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
	435040	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702

(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 6/26/22 through 6/29/22. Avantara Mountain View was found not in compliance with the following requirements: F657, F658, F686, F761, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/26/22 through 6/29/22. Areas surveyed included quality of care and quality of life. Avantara Mountain View was found in compliance.	F 000		July 28, 2022
F 657 SS=D	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 657	Resident 7 care plan has been updated to reflect the disctontinuation of serving the peanut butter and jelly sandwich as a snack on 06/28/2022. Resident 49 care plan has been updated to reflect the resident's noncompliance of oxygen use at times. Resident 49 care plan has been updated to reflect the resolution of the smoking management focused care plan completed on 07/14/2022. All residents are at risk. All resident care plans will be reviewed and revised as needed to ensure they reflect the current care needs no later than July 28, 2022. Administrator and Director of Nursing (DON) will educate the Interdisciplinary Team (IDT) that participate in the writing and editing of the care plan on the Care Planning policy. Included in this education will be a review of daily stand-up expectations to include communication of changes in resident's needs to be updated in the care plan timely. Education will occur no later than July 28, 2022. Thos associates 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laura Karlson	Administrator	July 18, 2022

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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure care plans had been updated to reflect current care needs for two of two sampled residents (7 and 49), including food, oxygen, and smoking. Findings include: 1. Observation on 6/27/22 at 9:11 a.m. of resident 7 revealed he: *Had been in the lounge area watching television. *Had yellow colored, thick substance, extending down the front of his shirt approximately 3 inches long by 2 inches wide. Review of resident 7's medical record revealed his: *4/1/22 Brief Interview for Mental Status had a score of 0, meaning he had severe cognitive impairment. *Care plan included: -He was at risk for altered nutrition and hydration status due to paralysis on one side of his body, swallowing difficulties, and dementia. -He was on a pureed diet, with nectar thickened liquids. -He had required full supervision when eating since 2018. -He was able to have soft white bread, peanut butter and jelly sandwiches while being supervised.	F 657	The IDT will review the day prior progress notes and clinical alerts each weekday morning in the daily stand-up meeting to identify any needed care plan updates. Additionally, the DON or designee will audit 5 care plans each week to ensure the care plan is accurate and reflects resident's care needs. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Performance Improvement (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 657	Continued From page 2 --A sandwich would have been inconsistent with his puree diet. Interview on 6/28/22 at 4:08 p.m. with licensed practical nurse J regarding resident 7 revealed: *He received pureed food. *She thought the speech therapist had discontinued his bedtime snack of a peanut butter sandwich about a month ago. Interview on 6/29/22 at 8:34 a.m. with dietary manager E regarding resident 7's diet revealed: *He used to receive peanut butter sandwiches as a snack. *He had a history of choking on food. *The provider's dietitian had discontinued the peanut butter sandwiches a "couple of months ago", as it was no longer safe for him to eat them. *She was responsible for updating the dietary care plans. -His care plan had not been updated to reflect he was no longer receiving peanut butter sandwiches as a snack. 2. Observation on 6/26/22 at 3:34 p.m. of resident 49 revealed: *He was sleeping in his bed. *There was an oxygen (O2) concentrator set at 2 liters and was turned on. -The cannula attached to this concentrator was on a bedside table. *An unidentified visitor, who was in the room, stated his cannula was often on the floor or in his mouth. Interview on 6/28/22 at 3:53 p.m. with licensed practical nurse (LPN) G regarding resident 49's O2 usage revealed: *He often placed O2 cannula in his mouth rather	F 657		

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than his nostrils.
*The cannula was often found on the dresser and floor.
*She was not able to replace the cannula each time it had become contaminated because he would not let her replace it.

Review of resident 49's medical record revealed:
*His 5/10/22 brief interview for mental status had a score of 4 meaning he had severe cognitive impairment.
*His care plan included that:
-He preferred to have the O2 cannula in his mouth.
*There was no mention in his care plan of him not allowing the contaminated cannula to be replaced with a new one.

3. Interview on 6/26/22 at 2:00 p.m. with director of nursing C revealed the provider was a non-smoking facility.

Review of resident 49's care plan revealed:
*He had a potential for non-compliance with smoking.
-He had an order for Nicotine patches but had refused them, stating they do not work.
--"If he/she is continually non-compliant with the safe smoking policy remove all of his/her smoking materials and place the resident on supervised smoking pursuant to the facility policy."

4. Interview on 6/28/22 at 11:37 a.m. with social services director F regarding care plans revealed:
*Care plans should have been updated whenever care changes occurred.
*Resident 49 no longer smoked.

Interview on 6/29/22 at 11:56 a.m. with director of

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nursing (DON) C and administrator A regarding care plans revealed:
*Each morning a clinical "standup" was held.
-During this meeting the minimum data set (MDS) nurse would review new orders and progress notes of residents and then delegation of who was going to update care plans would be done.
Updates would be completed by the:
--Infection control nurse for infections.
--Dietary manager for any diet concerns.
--Interdisciplinary team for falls.
--All other issues would be addressed in the care plan by the MDS nurses.
*Her expectation was that when changes occurred in resident's care, their care plan was updated within 24 hours.
*Resident 49's noncompliance of O2 usage should have been on his care plan.
*Anyone of the professional nurses could have updated the care plan.
*DON C agreed the peanut butter sandwich should have been removed from the care plan.
*Administrator A stated she would have expected the care plan to reflect the care being provided to that resident.

Review of provider's 9/2019 care planning policy revealed:
*"POLICY: 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. In doing so, the following considerations are made: ...
3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death."
*"Procedure:
-1. Each disciplinary team member is educated

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F 657	Continued From page 5 during orientation and at least annually thereafter about assessment and care planning per each department's role in the process. Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing." -"6. Care plans are accessible to all direct-care staff, including the resident's physician/nurse practitioner. It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes." -"8. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (69) had routine skin evaluations to monitor the skin integrity of her left, second toe, according to provider's policy. 1. Observation and interview on 6/27/22 at 9:24 a.m. with resident 69 revealed: *She was sitting in her wheelchair. *Her left foot had a bandage covering it, and the foot was resting on the floor. *She said her foot had got infected, and she had a toe missing.	F 658	No immediate action could be taken for resident 69 regarding a missed skin alteration evaluation UDA. All residents are at risk ad will be reviewed for completion of the skin alteration evaluation UDA in the last 7 days, target date of completion is July 28, 2022. DON or designee will educate all nurses on the Skin Program policy. Education will occur no later than July 28, 2022. Those associates not in attendance at the education session due to vacation, sick leave, or casual work satus will be educated prior to their first shift worked. DON or designee will audit 5 residents' Skin Alteration Evaluation UDA's for completion and accuracy. Audits will be weekly for four week, and then monthly for two months. Results of audits will be discussed by the DON 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.	July 28,2022

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F 658	Continued From page 6 Review of resident 69's medical record revealed: -She had poor safety awareness due to her cognitive decline. *Her diagnoses included: acute kidney failure, assistance with personal cares, unsteadiness on feet, abnormalities of gait and mobility, cerebral infarctions, hemiplegia, and hemiparesis, encounter for orthopedic aftercare following surgical amputation, complete traumatic amputation of two or more left lesser toes. *She had been hospitalized from: 3/18/22 to 3/22/22, 5/17/22 to 5/20/22, and 5/22/22 to 6/8/22. *Her medication administration record revealed beginning on 3/23/22 wound care to her left second toe was started by cleansing the wound site with normal saline. *Her skin evaluations revealed: -On 3/22/22 small scab on her left toe when she returned from the hospital. -On 3/29/22 mentioned the left second toe but had no description of it. -On 4/5/22 the left second toe was not identified on the skin assessment. -On 4/12/22 indicated the left second toe was tender when touched. *On 4/12/22 her physician was notified and ordered an antibiotic treatment for the toe. *On 4/14/22 a diagnosis of cellulitis (infection) of the left toe that was being treated with an antibiotic. -On 6/8/22 she returned from the hospital with a left second toe amputation and "Ray amputation" (which involves the removal of the toe and part of the metatarsal.) -She had a left second toe amputation on 6/3/22. *Her left second toe had not had a skin evaluation completed from 3/29/22 to 4/12/22.	F 658		

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F 658	Continued From page 7 Interview on 6/29/22 at 12:04 p.m. with director of nursing C regarding skin evaluations revealed: *Skin evaluations were to be completed upon admission and then every seven days. *Resident 69's 4/5/22 skin evaluation had not identified the issue with her left second toe, and should have. -The nurse who had completed the 4/5/22 skin evaluation was no longer employed by the provider. Review of the provider's skin program policy revealed: *Policy: -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 are unavoidable. -To provide care and services to prevent pressure injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds." *Procedure:" -"6. ...Following identification of a skin issue, the Skin Alteration Evaluation UDA (User Defined Assessment] will be completed weekly until resolved."	F 658		
F 686 SS=G	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	F 686		

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F 686	Continued From page 8 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 four sampled residents (59) who had been identified at risk for pressure ulcers had interventions in place timely to prevent pressure ulcer development. Findings include: 1. Observation on 6/26/22 at 6:30 p.m. of resident 59 revealed he: *Was residing on the COVID-19 unit. *Was sitting in his wheelchair, and had foam boots on both feet. Observation on 6/28/22 at 4:45 p.m. of resident 59's dressing change revealed: *He was on the bed with foam boots on both feet. *He was placed on his left side, dressing changed to his right, and left buttock by wound care/unit manager D. -Wound care/unit manager D cleansed, and measured wound. --She stated wound was getting better with less drainage then previous. *He was placed on his back. *Foam boots were removed, and heels cleansed and measured. -Heels were dry and cracked. -She applied betadine to bilateral heels. Interview on 6/28/22 at 4:45 p.m. with wound	F 686	Resident 59 skin care plan has been reviewed and updated appropriately to reflect the necessary interventions related to his current needs based upon his Braden score. All current residents Braden scale assessment will be audited by July 28, 2022 to identify their risk for skin injury to ensure appropriate interventions are implemented and care plans will be reviewed and revised accordingly. Administrator, DON, and IDT in collaboration with the medical director and Certified Wound Specialist will review the Skin Program policy and procedures by July 28, 2022 to ensure assessment and ongoing assessment with evidence-based interventions are planned for and have been reviewed for effectiveness of all individuals identified at risk for skin injury. Contracted Certified Wound Specialist from Gentell will educate DON, IDT and all nurses regarding the Skin Program policy by July 28, 2022. Those associates 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. Upon completion of every Braden scale for all residents newly admitted and current, the intvention worksheet from the WoundRounds Platform will be brought to clinical start up daily on weekdays for review by the IDT	July 28, 2022

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F 686	Continued From page 9 care/unit manager D regarding wound care and resident 59 revealed: *She had never been a wound care nurse before. *She started training for wound care in March. *She had been on her own since May. *She assessed and measured wounds weekly. *She was unaware that his sensory in the peri area was so low. Review of resident 59's medical record revealed: *He was admitted on 5/26/22. *His diagnosis included: polymyositis with organ involvement, muscle wasting and atrophy, rhabdomyolysis (A breakdown of muscle tissue that releases a damaging protein into the blood), COVID positive on 6/20/22. *His 5/26/22 Nursing-Admission revealed: -His Braden scale for predicting pressure sore risk was 18 indicating he was at high risk for developing pressure ulcer. -He was incontinent of bladder. *He had skin evaluations on 5/26/22, 6/2/22, 6/9/22, 6/16/22. *On 5/26/22 skin was assessed as normal, pale, elastic and sacrum redness. -Interventions listed in care plan were: --To keep skin clean, dry and apply lotion to dry skin. --Turn and reposition every two hours and as needed. *On 5/29/22 in progress notes under health status "Excoriation/shearing noted to left buttock. Dressing has been in place but due to incontinence it was removed and barrier cream applied with each brief change. He has been encouraged to off load and reposition frequently.". *On 6/1/22 skin/Wound note revealed left buttock was open and measured 2.5 cm (centimeters) x 2 cm.	F 686	/All appropriate interventions will be implemented, care planned and educated through mini huddles. A new process for residents with active pressure injuries was implemented on 07/15/2022. The wound care nurse will print wound assessment from the WoundRound's platform on a weekly basis to provide to the floor nurses. The location and stage of the wound will be noted in the skin evaluation UDA to match the wound assessment from the WoundRound's platform. Wound mesurements will continue to be documented and monitored via the WoundRound's platform by the wound care nurse or designee. DON or designee will audit 5 resident medical record for completion of Braden and approrpriate interventions in place to reflect the Braden score risk. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting with the IDT and Medical Director for analysis and recommendations for continuation/disctonuation/revision of audits based on audit findings.	

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F 686	Continued From page 10 -Fax sent to provider on 6/2/22. *On 6/2/22 Skin evaluation indicating resident has: -Excoriation with opening to left buttock. --No measurements given. -Stage 2 pressure to left heel (2 in length x 3 in width and 0 depth). -Deep tissue injury (blister) to right heel (2.5 length x 4 width x 0 depth). *On 6/2/22 skin/wound note stated that left buttock open area measured 2.5 cm x 2 cm. *On 6/2/22 Minimum data set (MDS) note stated "No skin concerns. Has a pressure redistributing mattress on his bed and cushion in his w/c.". *On 6/3/22 MDS note revealed: -He is frequently incontinent of bowel and bladder. -New skin concerns with stage 2 PU (pressure ulcer) on Lt (left) heel and DTI (deep tissue injury) on Rt (right) heel. *On 6/3/22 order signed for Calmoseptine to left buttock, Batadine to right heel, and wound care to evaluate and treat left heel stage 2 wound. Foam heel protectors on at bedtime. *On 6/4/22 recommendations from registered dietitian to have Ensure clear twice a day (BID), 30 ml Prostat BID. *On 6/6/22 resident agreed to wear foam boots at all times, with white socks with one pair of gripper socks on top of white socks. *On 6/9/22 skin evaluation revealed: -Left buttock, red, barrier cream applied, wound care nurse notified. --No measurements given. -Right buttock, red, barrier cream applied, wound care nurse notified. --No measurements given. -Left heel, breakdown, under care of facility wound care nurse, foam boots worn at all times.	F 686		

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F 686	Continued From page 11	F 686		

--No measurements given.
-Right heel breakdown, under care of facility wound care nurse, foam boots worn at all times.
--No measurements.
*On 6/9/22 order entered for:
-Foam boots on at all times.
-Low air loss mattress due to wound noted to left buttock and bilateral heels.
-Med pass 4 ounces in between meals two times a day.
-Ensure 237 ml (milliliter) two times a day.
*On 6/10/22 task for turn and reposition every two hour had been started.
*On 6/10/22 order note revealed:
-Wound care to left buttock was to apply Santyl to wound bed, cover with calcium alginate and secure with border foam dressing.
-Wound to left buttock had worsened to unstageable pressure sore.
-Will continue to follow wounds at the facility with weekly measurements and wound assessments.
*On 6/15/22 Skin/Wound note revealed:
-Wounds had worsen since last weekly wound assessment.
-He had an unstageable on the right buttock.
-His left buttock had not improved.
-Will be requesting referral for outpatient wound care.
*On 6/16/22 skin evaluation revealed:
-Coccyx and type was pressure.
--No measurements.
-Right heel and type is DTI.
--No measurements.
*On 6/17/22 Order to schedule outpatient wound care.
-Outpatient wound care appointment was set for 7/11/22 at 10:00 a.m.
*Wound assessments revealed:
-On 6/15/22 right buttock was identifed and

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AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702

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F 686	Continued From page 12 measured 2.40 x 0.50 x 0.0. --Left buttock was identified on 5/31/22 and measured 7.5 x 3.5 x 0.0. -On 6/23/22 left buttock measured 7 cm x 2 cm x 0 (length x width x depth). -On 6/28/22 left buttock measured 5.5 x 1.5 x 0.5. --Left ischial tuberosity was identified on 6/21/22 and was closed. --Right buttock measured 1.5 x 0.30 x 0.0. --Right heel was identified on 6/2/22. It measured 0.90 x 1.0 x 0.0 --Left heel was identified 6/2/22 and was closed. *Plan of care on 5/26/22 revealed: -That he was at risk for alterations in bladder due to frequent incontinence. --Intervention for incontinence is to apply moisture barrier to the peri area after incontinence episode. --No other interventions in place for incontinence. Interview on 6/29/22 at 11:55 a.m. with director of nursing C regarding evaluating skin of residents revealed: *Upon admission a Braden Scale (an assessment used for predicting pressure ulcer risk) was completed and then again once a week for four weeks. *A resident who had a high score on the Braden scale was reviewed in the morning clinical meeting and interventions were discussed. *Interventions should have been started immediately. *A skin evaluation was completed every seven days for all residents. *When a pressure injury or skin issue was found, the nurse who found the issue should do a wound alteration evaluation and the wound nurse was notified. *The wound nurse would follow up on the issue.	F 686		

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F 686	Continued From page 13 Review of provider's updated 4/2021 skin program policy reveals: *"A plan of care (POC) will be put into place for resident that are identified with actual skin breakdown or at-risk for skin breakdown." **"Nursing personnel will utilize the results of the physical exam and the pressure injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident. This will include interventions to: a) Protect the skin against the effects of pressure, friction and shearing, b) Protect skin from moisture, c) Encourage optimal nutrition and fluid intake, d) Educate staff, resident and families, e) Train front-line caregivers, and f) Immediate prevention plan instituted when potential areas are identified." *"POC to include: Impaired mobility, Pressure relief, Nutritional status and interventions, Incontinence, Skin condition checks, Treatment, Pain, Infection, Education of resident and family, Possible causes for pressure injury and what interventions have been put into place to prevent. Skin checks to be completed at least weekly by a Licensed Nurse."	F 686		Ju
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761	Resident 22 is noted in the 2567 however there is not a resident 22 on the resident identifier list. Resident 37, 67 and 279 insulin pens have been removed from the resident's room. Reisdent 279 discharged from the facility on 07/15/2022. All residents who recieve insulin are at risk.	July 28, 2022

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F 761	Continued From page 14 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review the provider failed to ensure *Four of four sampled residents (22, 37, 67, and 279) had insulin medication stored in a safe manner according to the provider's policy. *One of one sampled (64) resident had been evaluated for his ability to self administer medications. 1. Observation and interview on 6/28/22 at 4:44 p.m. with licensed practical nurse (LPN) H and unlicensed assistive personnel (UAP) I regarding resident 279 revealed: *She administered her insulin. *A self-medication administration evaluation was completed by a nurse. *A glucometer, lancets, test strips, alcohol pads, gauze, two insulin pens, and needles were kept in a unlocked plastic box in her room on a shelf over her bed.	F 761	All other residents who have an order for blood glucose checks or insulin are not appropriate or have not voiced interest in self-administering this medication. All residents who have an order to check blood glucose and/or recieve insulin, now have their supplies related to the procedure, to include the insulin pens, stored in the locked treatment cart.A full house audit of all resident rooms to ensure no medications are stored inappropriately in their rooms no later than July 28, 2022. DON or designee will educate all nurses and medication aides on the Medication Storage policy. In addition, all nurses and medication aides will be educated on the updated process for storage of the blood glucose supplies and insulin pens in the locked treatment cart. Education will occur no later than July 28, 2022. Those associates 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. DON or Designee will audit all 4 treatment carts to ensure that all residents with an order for blood glucose checks or insulin have proper storage of their diabetic supplies. DON or Designee will audit 5 resident rooms to ensure no medications are inappropriately stored in their rooms. Audits will be weekly for four weeks, and then monthy for two months. Results of audits will be	

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F 761	Continued From page 15 Observation and interview on 6/29/22 at 8:35 a.m. with resident 279 revealed: *An unlocked open plastic box with a glucometer, test strips, lancets, alcohol pads, gauze, two insulin pens and needles were sitting on the over bed table next to her bed. *She kept her insulin and supplies on the table next to the bed so she could reach them. *She administered her insulin. *The nurse had completed an assessment and observed her administer insulin. *The nurses asked her what her blood sugar was and if she had her insulin. Interview on 06/29/22 at 8:35 a.m. with LPN G regarding resident 279's insulin administration revealed: *She confirmed with her that she had checked her blood sugar, what the blood sugar reading was and that she had taken her insulin. *If sliding scale insulin was needed what the dosage was. *She recorded the information in the residents electronic medical record (EMR). Record review of resident 279's EMR revealed: *She was admitted 6/22/22. *No Brief Interview for Mental Status (BIMS) score was listed. *She had a 6/24/22 self-administration evaluation completed. *Her diagnoses included type two diabetes mellitus. *She had physician orders for NovoLog insulin, Toujeo SoloStar insulin, blood sugar checks before meals and at bedtime, and may check her own blood sugar and self-administer her Insulin. 2. Observation and interview on 6/29/22 at 8:45	F 761	discussed by the DON 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 761	Continued From page 16	F 761		

a.m. of LPN G administering insulin to resident 67 revealed:
*His glucometer, test strips, lancets, alcohol pads, needles and two insulin pens were kept in his room in an unlocked plastic box on a shelf over the sink.
*Sometimes the plastic box of supplies and insulin pens were kept on a shelf over his bed.
*He had not been evaluated or approved for self medication administration.
*He had no physician order for self medication administration.

Record review of resident 67's EMR revealed:
*He was admitted on 12/1/21.
*His 6/9/22 BIMS score was 9 indicating moderately impaired cognition.
*His diagnoses included type two diabetes mellitus.
*He had physician orders for insulin glargine, insulin aspart, and blood sugar checks before meals and at bedtime.
3. Observation on 6/26/22 at 4:44 p.m. of resident 22 revealed:
*She was in her bed with headphones on watching television.
*She had an unlocked plastic box on her bedside table with glucometer, test strips, lancets, alcohol pads, gauze, insulin pens and needles in it.

Observation and interview on 6/29/22 at 8:35 a.m. with resident 22 revealed:
*Her plastic box with insulin and supplies was always kept on her bedside table.
*She checked her blood sugars four times a day and recorded the results in her notebook.
*She did not know how to use the insulin pens to give herself insulin.

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F 761	Continued From page 17 Record review of resident 22 's EMR revealed: *She was admitted on 4/18/22. *Her BIMS score was 14 indicating cognitively intact. *She had a diagnosis of type two diabetes mellitus. *She had a physician order for insulin glargine, insulin aspart, and blood sugars four times a day before meals, and at bedtime. 4. Observation on 6/26/22 at 5:15 p.m. of resident 37 revealed: *He had an unlocked plastic box in his room, on the shelf, next to the sink with glucometer, test strips, lancets, alcohol pads, gauze, insulin pens and needles in it. Record review of resident 37 EMR revealed: *He was admitted on 10/18/21. *His BIMS score was 9 indicating moderately impaired cognition. *He had a diagnosis of type two diabetes mellitus. *He had a physician order for insulin Lantus, insulin aspart, and blood sugars three times a day. 5. Interview on 6/28/22 at 4:50 p.m. with Wound care/Unit manager D regarding insulin storage revealed: *Insulin and supplies were kept in the resident rooms in plastic boxes. *The plastic box with insulin and supplies was to be stored in the resident's closet on top shelf with closet door closed. Interview on 6/29/22 at 11:55 a.m. with director of nursing (DON) C regarding insulin kept in resident rooms and residents that self- administer insulin revealed:	F 761		

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F 761	Continued From page 18 *There were two residents on the first floor that self-administered insulin. *They both had a self-medication evaluation completed by a nurse. *Any of the nurses were able to complete the self medication administration evaluations. *Residents who were not evaluated or approved for self-medication administration had insulin, glucometers and blood sugar testing supplies stored in their rooms in an unlocked plastic box. *All residents on the first floor with insulin prescribed started to keep their insulin and blood sugar testing supplies in their rooms during COVID. *One resident on the first floor had a cognitive impairment but that resident did not wander. *She had no way of guaranteeing the residents who had not been approved would not self administer insulin. *There was no documentation of an interdisciplinary team (IDT) evaluation or discussion regarding residents approval of not using a lock box for insulin medications stored in their rooms or approval of residents self medication administration. Review of the provider's September 2018 Storage of Medication policy revealed: *"Policy Medications and biological's are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. The medication supply shall be accessible only to licensed personnel, pharmacy personnel, or staff members lawfully authorized to administer medications." -"3. In order to limit access to prescription medications, only licensed nurses, pharmacy	F 761		

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F 761	Continued From page 19 staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access." Review of the provider's January 2020 Self-Administration of Medications policy revealed: *"3. If the resident is deemed capable to self-administer medications, then the drugs will be stored in a lock box in the resident's room, unless otherwise determined by the interdisciplinary team."	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880	No immediate action could be taken for resident 69 or 78 related to wound care infection prevention. All residents are at risk. For resident 49 the oxygen cannula was changed on 06/29/2022 and cotninues to be changed on a weekly basis. The reusable oxygen humidifiers were removed and replaced with disposable humidifiers on 07/14/2022. All oxygen concentrators were audited for placement fo hook that is used to hold oxygen cannula when not in use. The oxygen concentrators that did not have the hook placed will be replaced by 07/22/2022. The DON or designee will educate all nurses on infection control practices during wound care.	July 28, 2022

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F 880	Continued From page 20 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880	Employee K and D will be included in this education. Contracted Certifified Wound Specialist from Gentell will educate on infection control practices during wound dressing with DON, IDT and nurses by July 28, 2022. Those associates 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. A clean dressing competency will be completed will be completed with all nursing staff that perform dressing changes by July 28, 2022. Employee K and D will be included in these competencies and will be re-educated in areas of the deficient practice. Those associates not in attendance for the competency due to vacation, sick leave, or causal work status will complete the competency prior to their first shift worked. On 07/15/2022 the Administrator and DON attended a call with the South Dakota Quality Improvement Organization regarding Infection Prevention practices related to the citation. During this call we discussed the root cause for failure to follow appropriate maintenance of oxygen cannulas and the discontinuation of the use of reusable oxygen humidifiers. During this call we discussed the root cause for failure to follow appropriate procedural techniques during wound care to aide in infection prevention as well as appropriate maintenance of oxygen cannulas and the discontinuation of the use of resuable oxygen humidifiers.	

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F 880	Continued From page 21 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review the provider failed to ensure: *Two of two sampled residents (69 and 78) had infection prevention process followed during two of two wound care observations by two of two licensed nurses (D and K). *A cannula for oxygen (O2) was maintained in a sanitary manner for one of one sampled resident (49). *A reusable oxygen humidifier for one of one sampled resident (40) had been cleaned on a routine basis. 1. Observation and interview on 6/27/22 at 11:12 a.m. of wound care nurse D and registered nurse (RN) K completing wound care for resident 69 revealed: *The resident had a dressing change to her left foot. *Registered nurse K used a pair of scissors to remove the soiled dressing from resident 69's left foot. -She did not clean these scissors. *The foot was missing the left, second toe. *Wound nurse D stated resident 69 had a bone infection in her second left toe, so it had been amputated. *After completion of the wound care, RN K used the same pair of scissors to cut the new dressing in half. *Wound nurse D confirmed the scissors should have been cleaned before being used to cut the	F 880	During this call we also discussed the deficient practice during wound care treatment and recognized potential factors leading to the deficient practice to include alcohol pads not being present in the individual wound care bags and minimal staff training. Administrator, DON and/or deisgnee will conduct auditing of appropriate procedural techniques during wound care that aide in infection prevention. In addition, Administrator, DON and/or designee will audit for appropriate maintenance of oxygen cannula and the disposable oxygen humidifiers. These audits will be completed 2 to 3 times weekly over all shifts. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Mothly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by Administrator, DON and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined bye the committee	

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F 880	Continued From page 22 new dressing, as they were contaminated. 2. Observation and interview on 6/28/22 at 9:06 a.m. of wound care nurse D completing wound care for resident 78 revealed: *A discussion preceded the dressing change while wound care nurse D applied personal protective equipment (PPE) and revealed: -The resident had dressing changes for her lower leg wounds scheduled to be completed by the nurse working the floor on Sundays. -Tuesdays the wound care nurse took pictures of the leg wounds that included wound measurements and a wound description. -On Thursdays she was seen at the wound care clinic for dressing changes. *Wound care nurse D stated she was going to take pictures and measure the wound. *After taking off the soiled dressings she placed them on the bed. -She was going to put the soiled dressings back on the wound. -She agreed the dressings were not clean and she should use clean dressings on the wound. Interview on 6/29/22 at 11:55 a.m. with director of nursing (DON) C regarding infection prevention during wound care for resident (78) revealed: *Her expectation was a clean dressing to be applied to the wound after measurements and pictures were taken. *Soiled dressings should not be put on the bed sheet of the residents bed. *The wound care nurse had received training from: -The previous wound care nurse. -A certified wound care contractor. *The wound care nurse had completed the competency for clean dressing change.	F 880		

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F 880	Continued From page 23 *The wound care nurse was scheduled to go to wound care boot camp training this week with the DON, but it was canceled due to the survey. Review of the provider's 12/1/19 Treatment Nurse job description revealed: *"In keeping with our organization's goal of improving the lives of the guests we serve, the Treatment Nurse plays a critical role in providing superior customer service and nursing care to all guests. The treatment nurse is responsible for performing skin treatments for all guests under their care." -"13. Assure that established infection control and prevention practices and standard precautions are maintained at all times." Review of the provider's clean dressing change competency completed for wound care nurse D on 5/17/22 revealed: *"Gathers all dressing change supplies and positions on a clean field." *"Gently removes soiled dressing and discards in a disposable container." 3. Observation on 6/26/22 at 2:51 p.m. of resident 49 revealed: *He was sleeping in his bed. *There was an oxygen (O2) concentrator set at 2 liters and was turned on. *The cannula attached to the O2 concentrator was laying on top of a bedside table, which was visibly dirty, with a package of wet wipes on top of the cannula. *An unidentified certified nursing assistant (CNA) came into the room, placed clean linen in his bathroom and left. -She had not addressed the O2 cannula laying on the bedside table.	F 880		

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	435040	A. BUILDING _____ B. WING _____	C 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702

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F 880	Continued From page 24 Continued observations on 6/26/22 at 3:34 p.m. and 4:10 p.m. revealed the O2 cannula in the same place on his bedside table. Observation on 6/28/22 at 10:50 a.m. revealed resident 49: *Had been sleeping in his bed. *He had been laying on back, with his O2 cannula laying on the mattress behind his back. Interview on 6/28/22 at 3:35 p.m. with DON C regarding storage of cannula's revealed: *There were hooks on the concentrators for the cannula's to be stored when they were not in use. *Cannulas were to be changed when contaminated. *The provider did not have a policy for O2 usage. Interview on 6/28/22 at 3:53 p.m. with licensed practical nurse (LPN) G regarding resident 49's O2 usage revealed: *The cannula was often found on the dresser or the floor. *She was not able to replace the cannula each time it had become contaminated because he would not let her replace it. *He did not wear his O2 often, and when he did he would place it in his mouth rather than his nostrils. *His O2 saturations were taken when he was sleeping, as he did not like to have them taken. *She would have made sure his O2 saturations were above 90 percent. *She confirmed there was a physician order to keep the O2 saturations above 93% and the order had not said if the O2 was to be administered via a cannula or a mask. *If the O2 saturations fell below 90 percent, she would increase the O2 to 2 liters per minute	F 880		

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F 880	Continued From page 25	F 880		

(LPM) and call the physician.
*The cannula was changed every week, "if we can wrestle it away from him."
*The cannula was not changed each time it was contaminated.

4. Observation on 6/26/22 at 4:06 p.m. of resident 40 revealed:
*She was laying in her bed.
*There was O2 concentrator in her room that was turned on and set at 2 LPM.
-Attached to this concentrator was a re-usable humidifier that was dated 12/12/21.

Interview on 6/28/22 at 3:48 p.m. with LPN G regarding use of re-usable humidifiers for O2 concentrators revealed she:
*Did not know what the policy was for cleaning them.
-Would have cleaned it by filling it half-way with vinegar and water, and let it soak.
*Did not document when she cleaned it.
*Did not know when it was last cleaned.

Interview on 6/29/22 at 12:17 p.m. with DON C regarding O2 humidifiers revealed:
*There were disposable and re-usable humidifiers for the concentrators, the provider used both types.
*The night shift was responsible for cleaning the re-usable humidifiers on a weekly basis.
*There was no documentation to support the humidifiers had been cleaned.
*She stated the hospice agency may have been cleaning the humidifiers but was not certain.
*She confirmed the provider did not have a policy for oxygen usage.

5. Review of provider's 2/26/21 Infection

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	435040	A. BUILDING _____ B. WING _____	C 06/29/2022

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F 880	Continued From page 26 Prevention Program policy revealed; *"I. Goals -The goals of the infection prevention and control program are to: --A. Decrease the risk of infection to residents/patients and personnel. --B. Prevent, to the extent possible, the onset and spread of infection. --C. Maintain compliance with state and federal regulations and standards of practice relating to infection prevention and control." "II. Scope of the Infection Prevention and Control Program -It is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."	F 880		

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

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	435040	A. BUILDING _____ B. WING _____	06/29/2022

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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 6/26/22 through 6/29/22. Avantara Mountain View was found in compliance.	E 000		

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

Laura Karlson | Administrator | July 18, 2022

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435040	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/28/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA MOUNTAIN VIEW	**916 MOUNTAIN VIEW ROAD RAPID CITY, SD 57702**

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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 on 6/28/22. Avantara Mountain View was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10669	A. BUILDING: _____ B. WING _____	06/29/2022

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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 6/26/22 through 6/29/22. Avantara Mountain View was found in compliance.	S 000		
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 6/26/22 through 6/29/22. Avantara Mountain View was found in compliance.	S 000		

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Laura Karlson | Administrator | July 18, 2022