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
	435060	A. BUILDING ______ B. WING ______	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	**302 ST CLOUD STREET RAPID CITY, SD 57701**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 40788 A COVID-19 Focused Infection Control survey was conducted by the South Dakota Department of Health Office of Licensure and Certification on 11/1/21 and 11/2/21. Avantara Saint Cloud was found not in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulation F880. Avantara Saint Cloud was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations F550, F558, F562, F563, F583, F882, F883, F885, and F886. A COVID-19 Focused Emergency Preparedness survey was conducted by the South Dakota Department of Health Office of Licensure and Certification on 11/1/21 and 11/2/21. Avantara Saint Cloud was found in compliance with 42 CFR Part 482, Subpart B, Subsection 483.73 related to E-0024(b)(6). Total residents: 67	F 000	Directed Plan of Correction Avantara Saint Cloud F880 Corrective Action: 1. For the identification of lack of: *Appropriate hand hygiene during performance of tasks. *Appropriate and consistent use of personal protective equipment (PPE) by all staff working with residents that have cognitive challenges in understanding need for PPE. *A process to ensure timely fit testing of N95 masks for those required to wear them. The administrator, DON, and/or a designee in consultation with the medical director will review,revise, create as necessary policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 12/02/21 by the DON or designee.	12-02-21
F 880 SS=D	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.	F 880		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Kelly	Administrator	12/10/21

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.

DEC 10 2021

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F 880	Continued From page 1 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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	F 880	*The Maintenance Director was N95 fit tested on 11/08/2021. *CNA D is no longer employed at the facility. CNA D was educated on wearing appropriate and consistent use of PPE andperforming hand hygiene when entering COVID-12 positive rooms on 11/01/21. With CNA D no longer being employed at the facility there was not an opportunity to have an N95 fit test. *CNA F immediately put protective eye wear after the surveyor inquired about it. CNA F was educated on 11/01/21 on the policy and procedure on eye wear during a COVID-19 facility outbreak. *To ensure timely fitting of N95 an appointment will be made during the day of orientation with the Human Resources (HR) and employee. HR will call the N95 fit testing agency to request a copy of the fit test. This will be completed within the first week of employment. The HR representative will track of the scheduled fit test on a spreadsheet, and will keep the results in a binder.	

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(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Surveyor: 40788
Based on observation, interview, staff fit testing log, and policy review, the provider failed to ensure infection control practices were maintained for:
*Appropriate personal protective equipment (PPE) use by two of two certified nurse aides (CNAs) (D and F) and one of one maintenance director (E) observed in two of four residents living units where COVID-19 positive residents resided and wandered outside of their rooms.
*A process to ensure timely fit testing for staff wearing N95 masks.
Findings include:

1. Entrance conference interview on 11/1/21 at 10:00 a.m. with administrator A and director of nursing (DON) B revealed:
*Fifteen residents had COVID-19.
-COVID-19 positive and COVID-19 negative residents resided on each of the four resident living units.

F 880

Identification of Others:

2. ALL residents and staff have the potential to be affected if staff donot adhere to identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 12/02/21.

System Changes:

3. Root cause analysis conducted answered the 5 Whys: After completing the Root Cause Analysis and answering the 5 whys the predominate theme was an unvaccinated contract staff initially introduced the COVID-19 strain to the facility. The next cause was not all of the facility staff had been N95 fit tested.

Administrator, DON, infection control nurse, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 11/16/21. A meeting has been scheduled for 11/30/2021.

Monitoring:

4. Administrator, DON, infection control nurse, and/or a designee will conduct auditing and monitoring for area identified above. Monitoring of determined approachesto ensure effective implementation and ongoing sustainment include at a minimum 2-3 times weekly for 4 weeks, administrator, DON, infection control nurse, and/or a designee making observations across all shifts to ensure staff compliance with:

* Staff compliance in the above identified area.
* Any other areas identified through the Root Cause Analysis.

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-Positive residents had been encouraged to isolate in their rooms during their illness with their room doors closed, but this was difficult to enforce due to their impaired cognition.
--Residents who wandered outside of their rooms were provided surgical masks to wear and staff assisted them to properly wear their masks.
*All staff on resident living units had been expected to wear an N95 mask and eye protection outside of resident rooms and an N95 mask, eye protection, gown, and gloves inside COVID-19 positive resident rooms.
*All staff had been fit tested for N95 mask use.

Observation and interview on 11/1/21 at 12:30 p.m. with maintenance director E on the west hall resident living unit revealed he:
*Wore a surgical mask and eye protection as he worked in that hall.
*Stated he had not recently been fit tested for an N95 mask, but needed to.
*Was not vaccinated for COVID-19.

Observation and interview on 11/1/21 at 2:15 p.m. with CNA D on the west hall resident living unit revealed:
*A wheeled cart outside of residents 1 and 2s' room that contained incontinence briefs, incontinence wipes, and linen.
*CNA D exited that room without performing hand hygiene wearing only a surgical mask for personal protective equipment (PPE).
-Signage on that room door indicated an N95 mask, eye protection, gown, and gloves were required before entering that room.
*Residents 1 and 2 had COVID-19.
*CNA D attempted to answer surveyor questions regarding hand hygiene and PPE using a translator application on her phone, but was

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unsuccessful.
-She communicated through gestures that she was taking items from the cart into resident rooms on that hall.
*CNA D proceeded to enter residents 3 and 4s' room without performing hand hygiene and wearing that same surgical mask.
-Those residents were not positive for COVID-19.

Interview on 11/1/21 at 2:20 p.m. with DON B regarding the above observations revealed she expected:
*Staff had worn N95 masks and eye protection while in any resident living unit.
*An N95 mask, eye protection, gown, and gloves were worn inside rooms of any COVID-19 positive resident.
*Hand hygiene was performed before entering and after exiting any resident room.

Continued interview at that same time revealed she stated:
*This was CNA D's first experience working in the facility when there had been positive COVID-19 residents.
*CNA D may need more education and "that (educating her) was on her list of things to do."

Interview on 11/1/21 at 3:00 p.m. with human resource assistant G regarding CNA D revealed:
*Her date of hire was 8/2/21.
*She had completed COVID-19 and infection control education and testing on 8/3/21.

Observation and interview on 11/1/21 at 4:15 p.m. with CNA F on the south hall resident living unit revealed she:
*Wore an N95 mask and no eye protection as she walked hand in hand in that hallway with an

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unidentified resident.
*Was called into work unexpectedly and had forgotten to put on eye protection before starting her shift.

Observation on 11/1/21 at 4:20 p.m. of CNA D revealed she exited the west hall resident living unit wearing an N95 mask and no eye protection.

Review of the revised 9/16/21 Residents with Suspected/Confirmed COVID-19 policy revealed:
*Page 4:
-"Hand hygiene should be performed before and after all resident contact, contact with potentially infectious material and before putting on and after removing PPE, including gloves."
*Page 5:
-Gowns, gloves, respirators, and eye protection must be worn in pending/COVID areas.

2. Review of the staff fit testing roster revealed 28 of 68 staff had "pending" fit test appointments.

Interview on 11/2/21 at 12:30 p.m. with human resource assistant G regarding staff fit testing revealed she:
*Was responsible for ensuring staff had been fit tested.
*Expected new employees had been fit tested within two weeks of their hire date and existing staff had been fit tested annually.
*Educated staff on fit test completion expectations and where to get fit tested.
*Had no system to identify and follow-up on newly hired employees who had not completed their fit test and no system to identify and follow-up on existing employees whose annual fit test was coming due.
-Agreed a system was needed.

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F 880	Continued From page 6 Continued interview regarding staff referred to in Finding 1 revealed she confirmed: *CNA D was hired on 8/2/21 and had not been fit tested. *Maintenance director E's last fit test was 7/17/20. Review of the revised 9/16/21 Residents with Suspected/Confirmed COVID-19 policy revealed: *Page 4: -Per NIOSH [National Institute for Occupational Safety and Health], all staff should be Fit tested per OSHA [Occupational Safety and Health Administration] requirements. -Fit testing should be completed at least annually.	F 880		