. 3. The Director of Nursing (DON) or designee will educate all nurses, to include LPN C and LPN F, on the Medication Administration Subcutaneous Insulin policy to ensure professional standards of practice are followed when administrating insulin. Following education, the DON or designee will complete the Subcutaneous Insulin Pen (Licensed Nurses Only) competency with each licensed nurse. The DON will educate all nurses and IDT on the	02/11/23

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F 658	Continued From page 6 *She had: -Attached a needle to the insulin pen without cleaning the rubber seal first. -Not primed the insulin pen prior to dialing the correct dose to be administered. -Not held the needle in place until the count of ten. *After removing the needle, a drop of clear liquid was seen running from the injection site on the residents abdomen. Observation on 1/12/23 at 8:40 a.m. of LPN C administering Levemir and Novolog insulins to resident 9 revealed she had: *Attached a needle to each insulin pen with out cleaning the rubber seals first. *Not primed each insulin pen prior to dialing them to the correct dose. Interview on 1/13/23 at 10:34 a.m. with LPN C regarding the above observations revealed she: *Should have used an alcohol swab to clean the rubber seal on the insulin pens prior to attaching the needle. *Was aware that the insulin pens were to be primed prior to setting the prescribed dose. *Was aware that she had not hold the needle in the site for a count of ten when administering resident 2's insulin. 3. Interview on 1/12/23 at 3:22 p.m. with director of nursing B regarding insulin administration revealed nurses should have: *Cleaned the rubber seal on the insulin pen prior to attaching the needle. *Primed the insulin pen with two units prior to setting the insulin dose. *Held the needle in place for 10 seconds after injecting the insulin dose.	F 658	on the Hearing, Vision, Dental policy to ensure residents receive proper treatment and assistive devices to maintain their vision. The DON will educate all nurses on the Notification of Change of Condition policy to ensure that the physician and resident representative is notified of resident change of conditions. All education and competency will occur no later than February 11, 2023. Those not in attendance at the education session due vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit 5 insulin administrations to ensure professional standards of practice are followed when administering insulin to residents. The DON or designee will audit 5 residents to ensure their glasses fit appropriately and that they have attended scheduled optometry appointments to receive proper treatment as necessary. The DON or designee will audit 5 residents' medical records to ensure that the physician and resident representative have been of notified of resident change of conditions. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 658	Continued From page 7 4. Review of the provider's May 2016 Medication Administration Subcutaneous Insulin policy revealed: *The rubber seal should be cleaned with an antimicrobial agent. *A safety test should be performed prior to administering insulin by holding the insulin pen upward to ensure air bubbles rise and pressing the injection button to ensure insulin comes out of the needle. *To "slowly count to 10 before you withdraw the needle from the skin." 5. Observation and interview on 1/10/23 at 11:40 a.m. with resident 20 revealed: *Her eyeglasses were sitting crooked on her face. -On the right side of her face the glasses were about one-half inch above her eyebrow. -On the left side of her face the glasses were about one-fourth inch below her eyebrow. -She was not able to adjust them to fit her face correctly. *She stated, "I can't focus well due to the bifocals." *She had asked an unidentified staff member to help make an appointment to have them fitted to her face. -That staff member stated that perhaps her husband could help her with the appointment. *She was not able to make appointments for herself. *She stated, "The glasses are relatively new", and had not been fitted prior to her husband bringing her the glasses. *She had not been to an eye appointment to have them adjusted.	F 658		

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F 658	Continued From page 8 Review of resident 20's medical record revealed: *She was admitted on 3/2/21 and had multiple diagnoses that included breast cancer, heart failure, osteomyelitis of the vertebra, anemia, type 2 diabetes, glaucoma, malnutrition, bipolar disorder, peripheral vascular disease, left leg below the knee amputation, right leg above the knee amputation, and chronic kidney disease. *A 11/18/22 Brief Interview for Mental Status (BIMS), a screen used to assist with identifying a person's current cognition, the score was a 13 meaning she was cognitively intact. *Her progress notes included: -She had been to the optometrist on 5/21/22 for an appointment and ordered new glasses. --The next appointment was to be in six months. *Her care plan had a: -Focus of impaired vision due to Glaucoma. --Initiated intervention on 3/5/21 to arrange a consultation with her eye care practitioner as required. Interview on 1/11/23 at 1:56 p.m. with admissions director (AD) P regarding appointments revealed: *A nurse would schedule any appointment that was brought to their attention. *The social service designee, admissions coordinator, or business office manager would be able to assist with appointments. -There was no one staff member designated to ensure residents had scheduled appointments. *She was not aware of any issues with resident 20's glasses. *If glasses needed adjusting the social service director would coordinate and have been in charge of those appointments. Interview on 1/11/23 at 2:15 p.m. with AD P revealed she was unsure if resident 20 was able	F 658		

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F 658	Continued From page 9 to attend her eye appointment scheduled in November 2022. Interview on 1/12/23 at 11:27 a.m. with AD P regarding eye appointments for resident 20 revealed an eye appointment on 11/21/22 had been missed and was not rescheduled until surveyor inquiry on 1/12/23. Interview on 1/13/23 at 8:58 a.m. with licensed practical nurse C regarding appointments made for residents revealed: *Nurses make the appointments and if they do not have the time someone from the business office would have assisted the resident in making those appointments. *She was not aware resident 20 had missed an eye appointment. Interview on 1/13/23 9:01 a.m. with director of nursing B regarding appointments revealed: *Nurses made the appointments. *When residents appointment was missed "generally the nurse would do that [reschedule the appointment]." *She was not aware resident 20 had missed an eye appointment on 11/21/22. Review of the provider's March 2022 Hearing, Vision, Dental policy revealed: *The purpose of the policy was: -"To ensure that residents receive proper treatment and assistive devices to maintain vision, dental and hearing abilities. -The intent is to ensure the resident gains access to vision, dental and hearing services." *"The facility must, if necessary, assist the resident in making appointments and arranging the transportation to and from the office of a	F 658		

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F 658	Continued From page 10 practitioner specializing in the treatment of vision, dental or hearing impairment or the office of a professional specializing in the provision of vision, dental or hearing assistive devices or provide services by these professionals in-house if able." 6. Observation and interview on 1/10/23 at 9:01 a.m. with resident 36 revealed: *He was laying on his bed with his feet crossed watching television. *He said he felt dizzy all the time. -He told "everyone" that he was dizzy. -The staff had told him to relax and had given him Tylenol. -He wanted to see his doctor about his dizziness. --He was not sure if anyone had notified his doctor about the dizziness. -He hoped to go home soon. Review of resident 36's medical record revealed: *He had been admitted on 12/8/22 and his diagnoses included: stroke that affected his right dominant side, congestive heart failure, hypertension, anemia, and major depressive disorder. *His current care plan included: -A focus of remaining free of signs and symptoms or complications related to anemia. --Interventions included observing and reporting to his physician any signs and symptoms of anemia including dizziness. -A focus regarding, he was taking anti-anxiety medications. --A goal that he would be free from discomfort or adverse reactions related to his antianxiety therapy. --Interventions included observing and documenting side effects, including dizziness. *His medications included a 12/8/22 physician	F 658		

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F 658	Continued From page 11 order for buspirone HCl 5 milligram tablet [a medication used to treat anxiety] two times per day. -Side effects of the medication included dizziness. Interview on 1/11/23 at 2:26 p.m. with physical therapist (PT) L regarding resident 36's dizziness revealed: *He had complained of being dizzy all the time. *There had been interdisciplinary team meetings that included his concern of dizziness. Interview on 1/12/23 at 8:23 a.m. with director of nursing B regarding resident 36's dizziness revealed there was no documentation to support notification of the residents dizziness to the physician. Interview on 1/12/23 at 9:58 a.m. with physical therapist O regarding resident 36's dizziness revealed: *He reported more dizziness in the morning. *When therapy was completed in the morning he was more anxious and dizzier as compared to completing therapy after he had eaten and had taken his medications. *He had orthostatic hypotension (a form of low blood pressure that occurs when standing up from a sitting or lying position). *She had notified nursing and a blood pressure medication change was made. -That had not helped his dizziness. *His anxiety and dizziness had been a concern of his to be able to return home. Interview on 1/12/23 at 10:57 a.m. with director of nursing B regarding resident 36 revealed: *He had reported to the nurse "last weekend" that	F 658		

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F 658	Continued From page 12 he had some dizziness episodes. -That information had been documented. *He had reported his dizziness to the therapists. *He had a history of hypertension. *He had high blood pressure concerns and on 12/28/22 had been sent to the emergency room. -The physician had changed his blood pressure medication. --That had lessened his dizziness for a while. *He was on an anti-anxiety medication called risperidone which was also an antipsychotic medication. *One of the side-effects of antianxiety medications was dizziness. -He had been monitored for dizziness. *She confirmed his dizziness might be attributed to his antianxiety medication. -She had not reviewed why he would be dizzy all the time. *His physician had not been notified of the residents continued dizziness. Interview on 1/12/23 at 11:44 a.m. with licensed practical nurse F regarding resident 36's dizziness revealed: *He was administered a medication called buspirone and that causes dizziness. *She had not called the physician about the dizziness as the dizziness had not appeared to get worse. *She thought the buspirone medication was causing his dizziness. *She tried to administer his medications after meals as she thought that helped some with his dizziness. Interview on 1/12/23 at 11:53 a.m. with certified nursing assistant R regarding resident 36 revealed:	F 658		

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F 658	Continued From page 13 *He worked three twelve-hour days per week. -He took care of resident 36 on those three days each week. *Resident 36 reported he was dizzy "all the time". -He had reported the residents dizziness to the nurses each day that he worked with him. --He was unsure what the nurses had done regarding the dizziness. Review of the provider's December 2019 Notification of Change of Condition policy revealed: *"The facility will provide care to residents and provide notification of resident change in status." *"1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:" -"b. A significant change in the resident's physical, mental, or psychosocial status (i.e. [that is], a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; -c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);"	F 658		
F 675 SS=G	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the	F 675	1. Resident 52 was transferred to Aspire Incorporated, which is an agency that specializes in providing support to adults with intellectual disabilities lead to fulfilling lives on January 19, 2023. 2. All residents with unique and special needs are at risk for not being provided with appropriate activities to meet his/her sensory needs, isolation and being cared for by staff that lack the education to meet his/her unique needs. A full house	02/11/23

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F 675	Continued From page 14 resident's comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (52) had been: *Provided with appropriate activities to meet his sensory needs. *Free from isolation. *Cared for by staff that had been educated to meet his unique needs. Findings include: Resident 52 was admitted from a local group home on 8/18/22 and had multiple diagnoses that included Down syndrome, unspecified; autistic disorder; dysphagia, oral phase; and developmental disorder of scholastic skills, unspecified. Observation on 1/10/23 at 8:00 a.m. in the day room revealed: *There was a radio, two tables, two chairs, and some colorful fidget toys in the southeast corner of the room. *There were several recliners up against the west wall. *Resident 52, the only one in the room, was seated in his wheelchair in between two recliners. *He had two noticeable patches of hair that were shorter than the rest of the hair on his head. Observation on 1/10/23 at 11:23 a.m. in the day room revealed: *Resident 52 was sitting by himself near the radio, with the radio playing music. *With his body positioned facing the corner and his back to the room, he was moaning and	F 675	audit of all residents will be completed no later than February 11, 2023 to determine if residents with unique needs are identified to ensure they are provided with appropriate activities to meet his/her needs, free from isolation and staff providing care have been provided education to meet his/her needs. 3. The Administrator, DON and IDT in collaboration with the Medical Director thoroughly reviewed the provider's Resident Right's packet and Resident Dignity and Privacy policy, along with review of our vision statement "Our vision is to lead healthcare facilities back to a place where people are treated like people -one where care is more personal, empathetic, and customized to every individual ." The Administrator or designee will review the deficiency with all staff and share the observations that were identified during the survey. The Administrator or designee will educate all staff on the facility's vision statement, Resident Rights and Resident Dignity and Privacy. This education will include: Acknowledging residents as they pass by them sitting in common areas or in their room; provide interaction with a resident that has a positive outcome to share that with Administrator and/or DON so that it can be communicated with staff and included in the plan of care. The facility will review all potential admissions to determine if a unique need is identified and will ensure all staff are adequately trained to provide care to the resident. All education and competency will occur no later than February 11, 2023. Those not in	

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F 675	Continued From page 15 grunting every few seconds, and using his balled-up fists to rub his head. Observation on 1/10/23 from 12:10 p.m. to 1:04 p.m. in the dining room revealed: *Resident 52 was sitting in his wheelchair just outside the dining room doors. *At least five staff members walked past him without acknowledging him. *Resident 52's vocalizations became louder and more frequent. *At 12:59 p.m., a staff member wheeled resident 52 into the dining room, parked him at the assisted dining table and fed him his lunch. Observation on 1/10/23 at 3:19 .m. of resident 52 in his room revealed: *His call light was blinking. *The door was halfway open, the lights were dim, and his roommate was not in the room. *He was seated cross-legged on his bed facing the window, with his back to the door. *He was rocking back and forth, moaning and grunting every few seconds, using his balled-up fists to rub his head. *There was a cushioned mat on the floor next to his bed. Continued observation at 3:24 p.m. revealed certified nurse aide (CNA) D knocked on the door and entered the room. *She greeted him and asked if he was doing alright. *Offering no response, he continued rocking back and forth. *She turned off the call light and left the room stating, "He's a hard one because we can't tell what he needs."	F 675	attendance at the education prior to their shift worked. 4. The DON or designee will audit 5 resident's medical records, including all new admissions, to identify if a resident has a unique need and ensure all staff receive appropriate education to meet the resident's care and psychosocial needs. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 675	Continued From page 16 Observation on 1/11/23 at 9:57 a.m. in the hallway outside the dining room and near the day room revealed: *Resident 52 was sitting in his wheelchair in the middle of the hallway. *He was moaning and grunting every few seconds. *At times, he would ball up his fists and rub his head in the same two spots where his hair was shorter than the rest of the hair on his head. *At least two staff members walked past him without acknowledging him. Observation on 1/11/23 at 11:10 a.m. in the 200 hallway revealed: *Resident 52 was sitting in his wheelchair in the middle of the hallway. *He was sitting just outside the whirlpool room. -That section of hallway was particularly busy as it was near the nurse's station, the director of nursing office, and the business office. *Several staff members had walked past him without acknowledging him. *He continued to moan and grunt every few seconds. *He did not have any activities or items to occupy his time. Observation on 1/11/23 from 12:34 p.m. to 1:07 p.m. in the dining room revealed: *Residents had already been seated in the dining room. *Resident 52 was sitting in his wheelchair just outside the dining room doors. *No one assisted resident 52 to the dining room until administrator A wheeled him to his assigned spot at 12:54 p.m. *His meal was served at 1:07 p.m. and activity director Q assisted with feeding him.	F 675		

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F 675	Continued From page 17 Observation on 1/11/23 at 3:39 p.m. in resident 52's room revealed: *The door was mostly shut. *The lights were dim. *He was alone in his room. *Christian music was playing on the television. *Resident 52 was sitting cross-legged on his bed. -He was rocking back and forth. -He was continually moaning and grunting every so often. *There was a stuffed teddy bear sitting on his bedside table, out of reach. Confidential interview on 1/11/23 at 3:50 p.m. with a staff person revealed: *Staff did not bring resident 52 to any group activities. *One-to-one interactions with the resident were limited due to tight staffing schedules. *The staff were instructed to have resident 52 wait outside the dining room instead of sitting in the dining room with the other residents due to his moaning and grunting. -They usually had him wait in the hallway until his tray was set up and there was a staff member ready to assist him with his meal. *They had a few sensory toys in the day room, but no one had made the effort to find out what type of sensory items he enjoyed. -He did not have the cognition or sight abilities to reach out and grab an item. *Staff had a difficult time communicating with him and knowing what his needs were, such as: -When he was hungry or thirsty. -If he needed to go to the bathroom. -If he was sad, upset, tired, happy, etc. *He was not on a check and change schedule for incontinence cares.	F 675		

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F 675	Continued From page 18 *There was no education provided to them on how to: -Interact and communicate with resident 52. -Provide him with meaningful activities and enrichment. -Meet his social and mental wellbeing needs. Interview on 1/12/23 at 9:44 a.m. with certified nurse assistant (CNA) R about resident 52 and staff education related to the unique needs revealed: *He had been working at the facility for 24 years. *He usually did not work on the hallway that resident 52 lived on, but on occasion he would cover over there. *Since resident 52 was admitted in August 2022, there had been no education provided to staff on the unique needs the resident required. Observation on 1/12/23 at 2:51 p.m. of resident 52 in his room revealed: *He was sitting cross-legged on his bed. *Music was playing on the television. *He was alone. *He was moving his arms up and around his head, and at times would ball his fists up and rub his head. *He was moaning and grunting every so often. *The teddy bear was still sitting on his bedside table. *CNA D knocked on his door and entered. -She attempted to hand the teddy bear to him. -He was startled slightly at the introduction of the teddy bear as he shuddered suddenly and grunted. -He held the teddy bear for a few seconds, then threw it across the room. *The CNA picked up the teddy bear and placed it back on the bedside table.	F 675		

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F 675	Continued From page 19 Interview on 1/12/23 at 2:58 p.m. with CNA S about resident 52 revealed: *She and her coworkers had a hard time figuring out what resident 52 needed. *They based his needs on how agitated he became. -Such as, if he was squirming around or vocalizing more, they tried to determine what he needed. *She would usually turn on the music for him. *His attention span was not that long. *There were fidget toys in the day room, but he did not reach out for them. -He could not see very well, because his vision was highly impaired. *They would try to hand him things, but he tended to throw it away. *She had not been educated on the unique needs the resident required. *They went over that he was a two assist for care, but no other specific education was provided. Interview on 1/12/23 at 4:09 p.m. with activity director Q about resident 52 revealed: *He needed more appropriate placement where his needs could have been better met. *She believed he required more one-on-one care, which they were unable to provide. *She was unable to spend as much time as she would have liked with him and the other residents due to staffing issues. -She was also covering shifts in housekeeping, laundry, and as a CNA working on the floor. *Resident 52 tended to do a self-soothing motion, that was why he rubbed his head often. *When she did get the chance, she would provide physical touch enrichment through rubbing his back, putting lotion on his hands and arms, and	F 675		

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F 675	Continued From page 20 letting him feel different fabrics. *She could tell what kind of music he enjoyed because of his reactions. -He would become more agitated if he heard country music, but he seemed to enjoy classical and Christian music. *He did not like it when staff performed oral cares and would become increasingly agitated. -Oral cares included helping him brush his teeth, performing oral swabs, and helping him put lip balm on his dry/cracked lips. *She had previous education and experience on caring and interacting with people who had developmental disabilities. *The provider had not educated staff on resident 52's unique needs, such as how to communicate with him and how to provide meaningful activities that fulfilled his sensory needs. *She felt that some staff might have been timid of resident 52 because they were unsure how to interact with him. Interview on 1/12/23 at 5:13 p.m. with administrator A revealed: *Resident 52 deserved to be in a facility that had the capacity to meet his needs. *He was admitted from a group home in town for physical therapy rehabilitation in August 2022. *When he had completed rehab, the group home refused to readmit him. *They had a hard time trying to find placement for him due to requiring total assistance with care and activities of daily living. *Resident 52 was discharging to a different group home the following week. *Her staff did not have the background knowledge to care for a person with resident 52's diagnoses. -They should have provided an in-service to their	F 675		

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F 675	Continued From page 21 staff about resident 52, how to communicate with him, how to care for him, and how to meet all his needs. Interview on 1/12/23 at 5:59 p.m. with director of nursing (DON) B about resident 52 revealed: *She confirmed resident 52 was discharging the following week to a group home that could better meet his needs. *Her staff did not have the background knowledge to meet all the needs of a person with resident 52's diagnoses. *She indicated it would have been a good idea to educate the staff about resident 52, how to communicate with him, how to care for him, and how to meet all his needs Review of resident 52's care plan revealed: *He was to receive one-on-one sessions at least five times per week. *On 8/30/22, an intervention was added under the nutrition portion of his care plan which read, "Staff to not bring [resident 52] into the dining room until his food is at the table." *There was no information about: -Providing soothing touch enrichment. -The types of sensory items he had enjoyed. -The type of music he liked to listen to. -How staff could anticipate his needs. -That he disliked oral cares. -What staff should do if he refused care or became agitated. Review of resident 52's 11/16/22 quarterly Minimum Data Set assessment revealed: *His hearing was adequate. *He was rarely or never understood in terms of verbal and non-verbal communication. *He was rarely or never able to understand verbal	F 675		

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communication.
*His vision was highly impaired.
*He required extensive assistance of two or more people for toilet use, transferring, and bed mobility.
*He required extensive assistance of one person for locomotion on and off the unit, dressing, eating, bathing, and personal hygiene.
*He was always incontinent of bladder, and frequently incontinent of bowel.

Review of social services progress note from 10/18/22 revealed: "[DON B] expressed to [registered nurse from resident 52's previous group home] that this is not the appropriate setting for resident as he would benefit from more of a small group environment that would be able to provide more 1:1 attention."

Review of activity note from 11/16/22 at 10:26 a.m. by activity director Q revealed:
*"Activities such as movies, bingo, trivia, hangman have not been appropriate for him to participate due to him continually making loud noises."
*"[Resident 52] does some self-soothing activities, tapping his leg, rubbing his head etc..."
*"I have encouraged staff to interact with [resident 52] as frequently as possible. These interactions are not necessarily being charted as I am not necessarily informed when they occur."

Review of resident 52's one-to-one activity log for the past 30 days (from 1/11/23) revealed there were only 12 days out of the past 30 days when he received one-to-one activities.

Review of resident 52's independent activity log for the past 30 days (from 1/11/23) revealed:

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F 675	Continued From page 23 *There was a total of 10 days charted. *7 of the 10 days was recorded as "people/bird watching." *That activity would not be appropriate for resident 52 due to his highly impaired vision. Review of the provider's 10/12/22 Facility Assessment indicated they were able to admit residents with medical conditions such as Down syndrome, autism, and loss of vision. Review of the provider's September 2019 "Resident Dignity and Privacy" policy revealed: *Policy: -"It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment that maintains resident privacy." -"15. During meals, each table should be served at the same time." Review of the provider's resident rights packet revealed: *Residents have the right to "be treated with respect." -"You have the right to be treated with dignity and respect ..." *Residents have the right to "participate in activities." -"You have the right to participate in an activities program designed to meet your needs..." *Residents have the right to "be free from abuse and neglect." -"You have the right to be free from verbal, sexual, physical, and mental abuse. Nursing homes can't keep you apart from everyone else against your will."	F 675		

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F 686 F 686 SS=D	Continued From page 24 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of two sampled residents (4) who was dependent upon staff to assist her with activities of daily living (ADL) had been repositioned and had her care plan updated with new interventions after she developed a facility acquired pressure ulcer. *One of three sampled residents (4) had correct documentation related to staging of a pressure ulcer according to professional standards. *One of three sampled residents (23) with a facility acquired pressure ulcer had interventions in place to prevent her pressure ulcer from developing and worsening. *The resident's responsible party and the physician had been notified in a timely manner of the development the pressure ulcer for one of three sampled residents (23). Findings include:	F 686 F 686	1. No immediate corrective action could be taken for the failure to appropriately reposition resident 4. Resident 4's pressure ulcer was healed on 1/10/23. Resident 4's care plan has been reviewed and revised to prevent the development new pressure ulcers. Resident 23's pressure ulcer was healed on 9/20/22. Resident 23's care plan has been reviewed and revised to prevent the development of new pressure ulcers. No immediate corrective action could be taken for the failure to ensure that resident 23's responsible party and physician had been notified in a timely manner of the development of a pressure ulcer. 2. All residents are at risk for the lack of appropriate interventions to prevent the development of new pressure ulcers, lack of assistance with repositioning and failure to notify resident's responsible party and physician of the development of a pressure ulcer in a timely manner. All current residents' Braden Scales will be audited to identify their risk for pressure ulcers to ensure appropriate interventions are implemented and their care plans will be reviewed and revised accordingly no later than February 11, 2023. 3.Director of Clinical Services for Gentell, contracted wound care company, will educate all licensed nurses on the Skin Program policy to include identification and measuring of pressure ulcers, appropriate repositioning residents to prevent pressure injuries. All education	02/11/23

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F 686	Continued From page 25 1. Random observations on 1/10/23 from 9:27 a.m. through 12:00 p.m. and from 2:20 p.m. through 5:00 p.m. of resident 4 revealed she had been in bed, on top of an air mattress, and on her back with the head of her bed elevated. Review of resident 4's 11/28/22 quarterly Minimum Data Set assessment (MDS) revealed: *Her Brief Interview for Mental Status score was 7, indicating her cognition was severely impaired. *She had not exhibited any behaviors or rejection of care, that was unchanged from the prior assessment. *She was at risk for developing pressure ulcers. *She had a pressure reducing device for her bed and her chair. Review of resident 4's medical record revealed: *She was admitted on 3/6/20. *Her diagnoses included: chronic pain, chronic respiratory failure with hypoxia, vascular dementia, spondylosis of the lumbar region, and squamous cell carcinoma. *11/28/22 side rail assessment indicated she needed assistance to reposition or turn. *She had twenty-one Braden Scale assessment scores (used to determine the risk of developing a pressure ulcer) completed in 2022 and they all indicated she was at high risk for developing a pressure ulcer. *Wound documentation on: -12/6/22 she had a fluid filled blister to her left buttock, classified as a suspected deep tissue injury (SDTI). --A SDTI is a non-blanchable deep red, purple or maroon area of intact skin, non-intact skin or blood-filled blisters caused by damage to the underlying soft tissues of the skin.	F 686	will occur no later than February 11, 2023. Those 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. 4. The DON or designee will audit 5 residents at risk for pressure ulcers to ensure resident is being assisted to reposition appropriately to prevent pressure ulcers and care plan reflects appropriate interventions to assist in the prevention of pressure ulcers. The DON or designee will audit all residents with pressure ulcers to ensure they are being repositioned appropriately, appropriate interventions are in place to heal current pressure ulcers and prevent the development of new pressure ulcers, the pressure ulcer is staged appropriately, and the responsible party and physician have been notified of the pressure ulcer. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 686	Continued From page 26 -12/20/22 the wound to her left buttock was now classified as a stage III pressure ulcer (full-thickness skin loss potentially extending into the subcutaneous tissue layer of the skin). --A new wound to her coccyx (bone at the base of the spinal column) classified as a stage II pressure ulcer (partial-thickness skin loss into but no deeper than the thick layer of tissue under the top layer of the skin). -12/27/22 the wound to her left buttock was now classified as a stage II pressure ulcer. --A new wound to her right buttock classified as a stage II pressure ulcer. --There was no documentation regarding the pressure ulcer to her coccyx. -1/3/23 the wound to her left buttock was now classified as a stage I pressure ulcer (skin appears reddened and does not lose color briefly when you press your finger on it and then remove your finger). --There was no documentation of the pressure ulcers to her coccyx or her right buttock. -1/10/23 Her left buttock was healed with scar tissue noted at the site. --There was no documentation of the pressure ulcers to her coccyx or her right buttock. Review of resident 4's turning and repositioning documentation from 11/13/22 through 1/12/23 revealed she was not turned and repositioned every two hours. Review of resident 4's last reviewed 1/3/23 Care Plan revealed: *She needed extensive assist of two staff members for bed mobility. *She was always incontinent of bladder. *She was at risk for skin breakdown related to immobility and incontinence.	F 686		

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*"Air mattress to bed to relieve pressure."
*"[Resident's name] is on a turn/reposition approximately every 2 hours, more often as needed or requested."
*"[Resident's name] utilizes an ROHO w/c [wheelchair] cushion."
*"[Resident's name] utilizes bilateral assist rails to assist with bed mobility."
*"Bilateral heel protectors on at all times. Staff to encourage me to wear them[.] I often refuse to wear them as they make me too hot."
*It did not include any information on her refusal to let staff assist her with repositioning.
*There had been no interventions added after she developed the pressure ulcer on her left buttock on 12/6/22.

Interview on 1/10/23 at 2:35 p.m. with registered nurse (RN) K revealed all of resident 4's pressure ulcers were healed.

Interview on 1/12/23 at 3:27 p.m. with director of nursing (DON) B regarding resident 4 revealed she:
*Refused to get out of bed.
*Did have an air mattress but refused to lay flat and often had the head of the bed up.
-When the head of the bed was elevated it could cause a flat spot in the mattress and that could result in pressure to the resident's body.
*Thought resident 4 could reposition herself and refused to let staff reposition her at times.

Interview on 1/13/23 at 10:05 a.m. with certified nursing assistant (CNA) D regarding resident 4 revealed:
*She could not reposition herself.
*It took two staff to turn and reposition her.
*Staff did not always turn her every two hours

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because they did not have time or they would forget to reposition the resident.
*They did attempt to turn her every two hours.
*She would at times refuse care but then would agree and let them turn and change her incontinent briefs.

Interview 1/13/23 at 10:34 a.m. with licensed practical nurse (LPN) C regarding resident 4 revealed:
*Resident 4 was supposed to have been turned and repositioned every two hours but that did not always get done.
*She had never heard resident 4 refuse care.
*Resident 4 was not able to reposition herself in the bed because she could not move herself from the waist down.

Continued interview on 1/13/23 at 10:45 a.m. with DON B regarding resident 4 revealed:
*If a SDTI opened up and a wound bed could be seen then it could have been changed to a stage IV pressure ulcer.
*A pressure ulcer can never be downgraded, if it starts at a stage IV then it is always a stage IV until it heals.
*The provider contracted with a wound care company to assist with wound care needs and training.
*DON B and RN K had gone to a wound care training in July 2022.
*11/28/22 all nurses attended an in-service provided by the contracted wound care company to learn about wound care.
-It had included staging of pressure ulcers.
*Resident 4 probably did not get turned and repositioned every two hours but the staff was trying.
*She was not aware resident 4 was unable to

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reposition herself.
*When she assisted resident 4, resident 4 was able to use the side rail to assist in turning herself.
*There had not been any new interventions put into place after resident 4 had developed the pressure ulcer 12/6/22 to prevent her from developing any other pressure ulcers.

2. Review of resident 23's medical record revealed:
*She was admitted on 5/25/21.
*Her diagnosis included: transient ischemic attack and cerebral infarctions and Alzheimer's disease.
*On 7/15/21 her Braden Scale assessment score showed she was at high risk for developing a pressure ulcer.
*On 12/15/21 her Braden Scale assessment score showed she was at high risk for developing a pressure ulcer.
*Wound documentation revealed on:
-7/22/21 she developed an unstageable pressure ulcer to her left heel.
--Interventions put into place were heel protectors and to apply Skin-Prep (used as protection) to the area twice a day.
--There was no documentation that her family or physician had been notified of the pressure ulcer.
-8/9/21 the pressure ulcer to her left heel was healed.
--There was no documentation that her family or physician had been notified the pressure ulcer was healed.
-12/20/21 the unstageable pressure ulcer to her left heel had redeveloped.
--There was no documentation that her family or physician had been notified of the pressure ulcer until 3/24/22.
-The physician's treatment order for the pressure

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F 686	Continued From page 30 ulcer had been changed eight times from 12/20/21 through 9/20/22. -No new interventions had been added to the care plan until 3/22/22 when the heel protectors were discontinued and bilateral Podus boots had been added. *Lab testing had confirmed infection to the pressure ulcer on her left heel and she had been treated with two antibiotics starting 3/9/22. Interview on 1/11/23 at 2:24 p.m. with physical therapist L regarding resident 23 revealed: *She had developed the pressure ulcer from using her heel to propel herself in her wheel chair. *When the pressure ulcer was first found in December 2021 it was just a brown area and then it had opened up. *She had received therapy services to assist with wound healing. Interview and care plan review on 1/12/23 at 11:51 a.m. with director of nursing (DON) B regarding resident 23 revealed: *There was no notification of family or physician regarding the pressure ulcer on 7/22/21. *The internal investigation form indicated the family and the physician were notified of the pressure ulcer development on 12/20/21. -The internal investigation form was not part of the medical record. *Interventions in place upon admission included: -5/25/21 Nutrition and hydration to promote healthy skin. -6/9/21 Encourage her to elevate her feet to prevent edema. -6/1/21 Using bilateral Tensoshapes (provides compression and promotes improved blood flow) on lower legs for edema.	F 686		

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F 686	Continued From page 31 -6/9/21: --To wear appropriate footwear when propelling herself or transferring. --Apply barrier cream every shift. Did not specify where to apply the cream. ---DON B stated the barrier cream was applied by staff to prevent breakdown from incontinence episodes. *Once a resident developed a pressure ulcer then a Braden Scale assessment would be completed weekly. *All mattresses in the facility were pressure relieving devices and all residents had pressure relieving cushions in their wheelchairs. *On 7/29/21 an air mattress was placed on her bed. *Heel protectors would not have relieved pressure to the heels, but the Podus boots put in place later did relieve pressure on the heels. *Podus boots started on or around 3/22/22 after recommendation from the therapy department, up until then she was wearing the heel protectors. *She was unsure why the Podus boots had not been started earlier as she stated they do relieve pressure to the heels. *After she redeveloped the pressure ulcer on 12/20/21 no other interventions were put into place to prevent further breakdown until March 2022 when the Podus boots where initiated. *She thought the pressure ulcer had developed from her rubbing her heels while propelling in the wheelchair. 3. Review of the documents provided from the 11/28/22 wound care in-service provided to all the nurses revealed: *What should always be included in a wound assessment. *To never backstage a pressure ulcer as it	F 686		

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F 686	Continued From page 32 improved during the healing process. Review of the provider's April 2021 Skin Program policy revealed: *"To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical condition demonstrates that they were unavoidable." *An immediate prevention plan should be implemented when a potential skin alteration is identified.	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	F 692	1. Family/responsible party and provider for resident 23 notified of weight changes and current plan. 2. All resident's weights were obtained. All residents who triggered for a significant weight loss were reviewed on 1/25/2023 and 1/27/2023. Any resident who triggered a significant weight loss were reviewed by RD and DON, and all families and providers were notified of weight change and current interventions. All care plans of triggered residents were updated to reflect current interventions. 3. The IDT will be educated by the Registered Dietician (RD)by Feburary 11, 2023, on the elements of weight loss and notification to family/responsible party and resident provider. The DON or designee will evaluate weight loss weekly and report weight loss to families and providers. The DON and RD or designee will determine which residents need weekly weights. 4. The DON or designee will audit resident significant weight losses weekly	02/11/23

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F 692	Continued From page 33 Based on observation, interview, record review, and policy review, the provider failed to ensure: *The nutritional status was monitored for one of two sampled residents (23) who had a significant weight loss and was nutritionally at risk. *The family, physician, and a registered dietician (RD) had been notified of a significant weight loss for one of two sampled residents (23). Findings include: 1. Observation on 1/10/23 of resident 23 revealed at: *11:56 a.m. she was sitting at the dining room table waiting to be served lunch. -She appeared thin. *12:59 p.m. she was served her tray and was able to feed herself after set-up assistance and verbal cues from a staff person sitting across the table. Review of resident 23's medical record revealed: *She had been admitted on 5/25/21. *Her diagnoses included: a history of transient ischemic attack and cerebral infarction, gastroesophageal reflux disease without esophagitis, Alzheimer's disease, unstageable pressure ulcer of left heel, and dysphasia. *Her weight on: -9/27/21 was 162 pounds. -2/16/22 was 152.8 pounds. -3/26/22 was 155 pounds. -4/1/22 was 136 pounds. --That was a 19 pound weight loss in six days. -5/9/22 was 134.3 pounds. *3/24/22 progress note written by director of nursing (DON) B indicated the resident's daughter-in-law wanted to be notified of any changes in resident or her care. *Progress note written by DON B on 4/25/22	F 692	to ensure provider and family notification occurs for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 692	Continued From page 34 addressed her pressure ulcers and nutritional supplements, but had not addressed her weight loss. *There was no documentation the family or the physician had been notified of the weight loss. Review of the progress notes written by a RD on: *3/30/22 revealed: -She was followed related to her pressure ulcers and weight loss. -"Resident's weight appears to be rebounding back toward admission weight." -"Favorable weight gain of 12.8 # [pound] (9%) x [times] 90 days." -She was receiving: fortified hot chocolate and super cereal at breakfast; fortified cookie and Reese's peanut butter cups at 3 pm [3:00 p.m.] snack; fortified milk, extra butter, high cal [calorie] juice [at] all meals; Juven 8 oz. [ounce] BID [twice a day], magic cup QDay [every day]." -No new recommendations were made. *5/31/2022 revealed: -"Resident is followed at high risk r/t [related to] pressure ulcer and significant weight loss. -Weights: --5/9/22: 134.3# --4/1/22: 136# --2/16/22: 152.8# --11/1/21: 152# -"Weight loss of 18.5# (12%) x 90 days. RD to add fortified pudding to lunch and supper menu. Unfortunately, continued weigh loss is expected as disease progresses." -"Diet: Regular, mechanical soft, no coffee/tea, utilizes inner lip plate, Dycem, and Kennedy cups. -Intake: 50-100% of most meals. Inconsistent snack acceptance. -Supplement: Fortified hot cocoa and super cereal at breakfast; fortified milk, [e]xtra butter,	F 692		

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F 692	Continued From page 35 high cal juice all meals; fortified cookie 3 pm snack." Review of a Long-Term Care progress note from a certified nurse practitioner on 4/26/22 regarding resident 23 revealed: *"She continues to eat well and weight is maintained, nursing denies additional concerns today." *Weight recorded in the note was 136.2 pounds. Review of resident 23's last reviewed 10/26/22 care plan revealed: *"[Resident's name] was at risk for alteration in nutritional status related to: an mechanical soft diet and Alzheimer's disease." *The goal revised on 5/31/22 stated: "[Resident's name] will be free from signs and symptoms of dehydration or malnutrition through the review date." *An intervention for: -Referral to RD to observe for any dietary needs had been added on 3/14/22. -"Supplements per RD recommendations" had been added on 5/24/22. Interview on 1/11/23 at 3:37 p.m. with DON B regarding resident 23 revealed: *There was no documentation the resident's family or physician had been notified of her weight loss. *The extra fortified foods that were given per the RD recommendations are not documented separately so she was unable to determine if the resident was accepting the fortified foods regularly. Interview on 1/12/23 at 3:03 p.m. with DON B regarding resident 23 revealed:	F 692		

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F 692	Continued From page 36 *A weight and wound meeting was held monthly with the interdisciplinary team, speech therapist, and RD. *During that meeting weights and wounds were reviewed. *A weight report for all residents was reviewed to monitor for changes. *After the first interview above she had reviewed resident 23's meal intake amounts prior to the weight loss on 4/1/22 and did not see a change. *She did not know what caused the weight loss. *Weights were monitored monthly. *All residents were weighed monthly unless ordered differently by a physician or nurse. *She had been treated for an infection in her left heel pressure ulcer with antibiotics for 10 days in March of 2022. -That could have caused her to lose her appetite. *The resident's weight loss had not been investigated. *The family, physician, and the RD had not been notified of the weight loss when it occurred. *It was her responsibility to notify the RD when a resident was noted to have weight loss. *She had not notified the RD about resident 23's weight loss. *The RD had not documented regarding the weight loss until 5/31/22. Interview on 1/13/23 at 8:44 a.m. with speech therapist E regarding resident 23 revealed: *She attended the monthly weight and wound meeting. *Resident 23 had been discussed at the 4/25/22 meeting for her pressure ulcer but not for her weight loss. *There was not a weight and wound meeting in May 2022 due to a COVID-19 outbreak. *Nursing or RD brought a weight report for all	F 692		

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residents to see who has triggered for weight loss loss during the monthly weight and wound meeting.
*She had resident 23 on case load from 2/22/22 through 4/19/22.
*On 3/1/22 her diet was changed from a regular diet to regular diet mechanical soft texture with fortified hot cocoa and super cereal at breakfast. Reese's peanut butter cups for a 3:00 p.m. snack. Fortified milk at meals. Inner lip plate, Dycem, and Kennedy cups.
*She was not aware resident had a weight loss.

Review of the provider's December 2019 Notification of Change of Condition policy revealed:
*"The facility will provide care to residents and provide notification of resident change in status."
*"1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:"
-"b. A significant change in the resident's physical, mental, or psychosocial status (i.e. [that is], a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;
-c. A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment);"

Review of the provider's January 2021 Weighing the Resident policy revealed:
*"The purpose of this procedure is to determine the resident's weight and height, to provide a baseline and an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and

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F 692	Continued From page 38 to provide a baseline height in order to determine the ideal weight of the resident." *"3. Weight is measured upon admission, weekly for four weeks, and then monthly (or per physician order) thereafter." *"5. Report significant weight loss/weight gain to the nurse supervisor who will then report to the RD and physician."	F 692		
F 802 SS=D	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to ensure three of three interviewed dietary staff (certified nurse assistant/cook G, cook I, and dietary aide J) had appropriate training and knowledge about: *How to test sanitizer solution concentration.	F 802	1. Resident 111 attended Resident Council on January 24, 2023 to address that all items on the menu displayed for the day will be offered. All residents attending resident council were notified that all dietary staff will receive education on providing meals with all items on each menu displayed in the dining room daily. 2. All residents are at risk for preferences not being met when the menus are not displayed correctly in the dining room. All residents are at risk if improper sanitation is used to clean and sanitize in the kitchen. All residents are at risk if the dishwasher is not de-limed correctly. 3. Meal substitutions must be posted before each meal if a change has been made by the dietary staff. The Regional Culinary Operations Manager (CDM) educated all dietary staff by February, 11, 2023 on posting all menu items that are daily in the dining room, including any food substitutions. All dietary staff including staff member, G, I and J will be trained by February 11, 2023 on how to communicate food substitutions to residents and how to	02/11/23

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F 802	Continued From page 39 *How to de-lime the dishwasher. *What to do if a menu item needed to be substituted. Findings include: 1. Observation and interview on 1/11/23 at 10:13 a.m. with certified nurse assistant (CNA)/cook G in the kitchen revealed she: *Was washing dishes in the three-compartment sink. *Indicated she did not know how to test the concentration of the sanitizer solution in the three-compartment sink. *Did not know where the testing strips were stored. *Did not get "really any training on anything" on dietary department procedures when upper management asked her to cover cooking shifts in the kitchen. *Indicated there was no dietary manager. Observation and interview on 1/11/23 at 10:22 a.m. with dietary aide J regarding cleaning procedures in the kitchen revealed she: *Was washing dishes in the dish room at the time of the interview. *Had been working in the dietary department since September 2022. *Had not been trained on how to delime the dishwasher properly, and how to test the concentration of the sanitizer solution in the three-compartment sink. *Stated her training for the dietary department consisted of on-the-job training for about a week. Observation and interview on 1/11/22 at 12:50 p.m. with resident 111 in the dining room revealed: *The menu for lunch was roast beef, beef gravy,	F 802	sanitize, clean, and test the dietary equipment. Prior to any new members of IDT or new dietary staff working in the kitchen, they will receive training by CDM or designee on how to communicate food substitutions to residents and how to sanitize, clean, and test the dietary equipment. 4. The Administrator or designee will audit five meal services weekly for three months to meal substitutions were posted prior to the meal. The Administrator or designee will audit three times per week to ensure sanitizer testing strips are available, testing of sanitizer is completed, and cleaning of the dietary equipment is completed. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendations for continuation/ discontinuation/revision of audits based on audit findings.	

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F 802	Continued From page 40 steamed broccoli florets, dinner roll, and applesauce spice cake. *Residents were served beef tips, mashed potatoes with beef gravy, steamed broccoli florets, and cake. -No dinner rolls were served, and an alternate was not provided. *Resident 111 voiced that he was upset he did not have the dinner roll, or even a piece of bread with his meal. Interview on 1/12/23 at 12:35 p.m. with CNA G regarding the previous day's lunch service revealed: *She was the main cook for lunch on 1/11/23. *The menu indicated residents should have received a dinner roll with their meal. -A dinner roll was not provided to any of the residents. -No substitute was provided either. *CNA G said she did not know how to bake the dinner rolls. *She was not aware that she needed to substitute a food item when they did not have what was on the menu. Interview on 1/12/23 at 4:39 p.m. with cook I about proper dishwashing procedures revealed he: *Indicated he did not know how to test the concentration of the sanitizer solution in the three-compartment sink. *Was unsure where the testing strips were stored. *Had not received training on how to properly set up the three-compartment sink. Review of dietary staff training records revealed: *CNA G, cook I, and dietary aide J had all received education on the following topics within	F 802		

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F 802	Continued From page 41 the past 12 months: food safety, handwashing, food handling and preparation, foodborne illnesses, serving and distribution, handling leftovers, time and temperature controls, nutrition and hydration, and sanitation.	F 802		
F 809 SS=F	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, resident council minutes review, and policy review, the provider failed to serve six of six meals observed throughout the survey in a timely manner and per posted scheduled mealtimes. Findings include: 1. Observation on 1/10/23 at 8:36 a.m. in the dining room revealed the posted mealtimes were	F 809	1. All residents, including the identified residents 26,27,29,37,40,51,52,54,111 and 112, were invited to a resident council on 1/24/2023 to discuss meal times and facility plan to ensure residents are served their meals as posted in the dining room. 2. All residents are at nutritional risk related to meal service being delayed past posted times. 3. Mealtimes were adjusted to begin meal trays one half before posted meal times in the dining room. The dining room service will be at 8:00 am, 12:00 pm, and 6:00 pm each day. The residents will be offered beverages upon request as they wait for meal service. All staff, including dietary staff, will be educated by February 11, 2023 by Regional Culinary Operations Manager CDM on new service times to ensure residents receive three meal times daily as posted. 4. The Administrator or designee will audit five meals weekly to ensure that the residents' meals are served per posted times. Audits will be weekly for three months. Results of the audits will be discussed at monthly QAPI meeting with IDT present for continuation/discontinuation/revision of audits based on audit findings.	02/11/23

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F 809	Continued From page 42 7:30 a.m. for breakfast, 11:30 a.m. for lunch, 5:30 p.m. for supper. Interview on 1/10/23 at 9:10 a.m. with resident 36 revealed that "every meal is late." Interview on 1/10/23 at 12:00 p.m. with resident 111 about the timeliness of meals revealed: *The aides had started to gather residents in the dining room at around 11:10 a.m. *He said, "I'm wondering if we're going to eat today because it's so late." *He mentioned that meals were late every day. Observation on 1/10/23 from 12:00 p.m. to 1:10 p.m. of the lunch meal service in the dining room revealed: *At 12:10 p.m., residents in the dining room had not been served yet. *At 12:23 p.m., dietary staff finished preparing room trays, and the room tray cart was wheeled out of the dining room. *At 12:24 p.m., the first resident in the dining room was served their meal. *By 1:04 p.m., all residents in the dining room had been served their meal. Interview on 1/10/23 at 3:13 p.m. with a member of the nursing staff who did not want to be identified revealed: *They did not administer resident's insulin until the meal was in front of the resident. *At times, they would have to wait up to two hours after the scheduled insulin administration time. Observation on 1/10/23 from 5:22 p.m. to 5:50 p.m. in the dining room revealed: *At 5:22 p.m., residents started to enter the dining room.	F 809		

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F 809	Continued From page 43 *By 5:50 p.m., All residents who choose to eat in the dining room were seated, and the supper service had not started yet. Observation on 1/11/23 at 10:07 a.m. in the dining room revealed there were 12 residents still eating breakfast, and dietary staff were clearing tables. Observation on 1/11/23 from 12:32 p.m. to 1:13 p.m. of the lunch meal service in the dining room revealed: *At 12:32 p.m., residents who chose to eat in dining room were seated at their tables, and dietary staff were preparing room trays. *At 12:39 p.m., staff started to serve the residents in dining room. *At 12:43 p.m., staff delivered the room trays to the 200-hallway. *Interview during the dining observation at 12:50 p.m. with resident 111 revealed: -Nursing staff came to his room at 11:00 a.m. to let him know that lunch was going to start soon. -He arrived in the dining room at 11:10 a.m. -It was an everyday occurrence that residents would sit in the dining room for about an hour and a half waiting for the meal to start. -At 12:59 p.m., resident 111 was finally served his meal. *At 12:54 p.m., the final resident (52) was brought into the dining room. *By 1:05 p.m., all the residents in the dining room had been served their meal. Observation on 1/11/23 at 1:50 p.m. in the dining room revealed: *There were five residents still in the dining room with plates of food in front of them. -Three of the residents appeared to be sleeping with their heads tipped downward and their eyes	F 809		

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F 809	Continued From page 44 closed. *Dietary staff were clearing tables and cleaning the dining room. Interviews on 1/12/23 from 10:00 a.m. to 11:06 a.m. during the resident council meeting revealed: *Residents in attendance included: 26, 27, 29, 34, 37, 40, 51, 54, 111, and 112. *Residents 29 and 34 voiced that their room trays were usually cold by the time it is delivered to them. *Residents 26, 27, 40, 51, 111, and 112 all ate in the dining room and voiced concerns that mealtimes were always late. -Mealtimes were usually about an hour or more late. -They were not usually offered any beverages or activities to keep them occupied while they waited. --They had requested to be served coffee while they waited for meals at the resident council meeting in November 2022. Observations and interviews on 1/12/23 from 12:15 p.m. to 12:35 p.m. of dietary staff in the kitchen revealed: *Assistant dietary manager H indicated she had the meal ready to go at 11:00 a.m. *She put the food items in the steam table at 11:15 a.m. *Both assistant dietary manager H and certified nurse assistant/cook G indicated their biggest obstacle with getting meals served on time was finding enough staff to deliver plates to the residents. -They radioed the nursing staff when they were ready to serve lunch, but the usual reply was, "We're busy right now."	F 809		

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F 809	Continued From page 45 *The dietary staff started to plate up the room trays at 12:22 p.m. *Assistant dietary manager H indicated she only worked two days a week to cook, clean the coolers of expired food, and submit the food order. Observation on 1/12/23 at 2:09 p.m. revealed that staff were still assisting residents with their lunch in the dining room. Interview on 1/12/23 at 5:05 p.m. with administrator A about the meal service times revealed: *She was aware that the meal service times were an issue. -Residents complained about the meal service times "a couple of months ago" in resident council. *She was planning on addressing the issue in the next quality improvement meeting. *Even though she had been aware of the meal service time issue for several months, they had not started a process yet to try to improve meal service timeliness. *She was going to coordinate meal service times with nursing to coincide with medication administration. *She needed to speak with resident council before changing mealtimes. Review of resident council minutes from 8/18/22 revealed: *In the "New Business" section: -"Meals are being served late. Breakfast is being served as late as 9AM [9:00 a.m.] and [lunch] being served at noon." -"This is generally due to CNAs not coming to help serve meals."	F 809		

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F 809	Continued From page 46 -"The kitchen staff may have the meal ready but when CNAs are walkied [radioed] to come help serve they respond that they are busy." -Six of six residents were documented as sharing the concern. *There was no evidence of follow-up documentation with the concerns identified in the resident council minutes binder. Review of resident council minutes from 11/18/22 revealed: *In the "New Business" section under letter B: -"Residents would like coffee available while waiting for their meal." *In the attached "Concern/Response Form," the concern about residents wanting coffee during meal wait times was referred to a cook, director of nursing B, and administrator A. *In the attached "Teachable Moment Form," the education provided to staff indicated, "We will place a small pot of coffee out and residents may be served coffee prior to meal if they request coffee...Dining room meals should be served promptly once the window is open staff need to be available after room trays go out." Review of the provider's July 2018 Meal Hours policy revealed: *Policy: -"Three meals a day are offered at regularly scheduled hours." *Procedure: -"2. The Director of Food and Nutrition Services or other clinically qualified nutrition professional is responsible for seeing that the established meal hour deadlines are met." Review of provider's 2018 Dining Room Service policy revealed:	F 809		

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F 809	Continued From page 47 *Procedure: -"4. ...Dining rooms should be served promptly."	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one kitchen was maintained to ensure a clean environment. *Four of four boxes of food and new coffee mugs were not stored on the floor. *Two of three dietary staff (assistant dietary manager H and dietary aide J) had washed their hands prior to handling and serving food to the residents. Findings include:	F 812	1. Facility kitchen will be cleaned including refrigerators, dishwasher, floors, and dishwasher by February 11, 2023. All items stored on floor in kitchen were removed on January 13, 2023. 2. All residents at risk if food is not stored, prepared, or distributed with professional standards. All residents are at risk if food handlers do not use proper hand hygiene prior to preparing food. 3. Regional Culinary Operations Manager, CDM Cleaning reviewed and revised storage and cleaning procedures and all dietary staff including staff members H and J will be trained no later than February 11, 2023. 4. The Administrator or designee will audit five meal services for observation of hand hygiene prior to serving weekly for three months. The Administrator or designee will audit cleanliness of kitchen, including floors, storage of food and equipment, and completion of cleaningchecklist three times per week for three months. Results of the audits will be discussed at monthly resident council for the next three months by Administrator or designee and at the monthly QAPI meeting with IDT present for continuation/discontinuation/revision of audit based on audit findings.	02/11/23

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F 812	Continued From page 48 1. Observation on 1/10/23 at 8:36 a.m. in the dish room revealed: *The outside surface of the dishwasher was contaminated with rust and limescale buildup. *There were unidentified crusty pieces sitting on top of the dishwasher. *The majority of the floor in the dish room was stained with an unidentified white and yellowish stains. -Most of the stain was concentrated under the dishwasher and close to the walls. Observation on 1/10/23 at 9:07 a.m. in the kitchen revealed: *The bottom shelf in the milk refrigerator had yellow-colored spilled milk residue. *The inside surfaces of both ovens were covered with splatters of burnt food. Interview on 1/11/23 at 10:22 a.m. with dietary aide J about cleaning duties revealed: *She had not been trained on how to clean and de-lime the dishwasher. *They had a cleaning checklist, but she did not know where to find it. Interview on 1/12/23 at 12:15 p.m. with assistant dietary manager H about cleaning duties revealed she: *Worked part-time twice a week. *Was not aware of the spilled milk residue in the refrigerator. *Was aware that the ovens were dirty. *Did not remember when the last time the oven was cleaned. *Said the oven was supposed to be cleaned about once a month. On 1/11/23, a copy of the provider's cleaning	F 812		

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	435047	A. BUILDING _____ B. WING _____	01/13/2023

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F 812	Continued From page 49 checklist was requested. *The most recent cleaning checklist that was provided was from September 2022. Review of the provider's 2018 "Cleaning Schedules" policy revealed: *Policy: -"The Food and Nutrition Services staff shall maintain the sanitation of the Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional." *Procedure: -"1. The Director of Food and Nutrition Services or other qualified nutrition professional shall record all cleaning and sanitation tasks for the Food and Nutrition Services Department." -"2. A cleaning schedule shall be posted with tasks designated to specific positions in the department." 2. Observations on the following dates and times in the kitchen revealed: *On 1/10/23 at 8:36 a.m. and 9:28 a.m., there was one box of new coffee mugs sitting on the stained floor in the dishroom, and there were three boxes of food sitting on the floor in the dry storage room. *On 1/11/23 at 10:09 a.m., the boxes were still sitting on the floor. *On 1/12/23 at 11:56 a.m., the boxes of food had been put away, but the box of new coffee mugs were still sitting on the stained floor in the dish room. *On 1/13/22 at 10:40 a.m., the box of coffee mugs was still sitting on the floor.	F 812		

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F 812	Continued From page 50 3. Observation on 1/12/23 from 12:15 p.m. to 12:35 p.m. of lunch service in the kitchen revealed: *Assistant dietary manager H and dietary aide J were preparing to serve lunch. *Neither one had performed hand hygiene before starting to serve lunch. -Dietary aide J walked from the dish room, where she had been washing dirty dishes, over to the steam table to help assemble meal trays without performing hand hygiene. Interview on 1/11/23 at 5:16 p.m. with registered dietitian consultant (RD) M about the services she provided revealed she: *Came to the facility once per month. *Would conduct a meal service audit. *Provided on-the-spot education and monthly in-services for dietary staff. -She consistently had to reeducate staff on food safety, hand hygiene, and kitchen cleanliness. *Was aware there was no dietary manager. Interview on 1/12/23 at 4:39 p.m. with administrator A about the dietary department revealed she: *Was aware of the ongoing concerns within the dietary department. *Agreed the kitchen needed to be maintained in a more clean and sanitary manner. *Indicated that the facility's quality improvement program was set to address the issues in the dietary department, but they had not developed a plan for improvement yet.	F 812		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance	F 865	1. Immediate corrections have been made for all residents affected with a deficient practice.	02/11/23

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F 865	Continued From page 51 improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full	F 865	2. All residents are at risk. Audits will be performed to ascertain compliance with facility policies and regulations and will be discussed at monthly QAPI as needed. 3. The IDT will be educated by the RDO or designee no later than February 11, 2023 on the elements of an effective process improvement program. 4. The RDO and/or RNC will attend monthly QAPI for three months and offer support and guidance. Need for continuation will re-evaluated at that time.	

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F 865	Continued From page 52 range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect	F 865		

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F 865	Continued From page 53 organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and quality assurance and performance improvement (QAPI) plan, the provider failed to ensure performance improvement projects (PIP) had been thoroughly implemented, monitored, and resolved with an effective QAPI process. Findings include: 1. Interview on 1/13/23 at 10:44 a.m. with administrator A revealed: *The provider held QAPI meetings monthly. *Most often the CASPER (Certification and Survey Provider Enhanced Reporting system) report was used to identify care issues. *They used information from their electronic	F 865		

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F 865	Continued From page 54 health record keeping system, grievances, and resident council minutes. *They would rank identified issues and then prioritized the issues from that listing. *They did not have any current PIPs in place. Review of the QAPI Member 2022 list provided by the administrator on 1/10/23 revealed: *The QAPI committee members were: -Administrator A. -Director of nursing B. -The assistant director of nursing. -The infection control nurse. -The social service director. -Activities director Q. -The human resource director. -The assistant dietary manager. -The business office manager. -The medical record/supply manager. -Minimum Data Set (MDS) coordinator/registered nurse (RN) N. -The maintenance director. -The housekeeping director. -The registered dietician. -The director of rehabilitation. -The medical director. Review of the provider's 7/30/20 QAPI policy revealed: *"2) The QAPI must address all systems of care and management practices and include clinical care, quality of life, and resident choice. It should utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents." *"3) The members of the QAPI committee must meet at least quarterly and as needed to	F 865		

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F 865	Continued From page 55 coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary." *"They must also develop and implement appropriate plans of action to correct identified quality deficiencies." Review of the provider's 2021 Quality Assurance and Performance (QAPI) Plan revealed: *"When the need is identified, we will implement corrective action plans or performance improvement projects to improve processes, systems, outcomes, and satisfaction." *"Our committee will prioritize topics for PIPs based upon current needs of the resident and our organization." *"Avantara Pierre will use data at every QAPI Committee to ensure performance measures are meeting QAPI goals." -That data was to come from: "input from caregivers, residents, families, and others, adverse events, quality measures/performance indicators, Survey and Living Center Annual Performance Assessment (LCPA) findings, complaints, and consultant reports." Refer to F657, F802, F809, and F812.	F 865		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2023
FORM APPROVED
OMB NO. 0938-0391

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 1/10/23 through 1/13/23. Avantara Pierre was found in compliance.	E 000		

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

Administrator 2/06/2023

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

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 1/11/23 through 1/12/23. Avantara Pierre was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K321, K324, and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 321 SS=D	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 Separation N/A — Automatic Sprinkler a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	1. All residents are at risk. The door noted in the deficiency is now self-. closing in accordance with Hazardous Enclosure NFPA 101 CFR guidelines as of January 15,2023. 2. Administrator will in-service maintenance director to ensure the facility follows the self-closing door guidance by February 11, 2023. 3. Administrator or designee will complete monthly audits for 4 months to ensure self-closing doors comply with regulation. Results of audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance/ discontinuance of audits. 4. February 11, 2023.	02/11/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/06/2023

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

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K 321	Continued From page 1 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: Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (kitchen pantry) as required. Findings include: 1. Observation on 1/11/23 at 10:00 a.m. revealed the dietary pantry storage was approximately 100 square feet in the area with canned goods and other combustible items. The pantry was connected to the kitchen with an opening that was not provided with a door. The kitchen door to the corridor (door closest to the boiler room) was not a self-closing door. With the pantry connected to the kitchen the corridor doors from the kitchen must be self-closing. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 321		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates,	K 324	1. All residents are at risk. The kitchen hood ductwork will be inspected by February 11, 2023. The next inspection is set for February 7, 2023 and the next inspection will be scheduled for 6 months after that initial inspection. 2. Administrator will in-service the maintenance director to ensure facility follows duct hood inspections from the rooftop fan unit to the kitchen hood in accordance with NFPA 96 every six	02/11/23

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K 324	Continued From page 2 toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the provider failed to conduct the required every six-months inspection of the cooking facility's ductwork from the rooftop to the range hood in the calendar year 2022. Findings include: 1. Document review on 1/11/23 at 10:45 a.m. revealed there were duct inspections from the rooftop fan unit to the kitchen hood to verify cleanliness in the calendar year 2022. The kitchen hood ductwork must be inspected not less than every six months and cleaned as necessary based on the inspections. Documentation must indicate the inspections taking place not less than six months apart. The deficiency affected one of several requirements for maintaining kitchen equipment.	K 324	months starting from the first inspection date set on February 7, 2023. 3. Administrator or designee will complete bi-annually audits to ensure the duct hood inspections occurred twice annually. 4. February 11, 2023.	

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K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview the provider failed to ensure staff were familiar with the provider's fire drill procedures (moving residents to safety in a fire drill). Findings include: 1. Observation on 1/11/23 at 10:30 a.m. revealed the fire alarm was sounded to initiate a drill for a simulated fire in an office in the therapy compartment. Staff response to the fire location in the office was correct. However, four residents were left in the therapy open area and were not moved to a room location or beyond the therapy suite separation doors to the nursing home. At no time were these residents taken to a place of refuge up to the point of the all-clear being sounded at the end of the drill. Interview with the administrator at the time of the observation confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712	1. All residents are at risk. No immediate action could be taken for deficient practice. 2. Administrator will conduct an in-service to ensure all facility staff including contracted therapy staff, are familiar with the facility's fire drill procedures which includes moving residents to safety in a fire drill before February 22, 2023. 3. Administrator or designee will conduct monthly fire drills to ensure that all staff follow proper procedures of moving residents to safety in a fire drill. These monthly audits will continue for 4 months. All findings will be brought to the monthly QAPI meeting for further review and recommendations and/or continuance/ discontinuance of the audits. 4. February 11, 2023.	2/11/23

South Dakota Department of Health

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AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/10/23 through 1/13/23. Avantara Pierre was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed rooms (mechanical room with a sump pit and oxygen bottle storage room). Findings include: 1. Observation at 9:50 a.m. on 1/11/23 revealed the exhaust ventilation for the mechanical room with the sump pit was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. 1. Observation at 10:15 a.m. on 1/11/23 revealed the exhaust ventilation for the bottled oxygen storage room was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the maintenance supervisor at 10:20 a.m. on 1/11/23 confirmed those findings. He revealed he was unaware as to why the exhaust ventilation was not working at those	S 157	1. All residents are at risk. The exhaust ventilation for the mechanical room with the sump pit room and bottled oxygen storage room have been replaced as of January 15, 2023. 2. The administrator will in-service maintenance director to ensure all exhaust ventilation systems are functioning in all rooms in the facility as of February 11, 2023. 3. The administrator or designee will complete monthly audits for 4 months to ensure exhaust ventilation systems are working in accordance with the Administrative Rule of South Dakota. Results of monthly audits will be reported by administrator or designee to monthly QAPI meeting for further review and recommendation and/or continuance of audits. 4. February 11, 2023.	02/11/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/06/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10663	A. BUILDING: _____ B. WING _____	01/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA PIERRE	950 E PARK PIERRE, SD 57501

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S 157	Continued From page 1 locations. Those rooms were required to have exhaust ventilation directed to the exterior of the building.	S 157		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/10/23 through 1/13/23. Avantara Pierre was found in compliance.	S 000		