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 |
|---|---|---|---|
| | 435050 | A. BUILDING ______ B. WING ______ | C 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA ARLINGTON | 120 CARE CENTER ROAD ARLINGTON, SD 57212 |

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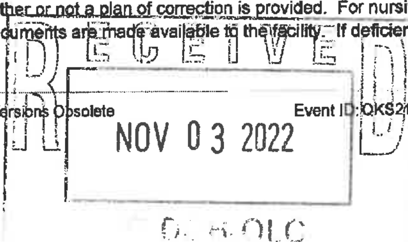
| F 000 | INITIAL COMMENTS<br><br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/11/22 through 10/13/22. Avantara Arlington was found not in compliance with the following requirements: F585, F656, F661, F725, F740, F880.<br><br>A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 10/11/22 through 10/13/22. Areas surveyed included quality of care and resident rights. Avantara Arlington was found in compliance. | F 000 | | |
| F 585 SS=E | Grievances<br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br>§483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. | F 585 | Past grievances of not receiving baths as scheduled and untimely call light responses have been reviewed. Residents provided resolution to their satisfaction. Resident Council was held on 10/27/22 and voiced concerns were addressed through the grievance process. All residents have the potential to be affected by the dificient practice.<br><br>Policy has been reviewed with no revisions needed. Administrator will be educated on resolution of grievances expressed during resident council by the Regional Director of Operations by 11/9/22. All other employees will be educated by the Administrator by 11/9/22. All employees not in attendance will be educated prior to their next shift worked. All grievances will be discussed and monitored daily in morning huddle. | 11/9/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/3/22

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



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| F 585 | Continued From page 1<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;<br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident | F 585 | Administrator or designee will audit all grievances weekly for resolution to resident's satisfaction for at least 3 months. Administrator will present audit findings to QAPI monthly for review and recommendations for at least 3 months. | |

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right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, resident council meeting notes review, policy review, and job description review, the provider failed to implement an effective grievance system that resolved identified resident grievances for long call light wait times and missed resident showers

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which had the potential to affect all 30 residents (1, 2, 3, 4, 5, 6, 7, 8, 9, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, and 81). Findings include:

1. Interview on 10/12/22 at 8:46 a.m. with resident 26 in his room revealed:
*He had been resting in his wheelchair.
*He required a full mechanical lift to transfer from his wheelchair and bed.
*He voiced concerns that wait times had happened on a regular basis.
*When asked if there had been a pattern as to when the long wait times took place, he said "No. They are always short-staffed and need more help."
*Sometimes the staff came in, shut off the call light, and then did not return for a long time.
*He had voiced his concerns to nursing staff but the situation had not improved.

Interview on 10/13/22 at 1:56 p.m. with activities director E regarding resident council meetings and resident grievances revealed:
*She had made arrangements for and attended the resident council meetings.
*The residents had requested staff assistance to help facilitate those meetings.
*If resident concerns had been identified during the meetings, she would assist the residents to fill out grievance forms.
*Once the form had been filled out she took it to administrator A.
*The administrator then took over the grievance process.
*She had not been involved in the resolution process, she thought administrator A did that.
*At the next scheduled resident council meeting she asked the residents if the issues from the

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past meeting and submitted grievances had been resolved to their satisfaction and then recorded their responses on the meeting notes form.
*That information was kept in a resident council meeting binder.

Record review of resident council monthly meeting minutes from December 2021 through September 2022 revealed during:
*The 12/9/21 meeting the twelve residents in attendance discussed not having their call lights answered timely and call lights being turned off by staff without helping the residents.
*The 1/24/22 meeting the six residents in attendance and discussed the concern with call lights not being answered timely again.
*The 3/10/22 meeting the eight residents in attendance discussed staff turning off the call lights without helping the residents.
*The 4/14/22 meeting, the eight residents in attendance discussed the concern brought up at the last meeting with staff turning off call lights without helping the residents and felt the issue had not been resolved.
-Meeting minutes recorded were signed by administrator A on 4/18/22.
-There were five grievance forms attached from residents attending the meeting, one concern stated resident 7's call light was on for 90 minutes on 4/14/22 and another resident's call light was on for 45 minutes on 4/13/22 (this resident has been discharged).
*The 5/5/22 meeting the six residents in attendance discussed concerns with staff turning off call lights without helping the residents and again felt the issue had not been resolved.
-The residents also discussed not getting baths when they were scheduled.
-Meeting minutes were signed 27 days later on

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6/1/22 by administrator A.
*The 6/2/22 meeting the eight residents in attendance discussed staff turning off call lights without helping the residents and again felt the issue had not been resolved.
-The residents also discussed the concern brought up at the last meeting with not getting baths when they were scheduled and felt this issue had also not been resolved.
-Meeting minutes were signed by administrator A on 6/6/22.
-There were four grievance forms attached from residents attending the meeting.
*The 7/14/22 meeting the thirteen residents in attendance discussed the concern brought up during previous meetings with staff turning off call lights without helping the residents and again, felt the issue had not been resolved.
-The residents also discussed the concern brought up during previous meeting with not getting baths when they were scheduled and felt this issue had also not been resolved.
-Meeting minutes were signed by administrator A on 7/14/22.
*The 8/11/22 meeting the nine residents in attendance discussed staff turning off call lights without helping the residents and again, felt the issue had not been resolved.
-The residents also discussed not getting baths when they were scheduled and again, felt the issue had not been resolved.
-Meeting minutes were signed by administrator A on 8/13/22.
*The 9/8/22 meeting the eleven residents in attendance discussed the two concerns brought up at previous meetings with staff turning off call lights without helping the residents and not getting baths when they were scheduled.
-The residents felt both issues had not been

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resolved.
-Meeting minutes were signed 23 days later on 10/1/22 by administrator A.

Record review of the provider's grievance forms for 2022 revealed:
*26 grievance forms:
-Five grievances related to showers or baths not getting done.
--One grievances had a documented notification after 19 days.
-Five grievances related to call lights not being answered, being turned off with no assistance, or response times ranging from 30 - 90 minutes.
--Three grievances had not documented a timely notification had been made to the resident of proposed remedies within three days per policy.

Interview on 10/13/22 at 5:35 p.m. with administrator A revealed:
*He had been the assigned grievance official along with the social services designee.
*He received the grievance forms from the social services designee and/or activities director.
*Once those grievance forms were brought to him, he sent it to the staff member most appropriate to investigate that particular issue.
*When the investigation was completed he then signed the form and he talked with the person who had filed the grievance to ensure it had been resolved.
*He confirmed they had received ongoing complaints of long call light response times and missed showers.

Review of provider's 1/5/21 Grievance policy revealed:
*"It is the policy of this facility to investigate all grievances registered by, or on behalf of a

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resident..."
*"Residents are encouraged to express grievances on behalf of themselves or other to the facility's Administrator, the Resident Council, State or Government Agencies, or other persons."
*"The facility Administrator or Administrator Designee, referred to as the grievance official, has been designated to receive all grievances."
*"The grievance official shall confer with persons involved in the incident and other relevant persons and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party..."
*"All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance [sic], and the date the written decision was issued."

Review of the provider's updated 12/1/19 activities director job description responsibilities revealed:
*..."19. Reports all Guest concerns to the appropriate department head.

Review of the provider's updated 12/1/19 social services designee job description responsibilities revealed:
*..."10. Provides consultation to Guests on a regular or as needed basis to discuss problems encountered by Guests and assists with the

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| F 585 | Continued From page 8<br>implementation of solutions."<br><br>Review of the provider's updated 12/1/19 administrator job description responsibilities revealed:<br>*..."15. Ensures that all resident complaints/concerns are addressed timely and works with appropriate department heads for resolution."<br><br>Refer to F725. | F 585 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§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 -<br>(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<br>(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).<br>(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 | F 656 | Care plan for resident 19 has been updated to reflect current needs. All residents have the potential to be affected.<br><br>All care plans will be reviewed and revised as needed by 11/9/22 by the IDT (Interdisciplinary Team). Policy has been reviewed with no revisions. IDT and nursing staff will be educated by DON or designee on updating care plans to reflect their current needs timely by 11/9/22. All staff not in attendance will be educated prior to their next shift worked.<br><br>DON, or designee will audit 3 random care plans for revisions and timeliness weekly for 3 months. DON or designee will present audit findings at QAPI meetings monthly for review and recommendations for at least 3 months. | 11/9/22 |

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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.
(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:
Based on observation, interview, and record review, the provider failed to develop and implement a comprehensive person centered care plan that reflected the individual hygiene needs for one (19) of thirteen sampled residents.
Findings include:

1. Observation on 10/12/22 at 8:41 a.m. of resident 19 in her room revealed her hair was oily and uncombed, and her lips were dry and cracked.

Observation on 10/12/22 at 1:39 p.m. of resident 19 in her room revealed:
*It appeared as if the resident was wearing mosquito netting around her face.
Upon closer inspection, it was discovered it was her hair that was covering her face.
-Her hair remained uncombed and oily.
*Her fingernails were long and jagged.
*There was unidentified black substance

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underneath her fingernails.

Interview on 10/12/22 at 2:11 p.m. with certified nurse assistant (CNA) J about assisting resident 19 with personal hygiene revealed:
*She often refused baths, showers, hair care, and nail care.
*They tried to reapproach at different times and/or with different employees to see if she would accept assistance with personal hygiene.
*She refused after they reapproached her, they have her a warm washcloth to let her wash her face.
*If she continued to refuse, they would inform the charge nurse.

Interview on 10/13/22 at 2:39 p.m. with activities director E about resident 19 revealed:
*She did not like showers or baths.
*She refused haircuts.
*Staff offered her showers throughout the week.

Interview on 10/13/22 at 2:53 p.m. with Minimum Data Set (MDS) registered nurse (RN) D about resident 19 revealed:
*She was very involved with developing the resident care plans.
*The resident often refused showers.
*Sometimes they had success when a different staff member came back later to ask her if she wanted to take a shower.
*They tried to make the task of taking a shower her idea.
*The above information was not on her care plan.

Interview on 10/13/22 at 4:37 p.m. with regional nurse consultant (RNC) C about resident 19 revealed:
*She had been the interim director of nursing at a

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| F 656 | Continued From page 11<br>different nursing home the resident had lived at previously.<br>*At that previous facility, staff were able to "reward" resident 19 with small trinkets when she would take a shower.<br>*They had not tried yet at the present facility to offer "rewards" if resident 19 took a shower.<br><br>Review of resident 19's electronic medical record revealed:<br>*The bathing record report generated from 9/13/22 to 10/13/22 indicated the resident had only received one shower on 10/1/22.<br>*The provider could not produce any other documentation to show if/when the resident had refused showers.<br><br>Review of resident 19's care plan revealed there were no descriptions or interventions regarding:<br>*How staff should respond when the resident had refused showers.<br>*Interventions that had worked in the past to encourage the resident to take showers on a regular basis. | F 656 | | |
| F 661<br>SS=D | Discharge Summary<br>CFR(s): 483.21(c)(2)(i)-(iv)<br><br>§483.21(c)(2) Discharge Summary<br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br>(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.<br>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for | F 661 | Resident 10 no longer resides in the facility. All residents have the potential to be affected by the deficient practice.<br><br>All employees of the Interdisciplinary Team (IDT) and any other employees responsible for assisting residents discharge the facility will be educated by the DON or designee on how to use the Point Click Care Discharge Summary and the Discharge Planning UDA by 11/9/22. The Discharge Summary will be printed, and a copy given to resident and/or POA. | 11/9/22 |

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| F 661 | Continued From page 12<br>release to authorized persons and agencies, with the consent of the resident or resident's representative.<br>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).<br>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and closed record review the provider failed to ensure one of two discharged residents (10) had discharge summaries documented in their electronic medical record (EMR). Findings include:<br><br>1. Review of resident 10's EMR revealed:<br>*He had been admitted on 7/29/22 for skilled wound care and discharged on10/6/22.<br>*Registered nurse (RN) K documented on10/6/22 at 7:53 p.m. a physician's order had been obtained to discharge resident to home on his current medications and home health services.<br>*No discharge summary, discharge instruction, or disposition of medications, or personal belongings had been found in resident's EMR.<br><br>Interview on 10/13/22 at 11:00 a.m. with administrator A and regional nurse consultant C regarding above documentation revealed: | F 661 | Administrator, DON, or designee will perform weekly audits of discharge planning UDAs on all residents planning on discharging. Audits will be conducted for 3 months and the bi-weekly for 2 months. Audits will be reviewed at QAPI where it will be determined to continue or cease. | |

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| F 661 | Continued From page 13<br>*The administrator indicated the resident had gone to a clinic appointment and had received approval to be discharged to home from there.<br>*Both agreed there was no discharge summary, discharge instructions, or disposition of medication or personal belongings.<br><br>Review of the provider's December 2021 Discharge/Transfer Policy revealed:<br>*"The Legacy Group Health Care Instruction and Summary for Discharge form will be completed with all planned discharges." | F 661 | | |
| F 725 SS=E | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2)<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides. | F 725 | Administrator, DON, and/or Social Services Designee will meet with all residents individually to determine their preferred daily routines, including bathing schedule. All care plans will be updated to reflect those preferences by 11/9/22. All residents have the potential to be affected.<br><br>The Administrator, DON, and multidisciplinary team in collaboration with medical director and governing board to review and revise as necessary facility assessment and assemble a realistic staffing model, including input from direct care staff, residents, and family by 11/9/22. Policies and procedures relevant to findings in F858, F656, F661, F740, and F880 will be reviewed and updated as necessary. All facility and agency staff will be educated about their roles and responsibilities for their their assigned task(s). All caregivers will receive education by DON or designee on following their preferences as indicated on their care plans by 11/9/22. All staff not in attendace will be educated prior to their next shift worked. Updates to resident preferences will be shared utilizing a communication book that should | 11/9/22 |

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| F 725 | Continued From page 14<br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, facility assessment review, and job description review, the provider failed to ensure sufficient nursing staff were available to:<br>*Meet individual resident acuity needs for 16 of 30 residents (1, 3, 6, 7, 9, 11, 12, 13, 16, 17, 24, 25, 26, 27, 28, and 30) who required use of mechanical lifts..<br>*Meet individual resident preference for bathing for three of eighteen sampled residents (19, 22, and 81).<br>*Meet resident needs timely and in a manner that promoted individual rights and maintained physical, mental, and psychosocial wellbeing for all 30 current residents.<br>Findings include:<br><br>1. Observation at 1:20 p.m. on 10/11/22 upon entrance to the facility revealed:<br>*Two resident hallways that contained several mechanical lifts used for resident care.<br>*The nursing staff on duty included:<br>-One certified nurse assistant (CNA) assigned to each of the two resident hallways.<br>-One medication aide.<br>-One registered nurse (RN).<br>*The surveyors noted audible call lights were sounding on a consistent basis.<br><br>Interview on 10/12/22 at 8:46 a.m. with resident 26 in his room revealed:<br>*He had been resting in his wheelchair.<br>*He required a full mechanical lift to transfer from | F 725 | be reviewed by staff at the start of their shift. Communication book will be reviewed and updated during daily huddle.<br><br>Social Services Designee or designee(s) will interview 10 random residents to ensure their needs are being met weekly for 4 weeks, then 5 residents weekly for at least 2 months. Social Services Designee will present audit findings to QAPI monthly for review and recommendations for at least 3 months. | |

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his wheelchair and bed.
*He voiced concerns about long call light wait times.
*When asked if there had been a pattern as to when the long wait times took place, he said "No. They are always short-staffed and need more help."
*The long wait times had happened on a regular basis.
*Sometimes the staff came in, shut off the call light, and then do not return for a long time.
*He had voiced his concerns to nursing staff, but the situation had not improved.

Review of the facility list of residents who required the use of mechanical lifts for transfer revealed 16 of 30 current residents were on that list (1, 3, 6, 7, 9, 11, 12, 13, 16, 17, 24, 25, 26, 27, 28, and 30).

Interview on 10/13/22 at 1:56 p.m. with activities director D revealed:
*She had been in her current position for four years.
*She was a CNA and assisted on the floor.
*She assisted the CNAs with transfers and answering call lights on a regular basis.
*In the past four to five months they had several staff leave.
*That loss of staff had made it difficult to fill the staff schedule.
*They had used contracted agency staff to help fill those gaps.

Interview on 10/13/22 at 3:26 p.m. with administrator A and regional nurse consultant C revealed:
*The administrator indicated he had been in his position for two years.

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| F 725 | Continued From page 16<br>*They had followed their facility assessment for the staff schedule.<br>-That facility assessment had not included information to account for resident acuity within the staffing/resident ratio section.<br>*There had been one CNA on each hallway, one medication aide, and one RN during the day.<br>*They had not scheduled a separate bath aide or a float staff to assist the residents.<br>-They used the activity director, social services designee, and office manager who were also trained as CNAs.<br>-If those staff had been pulled to the floor to assist it would take them away from their regular duties.<br>*Staff were kept busy with more than half of the residents requiring the assistance of a mechanical lift for transfers.<br>*The full mechanical lift required two staff to operate safely.<br>-At those times, there would not always be staff available in the opposite hallway to assist those residents.<br>*When asked if they could schedule extra staff to assist with resident needs, administrator A stated he thought what they scheduled was working.<br>*Their staff budget had not allowed for more assistance than what they currently scheduled.<br>*They had repeated complaints from resident council meetings of long call light wait times and missed scheduled showers.<br>*They were not able to run call light audit reports because their system was older and did not have audit capabilities.<br>-Instead, they would conduct random audits of call lights by tripping the button and timing the staff response time.<br>--They completed the audits at various times and shifts throughout the day. | F 725 | | |

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*When call light grievances were raised by the residents, they educated staff to ensure they answered call lights promptly.

Interview on 10/13/22 at 4:47 p.m. with CNA J revealed:
*She had been employed there for six months.
*Her regular shift had been from 2:00 p.m. to 9:00 p.m.
*It had been difficult to get the call lights answered timely because there were many residents that needed two or more staff to complete transfers.
*There were long call light wait times for the residents, but they did their best to get them answered as soon as possible.
*They tried to answer the call lights in order, but sometimes they would address the "easy ones" quickly and go back to the other residents.
*Showers had not always been completed at times because they were so busy.
*They could use more help to take care of resident's needs.

Review of the provider's facility assessment revealed updated August 2022 revealed:
*On page 15, under the "Staffing plan" section:
-"2. Based on our resident population and their needs for care and support, and other assignments required to support operations and compliance with regulations, the following table displays the number of full-time equivalents (FTE = 40 hours/week) for each of the services/assignments above."
--"Staff: Licensed Nurses: [registered nurses], [licensed practical nurses] providing direct care.
---"Plan: [Director of nursing]: one director of nursing full-time days ..."
---"[Critical care coordinator]: one critical care

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coordinator registered nurse full-time days."
—"RN or LPN charge nurse: one for each shift. 1-30 residents the DON may be charge nurse."
—"1:30 [certified medication aide] CMA ratio Days."
--"Staff: Direct care staff."
—"Plan: 2-3:30 ratio Days (total licensed or certified). 1-2:30 ratio Evenings. 1-2:30 ratio Nights."
--"Staff: Other ..."
—"Plan: Medical Records: one Medical Records, CMA, full-time days. Activities Director: one Activities Director, CNA, full-time days. Social Services Designee [SSD]: 1 SSD, CNA, full-time days."

Review of the update 12/1/19 administrator job description revealed he had been responsible to:
*"...12. Ensure that appropriate staffing levels are maintained at all times to meet governing requirements and resident needs."

2. Observation on 10/12/22 at 8:41 a.m. of resident 19 in her room revealed her hair appeared oily and uncombed, and her lips were dry and cracked.

Observation on 10/12/22 at 1:39 p.m. of resident 19 in her room revealed:
*It appeared as if resident 19 was wearing mosquito netting around her head.
-Upon closer inspection, it was discovered it was her hair that was covering her face.
-Her hair remained uncombed and oily.
*Her fingernails were long and jagged.
*There was unidentified black substance underneath her fingernails.

Interview on 10/13/22 at 2:39 p.m. with activities

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director E about resident 19 revealed:
*Resident 19 did not like showers or baths.
*She refused haircuts.
*Staff offered showers to her throughout the week.
*Activities director E was not aware that staff had not been documenting in resident 19's electronic medical record when she refused showers or baths.

Interview on 10/13/22 at 2:53 p.m. with minimum data set (MDS)/care plan coordinator D about resident 19 revealed:
*She would often refuse showers.
*Sometimes they had success when a different staff member came back later to ask her if she wanted to take a shower.
*They tried to make the task of taking a shower her idea.
*MDS/care plan coordinator D was not aware that staff had not been documenting when resident 19 refused showers.

Interview on 10/13/22 at 4:37 p.m. with administrator A and regional nurse consultant (RNC) C about resident 19 revealed:
*Neither administrator A nor RNC C was aware that staff had not been documenting when resident 19 refused showers or baths.
*They were unable to provide documentation indicating when the resident had refused showers.

Review of resident 19's electronic medical record revealed:
*The bathing record report generated from 9/13/22 to 10/13/22 indicated resident 19 only received one shower on 10/1/22.
*There were no other records to show if/when

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resident 19 had refused showers.

3. Observation and interview on 10/12/22 at 9:15 a.m. with resident 81 revealed:
*He was seated in his wheelchair in his room watching television.
*He had admitted on 9/22/22.
*He was able to communicate by gesturing and the use of a communication board.
*When asked if he had received regular showers, he shook his head to indicate he had not.
*When asked if he had missed showers since his admission he nodded his head, yes.

Review of the provider's 9/22 and 10/22 shower record revealed:
*He preferred his showers to be completed on Tuesdays.
*Showers had been documented as completed on 9/27/22, and 10/11/22, which were Tuesdays.
*There had been no documentation of a shower completed the week of 10/4/22.

Interview on 10/12/22 at 4:27 p.m. with activities director E regarding resident 81 revealed:
*He was a new admit in the past few weeks.
*She was not aware that he had not been offered a shower the week of 10/4/22.
*A shower had been completed on 10/11/22.
*She had not assisted with the shower but did assist the CNA to transfer him with the mechanical lift.
*She documented completion of the shower after she had assisted to transfer him back to his wheelchair after his shower.
*She assisted the nursing staff with resident cares when needed and that had happened on a regular basis.

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4. Observation and interview on 10/13/22 at 1:55 p.m. with resident 22 revealed she was sitting in her wheelchair in her room. During the conversation, the resident was asked if she had been given a bath and she stated "It's been awhile." Resident was asked if she'd had a bath since being admitted and the resident shook her head no.

Review of resident 22's electronic medical record revealed:
*She had been admitted on 9/9/22.
*Her diagnoses included recent fracture of neck of right femur with surgical repair, unspecified visual loss, unsteadiness, and weakness.
*Her initial care plan reviewed with the resident on 9/10/22 included an intervention "...extensive assist of one with bathing..."
*Her 9/11/22 brief interview for mental status score was 14, which indicated she was cognitively intact.
*Her 9/16/22 admission minimum data set assessment question on bathing was coded as "Bathing did not occur."
*A 9/19/22 progress note stating resident 22 "...did not have a bath during reference period [9/10/22-9/16/22]..."
*Her care plan was updated on 9/20/22 with a specific intervention regarding bathing, "Bathing: extensive assist of one. I need physical assist with washing of my body and my hair. I can wash my face and hands when handed a washcloth."
*She was transferred and admitted to the hospital on 9/24/22 with a diagnosis of congestive heart failure exacerbation.
*She returned from the hospital to the provider on 10/3/22.
*A 10/13/22 review of her bathing task in the provider's electronic medical record for the past

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30 days revealed no data had been documented for the following related to bathing:
-"Did the resident take a shower, bath or bed bath?"
-"Specify type of bathing:" with options included shower, bath, bed bath, resident not available, resident refused, and not applicable.
-"BATHING: SELF PERFORMANCE - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair)."
-"BATHING: SUPPORT PROVIDED - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair)."

Interview on 10/13/22 at 1:59 p.m. with activities director E after discussing no baths or showers had been documented for resident 22 since her admission on 9/9/22 revealed:
*She had been cross-trained as a CNA and would work shifts as a CNA when there was not enough staff to cover the shift.
*She stated it did not surprise her that resident 22 had not received a bath since her admission.

Interview on 10/13/22 at 2:52 p.m. with administrator A revealed:
*Staffing was a challenge, especially since the COVID-19 pandemic.
-At the time of the survey, the provider was in an outbreak of COVID-19 infection.
*He stated, "We do our best," and explained how dietary, activity, social service, and medical records staff were cross-trained as CNAs to assist with filling in shifts and working as needed to assist nursing staff.
*He was actively using agency CNAs, licensed practical nurses, and RNs to assist with providing

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| F 725 | Continued From page 23<br>resident care.<br>*He was not aware that resident 22 had not received a bath or shower since her admission on 9/9/22.<br><br>A request was made for resident 22's bath or shower documentation since her admission and on 10/13/22 at 3:26 p.m. a conversation with regional nurse consultant (RNC) C revealed RNC C stated she had looked for the paper shower documentation for resident 22 and was not able to find any.<br><br>Interview on 10/13/22 at 5:52 p.m. with administrator A revealed:<br>*Residents get at least a weekly bath and more often based on resident preferences.<br>*The provider's September 2019 "Bathing Policy" covered both showers & baths.<br>*The September 2019 bathing policy was the current policy.<br><br>Review of the provider's September 2019 "Bathing Policy" revealed "Bathing Preferences are asked upon admission and during quarterly care conference." | F 725 | | |
| F 740 SS=D | Behavioral Health Services<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not | F 740 | Behavioral Health Services have been initiated for resident 19. All similiar residents have the potential to be affected.<br><br>All residents with applicable diagnosis and/or level 2 PASRRs will be reviewed and offered mental health services as needed by the Social Services Designee or designee. Policy was reviewed with no revisions needed. All nursing and social services staff will be educated on offering mental health services for residents with applicable diagnoses and/or level 2 | 11/9/22 |

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

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| | 435050 | A. BUILDING ______ B. WING ______ | C 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
| --- | --- |
| AVANTARA ARLINGTON | 120 CARE CENTER ROAD ARLINGTON, SD 57212 |

| (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 |
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| F 740 | Continued From page 24<br>limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the provider failed to ensure one of one sampled resident (19) had been set up with continued mental health services after admission. Findings include:<br><br>1. Review of resident 19's electronic medical record revealed:<br>*She was 56 years old.<br>*She was admitted on 8/30/22.<br>*She had multiple diagnoses, including:<br>Bipolar disorder.<br>Major depressive disorder.<br>Psychotic disorder with delusions.<br>-Schizophrenia disorders.<br>-Attention-deficit hyperactive disorder.<br>*She previously lived at a different nursing facility which was owned by the same company.<br>*A pre admission screening and resident review was completed on 1/12/22 by the social worker from a previous nursing facility the resident had been living at, and the South Dakota Department of Social Services. The screening indicated:<br>-The resident had been approved for skilled nursing care.<br>-Mental health services were to be continued.<br>-Round-the-clock supervision was required.<br>*She had been receiving telehealth mental health services at the previous nursing facility she had been living at.<br>*There was no documentation indicating she had been set up with mental health services yet since admission to the current facility.<br><br>Interview on 10/13/22 at 2:57 p.m. with Minimum | F 740 | PASRR by the Administrator or designee by 11/9/22.<br><br>Administrator or designee will audit 3 random residents weekly for 4 weeks for at least 3 months. Administrator or designee will present audit findings to QAPI monthly for review and recommendations for at least 3 months. | |

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| F 740 | Continued From page 25<br>Data Set (MDS)/care plan coordinator D regarding resident 19 revealed she:<br>*Was not aware if the resident received mental health services.<br>*Thought that either the social services designee or administrator A would know if the resident received mental health services.<br><br>Interview on 10/13/22 at 4:48 p.m. with administrator A and regional nurse consultant (RNC) C regarding resident 19 revealed:<br>*Administrator A did not know if the resident received mental health services.<br>*RNC C said the resident had received mental health services at two other nursing facilities owned by the same company.<br><br>Interview on 10/13/22 at 5:49 p.m. with RNC C regarding resident 19 revealed:<br>*She had called director of nursing B and confirmed the resident had not been set up with mental health services yet.<br>*She agreed the resident should have been set up with mental health services right away upon admission to the facility. | F 740 | | |
| F 880 SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program. | F 880 | For the identification of lack of:<br>*Appropriate infection control practices for use of personal protective equipment (PPE) while performing COVID testing.<br>*Appropriate cohorting of residents when identified as COVID positive per provider policy.<br>The administrator, DON, and/or designee reviewed the policies and procedures for the above identified areas. The Medical Director was not available for review at the time of this plan of correction but had reviewed and approved the infection prevention and control policies prior to survey. No revisions were necessary as | 11/9/22 |

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F 880 Continued From page 26

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

they are in line with CDC and CMS recommendations 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 11/9/22 by the DON or designee.
All staff not in attendance will be educated prior to their next shift worked.

All residents and staff have the potential to be affected by lack of:
*Appropriate procedure technique in use of PPE while performing COVID testing.
*Appropriate cohorting of residents when identified as COVID policy per provider policy.
Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the DON or designee by 11/9/22. Staff not in attendance will be educated prior to their next shift worked.

Root caus analysis conducted using the 5 whys system. Root cause was identified as the guidance given by RNC C in the absence of the facility's infection prevetionist, did not follow company infection prevention and control policies. Administrator, DON, 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 DON/Infection Preventionist contacted the South Dakota Quality Improvement Organization (QIN) and collaborated with the QIN Hot Spot meeting on 11/2/22. The root cause analysis and this plan of correction were discussed. The QIN agreed with the plan of correction.

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**F 880** Continued From page 27

(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:
Based on observation, interview , and policy review, the provider failed to:
*Ensure infection control practices for use of personal protective equipment (PPE) by Minimum Data Set (MDS) registered nurse (RN) D while performing COVID testing.
*Ensure facility staff had followed the corporate policy for use of PPE while performing tests and appropriate cohorting of residents when identified as COVID positive.
Findings include:

1. Observations on 10/11/22 survey start through 10/13/22 through survey conclusion revealed:
*On 10/11/22 the provider had three identified COVID positive residents.
*On 10/12/22 the provider had five identified COVID positive residents.
*On 10/13/22 the provider had 12 identified COVID positive residents.

Interview on 10/11/22 with regional nurse

**F 880** (Plan of Correction)

Administrator, DON, and/or designee will conduct auditing and monitoring 1-2 times weekly when COVID testing is being performed and will make observations over all shifts to ensure identified and assigned tasks for cohorting residents are being done as educated and trained.
Monitoring for determined approaches to ensure effective implementation and ongoing sustainment of staff compliance with:
*Appropriate infection control practices for use of personal protective equipment (PPE) while performing COVID testing.
*Appropriate cohorting of residents when identified as COVID positive per provider policy.
After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month.
Monthly 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 by committee.

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

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FORM APPROVED
OMB NO. 0938-0391

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F 880 Continued From page 28 F 880

consultant C and administrator A regarding cohorting residents revealed:
*They were using the last QSO released and vaccination status of residents.
*They had not moved any COVID positive residents to another unit in the facility.
-COVID positive and COVID negative residents were remaining in the same room with no education provided to residents about risks of remaining in the same room.

Observation on 10/13/22 at 10:00 a.m. of Minimum Data Set (MDS) registered nurse (RN) D conducting COVID testing revealed:
*She had been wearing an N-95, face shield, gown and gloves.
*Exited a resident's room with the nasal swab and placed swab into tester.
*While wearing the same PPE she:
-Opened other test kits.
-Moved her med cart to another room.
-Entered another resident's room with a new nasal swab to obtain a sample for testing.
-Returned to the med cart and placed nasal swab in the tester.
-Resident's name were written on the tests.
*She removed her gloves and washed her hands, but continued to wear the same gown.

Interview on 10/13/22 at 10:30 a.m. with administrator A and regional nurse consultant C regarding the above observation revealed:
*The administrator indicated that he had visited with MDS RN D regarding the above observation.
-She was of understanding that you did not need to change her PPE when going from room to room performing COVID testing.
*He and MDS RN D thought everyone was negative and did not require frequent PPE

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| F 880 | Continued From page 29 | F 880 | | |

changes.
*Regional nurse consultant agreed that MDS RN D should have changed her PPE and performed hand hygiene after exiting resident room.

Interview on 10/13/22 at 1:45 p.m. with corporate infection control I regarding COVID positive and negative resident sharing a room and observation of resident testing revealed:
*It was not the corporate policy that residents who are COVID positive to remain in the same room with their COVID negative roommate.
*COVID positive residents should have been moved to another room.
*COVID negative resident should be moved to another room.
*If the resident refused to move, education would be provided and documentation of education provided documented in the resident's electronic medical record (EMR).
*Agreed the staff member performing COVID testing should have changed her PPE between each resident interaction.
*She had sent out education to staff regarding the proper use of PPE including:
-When to use PPE.
-When to change PPE.
-When to perform hand hygiene.
*Stated she had sent that guidance to the provider that morning regarding separating COVID positive and negative residents to have separate units.

Interview via phone on 10/13/22 at 5:04 p.m. with director of nursing B regarding observations and policies revealed:
*She had thought it was okay to let the resident's stay in the same room regardless of the their COVID positive status.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 880 | Continued From page 30<br>-Realized later resident's should have moved to a separate unit when they had become COVID positive.<br>*Agreed the resident's had not been educated and given an opportunity to change room once their roommate had tested positive for COVID.<br><br>Review of provider's August 2022 Resident with suspected/confirmed COVID-19/SARS COV-2 policy revealed:<br>*Gowns and gloves would be changed with each resident encounter.<br>*No documentation supported the cohorting of COVID positive residents with COVID negative residents. | F 880 | | |

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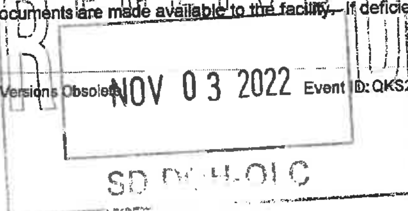
| E 000 | Initial Comments<br><br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 10/11/22 through 10/13/22. Avantara Arlington was found in compliance. | E 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/3/22

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



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| | 435050 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 10/12/2022 |

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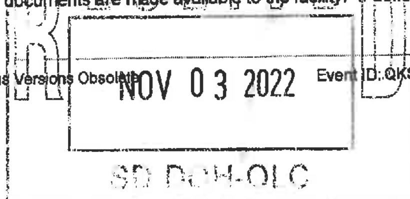
| K 000 | INITIAL COMMENTS<br><br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 10/12/22. Avantara Arlington was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K353, K522, and K915 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — [signature]
TITLE: Administrator
(X6) DATE: 11/3/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.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| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 435050 | MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING ______ | DATE SURVEY COMPLETE: **10/12/2022** |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **AVANTARA ARLINGTON** | **120 CARE CENTER ROAD ARLINGTON, SD** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| **K 353** | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.<br>a) Date sprinkler system last checked ______<br>b) Who provided system test ______<br>c) Water system supply source ______<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the provider failed to verify the required annual testing of the backflow preventer had been performed. Findings Include:<br><br>1. Review of the provider's sprinkler maintenance records revealed no documentation the required annual testing of the backflow preventer had been performed. Interview with the maintenance supervisor on 10/12/22 at 9:30 a.m. revealed the test had not been performed.<br><br>The deficiency affected a single component of the building's automatic fire sprinkler system required annual maintenance. |
| **K 522** | HVAC - Any Heating Device<br>CFR(s): NFPA 101<br><br>HVAC - Any Heating Device<br>Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:<br>* is chimney or vent connected.<br>* takes air for combustion from outside.<br>* provides for a combustion system separate from occupied area atmosphere.<br>19.5.2.2<br>This REQUIREMENT is not met as evidenced by:<br>Based on Observation, testing, and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include:<br><br>1. Observation of the two commercial natural gas-fired dryers in the laundry room on 10/12/22 at 9:00 a.m. revealed the following:<br>a. There was a dedicated combustion (fresh) air ductwork with an internal damper provided for the operation |

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

The above isolated deficiencies pose no actual harm to the residents

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 435050 | MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING | DATE SURVEY COMPLETE: **10/12/2022** |
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| NAME OF PROVIDER OR SUPPLIER **AVANTARA ARLINGTON** | STREET ADDRESS, CITY, STATE, ZIP CODE **120 CARE CENTER ROAD ARLINGTON, SD** | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| **K 522** | Continued From Page 1 of the natural gas-fired commercial clothes dryers.<br>b. Testing of both dryers in operation while observing the damper shaft in the fresh air duct on 10/12/22 at 9:05 a.m. determined the shaft did not move (rotate to either an open or closed position). The orientation of the damper in the ductwork could not be determined due to other laundry equipment positioning in front of the ductwork.<br>c. Interview with the maintenance supervisor at the time of the observation and testing confirmed those findings. He stated checking the operation of the fresh air damper was not yet on the preventive maintenance schedule.<br><br>The deficiency affected one of several requirements for fuel fired devices. |
| **K 915** | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Categories<br>*Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES.<br>*General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES.<br>*Basic care rooms (Category 3) in which electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours.<br>3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the provider failed to perform monthly generator testing as required (no cool down runs after load testing and battery conductivity) in calendar year 2022. Findings include:<br><br>1. Record review on 10/12/22 at 9:35 a.m. revealed only partial documentation of required monthly generator thirty minute load runs. The load runs showed thirty minutes for those tests (thirty minutes was the minimum required load runs) but did not indicate at least five minutes for post load run cool down run time.<br><br>2. Record review on 10/12/22 at 9:40 a.m. revealed no monthly documentation of the generator battery conductivity (formerly specific gravity testing).<br><br>3. Interview with the maintenance supervisor at the time of the record reviews confirmed the cool down runs and battery conductivity testing had not been done. He stated those tests were not yet on the preventive maintenance schedule. He revealed he had been a new employee in the past six months.<br><br>The deficiencies affected two of numerous generator maintenance requirements. |

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 |
|---|---|---|---|
| | 10592 | A. BUILDING: ______ B. WING ______ | 10/13/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA ARLINGTON | 120 CARE CENTER ROAD POST OFFICE BOX 280<br>ARLINGTON, SD 57212 |

| (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<br><br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 10/11/22 through 10/13/22. Avantara Arlington was found in compliance. | S 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

(X6) DATE: 11/3/22

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