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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435058	A. BUILDING _____ B. WING _____	C 10/05/2022

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

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/4/22 to 10/5/22. Areas surveyed included, resident neglect, resident rights, and quality of care. Avantara Clark City was found not in compliance with the following requirement: F684.	F 000		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview, record review, policy review, and review of the provider's facility assessment, the provider failed to ensure five of twelve sampled residents (3, 7, 10, 11, and 12) received a bath weekly. Findings include: 1. Observation and interview on 10/4/22 at 10:50 a.m. with resident 12 sitting in his wheel chair revealed: *He was admitted on 9/23/22. *He was receiving therapy for strengthening. *He had not had a bath since he was admitted. *His face was unshaven. *His call light was on because he needed to use the bathroom before his care conference at 11:00 a.m.	F 684	- Upon discovery of omitted documented bathing, resident 7 received a bath on 10/4; residents 3 and 11 received baths on 10/5; resident 10 received a bath on 10/6. Those baths were documented. Their skin assessments were also completed the week of their bath. Resident "12" was not identified in DOH documents. All residents who require bathing assistance have the potential to be affected. On 10/4/22, DON reviewed bathing and skin assessment documentation for all residents. All other residents were found to have received their bathing and skin assessments at least weekly. - The policy was reviewed with no revisions needed. All nursing staff will be re-educated on the skin policy and documentation process by the DON or designee by 11/24/22. Those not in attendance will be educated prior to their next shift worked. The DON or designee will utilize a bathing/skin assessment tracker to review documentation of completed baths and skin assessments daily. Any omissions or declined bathing/skin assessment offers will be added to the bathing/skin assessment list for the next day. That list will be provided to staff assigned to those tasks by the DON or designee. - The Administrator or designee will audit for completion and accurate documentation of bathing and skin assessments daily for 4 weeks, then weekly for an at least 2 more months. The Administrator or designee will present audit results to QAPI monthly for at least 3 months for review and recommendations.	11/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Than Carter
TITLE: Administrator
(X6) DATE: 10/27/22

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

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F 684	Continued From page 1 *"It takes a while for staff to answer his call light." Record review of resident's 12 bathing record revealed he had only received a bath on the day he had been admitted. *Two missed opportunities for a bath. 2. Observation and interview on 10/4/22 at 11:05 a.m. with resident 7 sitting in his wheel chair revealed: *He was admitted on 9/22/22. *He was receiving therapy for strengthening. *He had not had a bath since he was admitted. *His face was unshaven. *His razor had broken and no one had helped him with shaving. *"It takes staff a long time to answer his call light." -After 10:00 p.m. at night is when it took the longest for call lights to be answered. Record review of resident's 7 bathing record from 9/22/22 to 10/5/22 revealed no documentation of resident receiving or refusing a bath. *Two missed opportunities for a bath. 3. Observation and interview on 10/4/22 at 11:30 a.m. with resident 10 sitting in his wheel chair revealed: *His face was unshaven. *He got a shower every Friday. *"It takes a long time for staff to answer his call light in the evening and at night." Record review of resident 10's bathing record from 9/5/22 to 10/5/22 revealed he had received a bath on 9/9/22 and 9/16/22. *Two missed opportunities for a bath. 4. Observation and interview on 10/4/22 at 11:55	F 684		

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F 684	Continued From page 2 a.m. with resident 11 while sitting on the edge of her bed revealed: *She had moved in to the facility on 9/1/22. *She received a bath once since she had lived here. *"Staff took a long time to answer her call light around mealtimes and at bedtime. Record review of resident 11's bathing record from 9/5/22 to 10/5/22 revealed she had last received a bath on 9/20/22. *Three missed opportunities for a bath. 5. Interview on 10/4/22 at 2:42 p.m. with resident 3 and her daughter revealed: *Resident 3 had complained to her daughter about her lack of baths. *Resident 3's daughter stated a few weeks ago she had inquired about the last time her mother had received a bath. *She was told it had been nine days prior. *The nurse had told her they did not have a schedule of when a resident received a bath, but thought it was a good idea. *She stated she was very upset there was no schedule to ensure the residents received baths. 6. Interview on 10/5/22 at 2:25 p.m. with administrator A and director of nursing (DON) B regarding bathing and waiting for call lights to be answered revealed: *They had not had a bath aid working as much as needed to give baths. *Residents should have received a bath weekly. *DON B stated that she had noticed the lack of bathing, and started performing an audit to track the issue. *Many of their staff members had returned to college in August leaving open shifts.	F 684		

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F 684	Continued From page 3 Review of provider's Bathing policy date September 2019 revealed: *The purpose of the bathing procedure is promote cleanliness, provide comfort to the resident and observe the resident's skin condition. Review of the provider's undated Facility Assessment Tool revealed: *Based on the provider's resident population and their needs for care and support, the assessment revealed the staffing to ensure sufficient staff to meet the needs of the resident included: -One full-time DON. -RN or licensed practical nurse (LPN) one for each shift. -RN or LPN treatment nurse one for each shift. -Medication aide as needed. -Three to four certified nursing assistants (CNA) for day shift. -Two to three CNAs for evening shift. -One to two CNAs for night shift. -One registered nurse assessment coordinator Monday through Friday. *"Charge and Treatment nurses oversee the entire resident population. C.N.A.s are assigned an area with approximately 10-13 residents. One C.N.A. on the day shift works with the residents that have a restorative program. One C.N.A. per day is assigned to complete bath/showers for the residents." Interview on 10/5/22 at 2:20 p.m. with administrator A and DON B revealed: *Both administrator A and DON B felt the staffing they had was adequate to provide care to the residents. *They agreed the facility assessment had not	F 684		

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F 684	Continued From page 4 been followed as written. *There was usually one charge nurse and either a treatment nurse or medication aide for a 12 hour day shift from 7:00 a.m. to 7:30 p.m. and one licensed nurse from 7:00 p.m. to 7:30 a.m. *Three certified nursing assistants (CNA) were scheduled during the day shift. Those CNAs assisted the residents and that included the bath aide. The shifts varied to extend into the evening. *Two CNAs were scheduled for the evening shift and one CNA for the night shift. B. Based on observation, interview, record review, policy review, and review of provider's facility assessment, the provider failed to ensure two of five sampled residents (1 and 2) had received consistent skin assessments. Findings include: 1. Review of resident 1's medical record revealed: *She had been hospitalized on 5/29/22 and returned to the facility on 6/1/22 after a fall with injury. *A deep tissue injury (DTI) to her left heel was discovered on 6/14/22. -The DTI measured 2 centimeters (cm) by 3 cm. *A 6/20/22 skin assessment completed by a licensed nurse revealed she had a: -Alteration in skin integrity. -There were no measurements. -The treatment note stated "left heel wound-boots on at night-off loaded to reduce pressure." *Skin assessments revealed she had no alteration to her skin when completed on 7/4/22, 7/13/22, 7/27/22, and 7/31/22. *Skin assessments completed on 7/18/22, 8/16/22, 8/30/22, and 9/12/22 revealed skin issues due to red, rashy areas to her lower	F 684		

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F 684	Continued From page 5 abdomen and/or buttocks. There was no mention of her left heel DTI. *There were skin assessment forms on 6/29/22, 8/4/22, and 8/26/22 revealed measurements and a description for her left heel DTI had been completed. 2. Review of resident 2's medical record revealed: *He developed open areas to his right toes on 6/29/22. *Skin assessments had been completed in regards to his toes on his right foot on 8/26/22, 8/29/22, 9/8/22, and 9/20/22. Those were the only skin assessments that included measurements and a comprehensive description of his wounds. *Skin assessments from 6/5/22 through 9/26/22 had not been completed on 6/5/22, 6/17/22, 7/23/22, 8/20/22, and 9/26/22. Interview on 10/5/22 at 2:20 p.m. with administrator A and DON B revealed: *DON B confirmed documentation on alteration in skin documentation had been inconsistent. *There was not a primary nurse who evaluated the residents skin. *Each resident was to have a weekly skin assessment. *Any residents with impaired skin should have had those areas measured and assessed on a weekly basis.	F 684		