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
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/8/21 through 6/10/21. Avantara North was found not in compliance with the following requirements: F558, F656, and F700. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 6/8/21 through 6/10/21. Areas surveyed included quality of care/treatment and other services. Avantara North was found in compliance.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Surveyor: 43844 Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident's (48) call light had been within her reach during three of three observations. Findings include: 1. Review of resident 48's medical record and 5/20/21 care plan revealed she: *Was admitted on 6/11/20 and had multiple and varied diagnosis. *Was able to make simple decisions.	F 558		

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

Celine Lohre | Administrator | 7/2/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 558	Continued From page 1 *Required total assistance of one staff for dressing and personal hygiene. *Required the use of a mechanical lift and total assistance of two staff members for transferring. *Was able to utilize her call light for assistance and to report when she was uncomfortable. Observation on 6/8/21 at 9:34 a.m. of resident 48 in her room revealed: *Resident was sitting in her wheelchair, in the middle of the room. *There were two call lights in the room. *The call lights were on the floor directly behind the wheelchair and the other one was on her bed, approximately four feet away. -She was unable to reach either call light. Observation on 6/9/21 at 8:50 a.m. and on 6/9/21 at 10:16 a.m. of resident 48 in her room revealed: *Resident was sitting in her wheelchair, in the middle of the room. *There were two call lights in the room. *The call lights were on the floor by the wall behind the wheelchair and the other one was on her bed, approximately four feet away. -She was unable to reach either call light. Interview with certified nursing assistant C revealed she: *Knew resident 48 needed the call light within reach. *Stated "I forgot to give it to her." Interview on 6/10/21 at 10:25 a.m. with the director of nursing B regarding resident 48 and the above observations revealed they did not have a policy on call lights.	F 558	1. Education was completed immediately after receiving the 2567 with CNA (C) to ensure call light is within reach for all residents. 2. All residents are at risk for adverse effects related to reasonable accommodation/needs/preferences with ensuring call lights are always within reach. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing, and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Call Light Policy. The Administrator or DON/designee will conduct a facility all-staff meeting to educate all staff including CNA (C) on the Call Light Policy and the call light expectations. Education will occur no later than July 30th, and those not in attendance prior to that date due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The Administrator/DON or designee will audit five residents to ensure access to their call lights. Audits will be weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator/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 the findings.	7/30/2021
F 656 SS=D	Develop/Implement Comprehensive Care Plan	F 656		

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
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 656	Continued From page 2 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.	F 656	1. Resident 32's care plan was reviewed and updated to show no diagnosis of diabetes mellitus. Resident 48's care plan was reviewed and updated with orders for a wedge cushion that is now in place on resident's wheelchair. Resident 253's care plan was reviewed and updated to reflect no catheter per physician orders. 2. All residents are at risk for adverse effects related to incorrect care plans. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing, and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Care Plan Policy. The DON or designee will educate the nursing department on the facility Care Plan Policy and the importance of updating and following each of the residents' individualized care plans. Education will occur no later than July 30th, and those not in attendance prior to that date due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. A facility wide audit will occur no later than July 30th to review, revise, and update every resident's care plan in the facility. The MDS coordinator is to thoroughly review all care plans during their quarterly assessment. The facility will utilize the daily stand up meeting, weekly PAR meeting, and care conferences to ensure care plans stay updated. 4. The Administrator/DON or designee will audit five residents care plans to ensure their accuracy weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for continuation/discontinuation/revision of audits based on audit findings.	7/30/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 656	Continued From page 3	F 656		

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Surveyor: 43844
Based on observation, interview, record review, and policy review, the provider failed to ensure three of six residents (32, 48, and 253) care plans had been updated to reflect their current needs. Finding include:

1. Review of resident 32's 6/8/21 care plan revealed she:
*Had been at risk for fluctuating blood sugar due to diabetes mellitus.
-Required blood sugar levels checked per physician's order.
-Was to have been administered sliding scale insulin per physician's order.
-Was to have been observed for signs and symptoms of hypoglycemic or hyperglycemic reaction.

Review of resident 32's 6/10/21 physician orders revealed she had:
*No diagnosis for diabetes mellitus.
*No blood sugar checks to be checked or a sliding scale insulin had been administered.

Review of resident 32's June 2021 medication administration record and treatment administration record confirmed no blood sugar checks had been done or sliding scale insulin had been administered.

Interview on 6/10/21 at 1:10 p.m. with director of nursing (DON) A and assistant director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 656	Continued From page 4 (ADON) H revealed resident #32 did not have diabetes mellitus and it should not have been on the care plan. 2. Observation of resident 48 on 6/8/21 at 8:48 a.m. and on 6/10/21 at 8:30 a.m. revealed: *She sat in a wheelchair. -The back of the chair was tipped at a 45 degree angle. -There had been a pressure relieving cushion in the wheelchair. Review of resident 48's 6/2/21 physical therapy discharge summary revealed the patient would use a wedge cushion. Interview on 6/10/21 at 9:18 a.m. with certified nursing assistant D regarding resident 48 revealed she: *Would review each resident's care plan to find the information necessary to provide care. *Knew where the care plans were located in the facility electronic medical records. *Was unaware that resident 48 needed a wedge cushion. Interview on 6/10/21 at 9:23 a.m. with DON A regarding therapy orders regarding resident 48 revealed: *She was unaware of the orders for a wedge cushion for resident 48. *The orders should have been on the care plan for that resident. *Any nurse could have updated the care plan. *Agreed the care plan had not been updated. Interview on 6/10/21 at 9:32 a.m. with physical therapist G regarding resident 48's therapy orders revealed she:	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 656	Continued From page 5 *Had expected the therapy orders to have been implemented. *Had expected the nurses to update the care plan. *Agreed the wedge cushion was not on the care plan. 3. Review of resident 253's 6/8/21 care plan revealed: *She "will remain free from catheter related trauma." -Interventions for catheter care every shift and as needed. -Her Foley catheter was to be changed per facility protocol or physician order. -Her urine/catheter output was to be monitored every shift. Review of resident 253's 6/9/21 physician orders revealed she had no catheter and and did not require catheter care. Review of resident 253's June 2021 medication administration record and treatment administration record revealed no catheter care had been completed. Review of the provider's 8/5/20 care plan policy revealed: *Policy Statement: -"Based from the SOM F656 regulation a comprehensive care plan must be developed after the comprehensive assessment of the resident." *Procedures: -"4. After the comprehensive assessment (state/federal-required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident within 7	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 656	Continued From page 6 days." -"5. These will be periodically reviewed and revised by a team of qualified person after each assessment."	F 656	1. Residents 10, 22, 103, 154, and 253 were assessed for a need for bedrails, orders were obtained, consents were signed, zones were measured, and care plans have been updated. 2. All of residents are at risk for adverse effects related to unnecessary use of bedrails. 3. The Administrator/DON and the Interdisciplinary Team in collaboration with the governing body and Medical Director reviewed the Restraint Free Environment Policy and the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. All beds were audited, all side rails assessed as inappropriate for use have been removed and residents that were found appropriate for side rail use received orders, consents signed, assessments completed, zones measured, and care plan updated. The facility will utilize daily stand up, care conferences and the weekly PAR meeting to identify needs for bedrails, ensure accuracy for appropriate use and documentation. The DON or designee will educate all staff on our Restraint Free Environment. The Administrator or designee will educate the Maintenance Director on the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment to ensure appropriate assessment of the side rails, mattresses and beds has been completed when side rails are deemed appropriate for the resident. Education will occur no later than July 30th and those not in attendance to that date due to vacation, sick leave, or casual status will be educated prior to their first shift worked. 4. The Administrator/DON or designee will audit the all beds weekly for four weeks, and then monthly for two months to ensure assessments of the side rails in use are completed prior to initiation of use, quarterly and with a change of condition. Results for the audits will be discussed by the Administrator/DON or designee at the monthly QAPI meeting with the IDT and Medical Director for continuation/discontinuation/revision of audits based on audit findings.	7/30/2021
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 42558 Based on observation, interview, and policy review, the provider failed to ensure safety assessments were routinely completed and documented for five of fifteen sampled residents (10, 22, 103, 154, and 253) who had quarter length side rails on their beds. Findings include:	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 700	Continued From page 7 1. Observation and record review of resident 10 on 6/8/21 at 9:49 a.m. and on 6/09/21 at 3:00 p.m. revealed: *Had diagnosis of Alzheimer's dementia, unsteadiness on feet, and a history of falling. *He had been resting in bed with raised quarter length side rails on both sides of his bed. -His mattress had been a pressure relief mattress. *He had been observed using the side rails to reposition side-to-side and to maintain a sitting position at the side of the bed. *His most recent 4/23/21 care plan included: -"I have a side 1/4 side rail to the right side of my bed. My side rail does not limit access to my body and does not restrict movement of my body." -"Side rail assessment Q (every) 3 months and PRN (as needed). " *He had a side rail initial evaluation assessment performed on 11/17/19. -There had been no further side rail assessments located. 2. Observation, interview, and record review of resident 154 on 6/8/21 at 10:03 a.m. and on 6/9/21 at 3:15 p.m. revealed: *She had a diagnosis of cerebral infarction with flaccid hemiplegia (inability to move) affecting her left non-dominant side. -She was unable to move her left arm or leg. *She was sitting in her wheelchair with a brace to her lower left leg and her left arm. *Her bed was made and had raised quarter length side rails on both sides of her bed. -She had an air mattress on her bed. *She stated she had used the bed rails to support herself when being repositioned by staff. *Her most recent 4/23/21 care plan included:	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 700	Continued From page 8 -"I require assistance with ADL (activities of daily living) functions related to my Dx (diagnosis) of CVA (cerebral vascular accident) with hemiparesis." -"I use bilateral grab rails to assist me with repositioning when I am in bed." *She had a side rail initial evaluation assessment performed on 11/17/2019. -There had been no further side rail assessments located. Interview on 6/9/21 at 4:00 p.m. with director of nursing (DON) B (who was from another corporate facility) and assistant DON H revealed: *DON A kept track of residents who had side rails [she was currently not available]. *Their facility policy stated side rail assessments should have been performed upon determination of resident need then quarterly. -Quarter length side rails were included in this category. -This should have been documented in each resident's electronic file as a nurse assessment under the heading "side rail/other devices evaluation." *The maintenance director had been in charge of installing and inspecting the side rails for continued safety on a quarterly basis. Interview on 6/9/21 at 4:14 p.m. with director of maintenance I revealed he: *Had been notified from the director of nursing, through a daily stand up meeting, when a side rail needed installed on a bed. *Inspected the side rails every couple of weeks by performing a facility-wide "sweep". -This meant he would walk through every room in the facility to look for anything that needed maintained.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 700	Continued From page 9 *Had not kept a list of current residents with side rails or a log of his side rail inspections. *Had not been aware maintenance inspections needed to be documented. *Had not inspected the mattresses to ensure proper fit against the side rails. -Stated, "I just do it by hand. The rails are lock nutted into the frames. All the mattresses are standard size, so they will fit the bed frame and railings." Interview on 6/9/21 at 4:30 p.m. with DON B confirmed the maintenance director had not been aware he needed documentation of his side rail safety inspections. Review of the provider's November 2017 Proper Use of Side Side Rails Policy revealed: *"7. When used, the side rails must be correctly fitted and compatible with the design of the mattress and bed frame, and the manufactures' recommendations." *The above policy had not included routine inspections for safety. Surveyor: 43844 3. Observation on 6/8/21 at 12:43 p.m. of resident 253's bed revealed 2 quarter size rails raised on her bed. Review of resident 253's medical record revealed her: *Activities of daily living care plan intervention initiated on 4/15/21 had been "Side rails as ordered, ..." *Current physician orders had not included side rails. *Care record had not included side rail safety	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 700	Continued From page 10 assessments. Interview on 6/10/21 at 1:04 p.m. with director of nursing A and director of nursing B regarding resident 253's side rails revealed there had been no side rail assessments completed. Surveyor: 16385 4. Observations on 6/8/21 9:30 a.m. during tour of north hallway and random observations through 6/10/21 revealed two quarter side rails on resident 22's bed. Review of resident 22's 4/19/21 readmission side rail/other devices assessment revealed none were used by the resident. Review of resident 22's 5/20/21 care plan revealed no interventions related to two quarter side rails on his bed. 5. Observations on 6/8/21 at 10:30 a.m. during tour of east hallway and random observations through 6/10/21 revealed one quarter side rail on resident 103's bed on her left side. Review of resident 103's 5/27/21 readmission side rail/other devices assessment revealed none were used by the resident. Review of resident 103's 5/28/21 care plan revealed no interventions related to the quarter side rail on her bed. Interview on 6/10/21 at 10:40 a.m. with DON A revealed the nurses had not completed the assessments correctly after residents 22 and 103 had returned to the facility after hospitalization.	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING _____ B. WING _____	C 06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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 700	Continued From page 11 Review of the provider's 11/17 Proper Use of Side Rails policy revealed: *"2. An assessment of the residents' symptoms and the reason for using side rails will be conducted prior to use, including their mental status and reason for use of the side rail, and will be documented in the residents' record." *"6. The use of side rails as an assistive device will be addressed in the residents' care plan."	F 700		

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
	435064	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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
E 000	Initial Comments Surveyor: 16385 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 6/8/21 through 6/10/21. Avantara North was found in compliance.	E 000		

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

Celina Lalare | Administrator | 7/2/2021

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

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
	435064	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/08/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	**1620 NORTH 7TH 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
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/8/21. Avantara North was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K345 and K374 in conjunction with the providers commitment to continued compliance with the fire safety standards.	K 000		
K 345 SS=D	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to test the fire alarm system as required (repairing trouble and supervisory signals for the fire alarm panel) for calender year 2020. Findings include: 1. Record review on 6/8/21 at 1:30 p.m. revealed the Fire Alarm Inspection and Testing Report from	K 345	1. The facility has obtained a quote to replace the Fire Alarm System from Western States Fire Protection and on 6/29/21, they had Justice Fire and Safety come in to evaluate and are awaiting their quote. The system will be repaired/replaced once both quotes can be reviewed. 2. All residents are at risk for adverse effects if the fire alarm is not in working condition. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing, and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Life Safety Code K345. The Maintenance Director or designee will educate all-staff on this Life Safety code and to inform their immediate supervisor if issues with the system are noted. 4. The Maintenance Director or designee will audit this system to ensure proper working condition weekly for 4 weeks, then monthly for two months. Results of the audits will be discussed by the Administrator/Maintenance Director or designee at the monthly QAPI meeting with the IDT and Medical Director for continuation/discontinuation/revision or audits based on audit findings.	7/2/2021

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

Celina Lahr | Administrator | 7/9/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435064	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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
K 345	Continued From page 1 Western States Fire Protection Co. dated 8/7/20 noted deficiencies as follows: *No "Trouble" Signals were relayed to the monitoring company. *No "Trouble Restore" Signals were relayed to the monitoring company. *No "Supervisory" Signals were relayed to the monitoring company. *No "Supervisory Trouble" Signals were relayed to the monitoring company. Each item had been recommended to be investigated and corrected by Western States. Interview with the maintenance supervisor on 6/8/21 at 3:00 p.m. confirmed that finding. He revealed those noted items had not yet been corrected at the time of the survey. Failure to maintain the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 345		
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window	K 374		

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
	435064	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 NORTH 7TH 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
K 374	Continued From page 2 assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on measurement and document review, the provider failed to maintain the self-closing requirement for three of four smoke barrier doors (south wing, southeast wing, and service wing). Findings include: 1. Observation on 6/8/21 at 3:45 p.m. revealed the smoke barrier doors to the south wing, southeast wing, and service wing did not release from the magnetic hold-opens and automatically close as required upon activation of the fire alarm during the fire drill. Staff pulled the doors free from the magnets during the fire drill to close the doors. There was no documentation indicating the magnetic held-open smoke barrier doors had been tested for functional requirements. Interview with the maintenance supervisor at 3:55 p.m. confirmed those findings. The deficiency had the potential to affect 100% of the building occupants.	K 374	1. Due to the fire alarm system not working properly, the facility has obtained a quote to replace the Fire Alarm System from Western States Fire Protection and on 6/29/21, they had Justice Fire and Safety come in to evaluate and are awaiting their quote. The system will be repaired/replaced once both quotes can be reviewed. 2. All residents are at risk for adverse effects if the fire alarm is not in working condition. 3. The Administrator, Director of Nursing (DON), Assistant Director of Nursing, and Interdisciplinary Team (IDT) in collaboration with the governing body and Medical Director reviewed the Life Safety Code K374. The Maintenance Director or designee will educate all-staff on this Life Safety code and to inform their immediate supervisor if issues with the smoke barrier doors. 4. The Maintenance Director or designee will audit this system to ensure proper release of the smoke doors weekly for 4 weeks, then monthly for two months. Results of the audits will be	7/2/2021

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10665	A. BUILDING: _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA NORTH	1620 N 7TH ST 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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/8/21 through 6/10/21. Avantara North was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 6/8/21 through 6/10/21. Avantara North was found in compliance.	S 000		

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

Administrator — 7/2/2021

STATE FORM 6EG411 — If continuation sheet 1 of 1