| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 435049 | A. BUILDING _____ B. WING _____ | 03/04/2020 |

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| AVANTARA SALEM | 500 COLONIAL DRIVE SALEM, SD 57058 |

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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 26632<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/2/20 through 3/4/20. Avantara Salem was found not in compliance with the following requirements: F637, F658, and F697. | F 000 | | |
| F 637 SS=D | Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii)<br><br>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 18560<br><br>Surveyor: 26632<br>Based on interview and record review, the provider failed to ensure two of two sampled residents (29 and 32) who received hospice services had a significant change of condition Minimum Data Set (MDS) assessment done when they had been admitted to receive hospice services. Findings include:<br><br>1. Review of resident 32's record revealed he had | F 637 | | |

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| Ashley Nickel | LNHA | 03/26/2020 |

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 637 | Continued From page 1<br>been admitted to a hospice provider's services on 11/21/19. There was no significant change of condition MDS assessment completed at that time.<br><br>2. Review of resident 29's medical record revealed:<br>*He had been admitted to a hospice provider's services on 10/18/19.<br>*There was no significant change of condition MDS assessment completed at that time.<br><br>3. Interview on 3/3/20 at 4:00 p.m. with director of nursing B revealed she:<br>*Was aware when a resident was admitted to hospice, discharged from hospice, or changed hospice providers a MDS significant change of condition assessment was to have been completed.<br>*Did not know MDS assessment coordinator A had not completed those MDS assessments.<br><br>Interview on 3/4/20 at 10:20 a.m. with MDS coordinator A revealed she had:<br>*Not been aware until recently that a significant change of condition assessment was required when a resident was admitted to receive hospice services.<br>*Been completing MDS assessments since 1999 and was not aware of that requirement until recently. | F 637 | 1. After collaboration with ~~Jean Koch~~ **Department of Health (AN 03/26/2020),** facility unable to go back and submit addendum to MDS as the dates are too far out. Per ~~Jean~~ **Department of Health (AN 03/26/2020),** facility will place progress note in Resident 29's and Resident 32's medical record stating that a significant change was identified and MDS not completed appropriately. All residents have the potential to be affected by the same deficient practice. Regional Clinical Care Coordinator will provide education with IDT by 3/25/20.<br><br>2. DON or designee will review all hospice residents MDS to verify that significant change has been completed.<br><br>3. All residents that start hospice services will have a significant change MDS completed. Every hospice resident will be audited to ensure significant change was completed upon admit to hospice and discharge from hospice. DON or designee will audit hospice residents' MDS with all submissions to ensure the MDS reflects hospice status with any change in condition, quarterly, annually x 6 months. DON/Designee will report to QAPI monthly for recommendations and review. | 04/23/2020 |
| F 658 SS=D | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- | F 658 | | |

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| F 658 | Continued From page 2<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 41895<br>Based on observation, interview, record review, and policy review, the provider failed to ensure one of one observed unlicensed assistive personnel (UAP) (C) had followed professional standards for medication administration for three of ten randomly observed medication administrations (7, 29, and 44). Findings include:<br><br>1. Observation on 3/4/20 at 11:09 a.m. of UAP C during medication administration for resident 7 revealed she had given the resident one tablet of metoprolol succinate extended release (ER) 25 milligrams (mg).<br><br>Review of resident 7's medication administration record (MAR) revealed:<br>*She should have given metoprolol tartrate 25 mg.<br>-That order had been in place since 7/10/19.<br>*She was not the only staff person to have administered the medication incorrectly.<br><br>Interview on 3/4/20 at 11:40 a.m. with UAP C revealed she was aware the medication name on the prescription label and MAR did not match.<br><br>Interview on 3/4/20 at 11:40 a.m. with registered nurse (RN) D regarding resident 7's above medication administration revealed she had agreed it was not the correct medication.<br><br>Interview on 3/4/20 at 5:02 p.m. with director of nursing (DON) B revealed:<br>*She agreed it was not the correct medication.<br>*The order had been put in wrong, and the MAR | F 658 | 1. Resident 7's medication order was clarified via order review and the order was changed in Point Click Care (PCC), to ensure the medication label and order match. Resident 29's diltiazem medication was added to the treatment record, so it was only administered by LPN or RN. Resident 44's Vitamin D3 medication stock was changed to correct dosage to match order. All residents have the potential to be affected by the same deficient practice. ~~DON will educate UAP C on the five rights of medication administration, reading and understanding the entirety of the medication order, and will review the hypertension medication class.~~ **DON will educate all RN's, LPN's, and UAP's on the five rights of medication administration, reading and understanding the entirety of the medication order, and will review the hypertension medication class. (AN 03/26/2020)** UAP C will complete medication pass competency before March 31,2020.<br><br>2. DON or Designee will audit each resident's medication orders for clear and concise instructions. DON or designee will complete medication administration records compared to medication card audits by 4/23/20. | 04/23/2020 |

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| F 658 | Continued From page 3<br>should have read to give the metoprolol succinate.<br>-She agreed that error should have been corrected.<br><br>2. Observation on 3/4/20 at 11:15 a.m. of UAP C during medication administration for resident 44 revealed:<br>*She had given two tablets of vitamin D3, 25 micrograms (mcg).<br>*She had not clarified with the nurse if that was the correct dose.<br><br>Review of resident 44's MAR revealed the vitamin D3 order was for two tablets of 1000 international units (iu).<br><br>Interview on 3/4/20 at 1:29 p.m. with UAP C revealed:<br>*She realized it was the the wrong medication.<br>*She had removed the vitamin D3, 25 mcg bottle from the cart and put in a bottle of vitamin D3, 1000 iu.<br>-These bottles were facility stock supply from the pharmacy.<br>*She was not aware two tablets of vitamin D3, 25 mcg was equal to two tablets of vitamin D3, 1000 iu.<br><br>Interview on 3/4/20 at 2:24 p.m. with DON B revealed she was not aware the pharmacy had sent vitamin D3 in a 25 mcg dose.<br><br>3. Observation on 3/4/20 at 11:20 a.m. of UAP C during medication administration for resident 29 revealed:<br>*He was to have had his blood pressure (BP) checked prior to the administration of his diltiazem. | F 658 | 3. DON or Designee will audit 5 random residents medication orders and compare them to the medication cards weekly x 4 weeks, biweekly x 4, and monthly x 3. ~~UAP C will be randomly audited during medication pass monthly x4 months.~~ **All RN's, LPN's, and UAP's will be randomly audited during medication pass monthly x4 months. (AN 03/26/2020).** DON/ Designee will report to QAPI monthly for recommendations and review. | |

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| F 658 | Continued From page 4<br>-His BP was 113/48.<br>*She had given him one tablet of diltiazem 30 mg.<br><br>Review of resident 29's MAR revealed:<br>"dilTIAZem HCl Tablet 30 MG Give 1 tablet by mouth every 6 hours related to UNSPECIFIED ATRIAL FIBRILLATION (I48.91) hold if systolic b/p < [less than] 90 and notify physician - DO NOT D/C BP's."<br><br>Interview on 3/4/20 at 1:29 p.m. with UAP C revealed:<br>*She thought diltiazem was to increase BP.<br>*She thought < meant greater than.<br>*She was to hold the medication if the bottom number of his BP was higher than 90.<br><br>Interview on 3/4/20 at 2:24 p.m. with DON B revealed:<br>*She was not aware UAP did not know how to read the order.<br>*She was going to have a nurse administer his diltiazem until the UAP had further training.<br><br>4. Review of UAP C's 10/9/19 Medication Administration Observation Report revealed:<br>*She had not met the requirement of "Correct medication verified by visual check of med [medication], label, and MAR."<br>*She had a calculated error rate of 4.55%.<br><br>Review of the provider's Medication Administration policy revealed:<br>*"To administer the following: right medication, right dose, right dosage form, right documentation, right route, right resident/patient, right time."<br>*"Verify the pharmacy prescription label on the drug and the manufacturer's identification system | F 658 | | |

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| F 658 | Continued From page 5<br>matches the MAR."<br>*To check the original order and notify pharmacy if there was a discrepancy. | F 658 | | |
| F 697<br>SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 41895<br>Based on observation, interview, record review, and policy review, revealed the provider failed to ensure one of three sampled residents (25) had appropriate pain management and ongoing pain assessments in place. Findings include:<br><br>1. Review of resident 25's medical record revealed:<br>*She had been admitted on 8/15/18.<br>*She had a Brief Interview for Mental Status assessment score of twelve indicating moderate cognitive impairment.<br>*Her diagnoses included: cerebral infarction due to unspecified occlusion or stenosis of unspecified carotid artery, anxiety disorder, pain, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, major depressive disorder, bipolar disorder, other specified personality disorder, and adult failure to thrive.<br><br>Observation and interview on 3/3/20 at 2:50 p.m. with resident 25 revealed: | F 697 | 1. Resident 25's pain medications have been adjusted or changed to meet resident current pain needs. Care plan interventions have been reviewed and updated. All residents have the potential to be affected by ineffective pain management. Review of the updated Legacy Pain Management policy was completed on 3/20/20 by the DON. DON will educate pain management policy to the IDT and nursing staff by 3/31/20.<br><br>2. DON or designee will audit the most recent pain management assessment on each resident to ensure effective pain management techniques are being utilized.<br><br>3. DON or Designee will randomly audit 5 residents weekly x4, 5 biweekly x 4, 5 monthly x 3 for pain levels and effective pain management strategies. DON or Designee will report to QAPI monthly for recommendations and review | 04/23/2020 |

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| F 697 | Continued From page 6<br>*She was alert and able to answer questions appropriately.<br>*She had pain in her left arm that was contracted.<br>*She has just returned to her room from a bath and had told the staff person who assisted her about her pain.<br>*She was supposed to have a "rub down" on her left shoulder, but the night nurse would not do it.<br>*The staff did not do anything for her pain.<br>*She rated her pain at an eight on a scale of zero to ten with zero being no pain and ten as the worst pain she could imagine.<br><br>Review of resident 25's 1/19/20 pain assessment revealed:<br>*She had almost constant pain that made it hard for her to sleep at night and affected her day-to-day activities.<br>*She rated her pain at an eight on a zero to ten pain scale.<br>-She had used the verbal descriptor of "severe."<br>*The pain affected her mood and socialization.<br>*Resting helped with pain relief.<br>*Staff assessment of her pain revealed non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movements.<br>*She was on Tylenol twice a day.<br>-She had reported that did not help with pain.<br><br>Review of resident 25's 1/20/20 quarterly Minimum Data Set (MDS) assessment revealed:<br>*She was on a scheduled pain regimen.<br>*She had not received as needed pain medications nor were they offered and declined.<br>*She had not received non-medication intervention for pain.<br>*She had almost constant pain that made it hard for her to sleep at night and affected her | F 697 | | |

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| F 697 | Continued From page 7<br>day-to-day activities.<br>*She had rated her pain at an eight on a zero to ten scale.<br><br>Review of resident 25's pain levels since completion of 1/20/20 MDS revealed on:<br>*2/5/20 she rated her pain at zero on a zero to ten scale.<br>*2/12/20 she rated her pain at seven on a zero to ten scale.<br>*There were no other documentation of pain levels.<br><br>Review of resident 25's February 2020 medication administration record revealed:<br>*On 2/12/20 she was given an extra dose of acetaminophen 325 mg, two tablets for a pain level of seven.<br>-Follow-up pain relief was documented as unknown.<br>*There was not other documentation of as needed pain medications being administered.<br><br>Review of resident 25's 1/29/20 care plan revealed:<br>*"Evaluate the effectiveness of my pain interventions. alleviating of my symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Consult with DR [doctor] if current pain med [medication] regime is not adequately controlling pain."<br>*"Try to anticipate my need for pain relief and respond immediately to any complaint of pain that I may have."<br>*To have her rate her pain level prior to and after receiving pain medication.<br>*She was to have non-pharmacological interventions such as elevation, repositioning, and | F 697 | | |

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| F 697 | Continued From page 8<br>distraction.<br>*It stated she had an order for hydrocodone/acetaminophen as needed if scheduled acetaminophen was ineffective.<br><br>Review of resident 25's current physician's orders revealed orders for:<br>*"Acetaminophen Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Elevated Temperature;Mild Pain AND Give 2 tablet by mouth two times a day for Mild Pain." Start date of 11/7/19.<br>*"Biofreeze Gel 4% Menthol (Topical Analgesic) Apply to Right shoulder topically every 12 hours as needed for Mild Pain." Start date of 12/25/19.<br>*There was no order for hydrocodone/acetaminophen listed.<br><br>Review of resident 25's discontinued physician's orders revealed the hydrocodone/acetaminophen order that was to be given if the acetaminophen did not work had been discontinued on 2/15/20. The discontinued reason was because it had not been used since September.<br><br>Interview on 3/4/20 at 10:13 a.m. with licensed practical nurse (LPN) E regarding resident 25 revealed:<br>*She had schizophrenia and would say she had pain at times, but then a few minutes later she would tell you she had no pain.<br>*She often refused prescription medications.<br>*There was no process for monitoring resident's pain.<br>*When she did her medication pass she would ask each resident how they were and if they had pain.<br>*They did not do a formal assessment or document pain daily. | F 697 | | |

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| F 697 | Continued From page 9<br><br>Interview on 3/4/20 at 1:49 p.m. with MDS coordinator A regarding resident 25 revealed:<br>*She was not aware of what was going on day to day in the facility.<br>*She had not done the pain assessment for the MDS assessment.<br>*A nurse on the floor had done the assessment on 2/19/20, and she had used it for her MDS assessment.<br>-She had not done anything about her complaints of pain noted on that assessment.<br>*She agreed that something should have been done about the resident's pain.<br><br>Interview on 3/04/20 at 2:30 p.m. with director of nursing (DON) B regarding resident 25 revealed:<br>*She had received therapy in the past for her arm contracture and would often refuse the service.<br>*She was currently on a restorative program but would often refuse to participate.<br>*She could not find documentation the physician had been notified of the pain or that any intervention had been put in place.<br>*She agreed the nurse and the MDS coordinator should have done something about her pain after completing the above assessments.<br><br>Review of the provider's September 2013 Pain Management policy revealed:<br>*"To include the resident and family in evaluation of pain, potential interventions, and goals."<br>*"Identify the potential cause(s) for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment, as well as specific spiritual and cultural issues related to pain."<br>*"Determine appropriate interventions to manage pain and side effects. Appropriate interventions | F 697 | | |

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| F 697 | Continued From page 10<br>may include pharmacologic as well as non-pharmacologic interventions."<br>*"Notify physician if interventions are not effective in achieving resident comfort and/or functional goals." | F 697 | | |

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| E 000 | Initial Comments<br><br>Surveyor: 26632<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 3/2/20 through 3/4/20. Avantara Salem was found in compliance. | E 000 | | |

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

Ashley Nickel | LNHA | 03/26/2020

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 DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435049 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **03/03/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA SALEM** | **500 COLONIAL DRIVE**<br>**SALEM, SD 57058** |

| (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<br><br>Surveyor: 27198<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/3/20. Avantara Salem 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 K311 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 311<br>SS=D | Vertical Openings - Enclosure<br>CFR(s): NFPA 101<br><br>Vertical Openings - Enclosure<br>2012 EXISTING<br>Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6<br>If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 27198<br>Based on observation and interview, the provider failed to maintain a one-hour, fire-resistive enclosure for one of three vertical openings to the basement (stairwell from kitchen). Findings include: | K 311 | 1. Door at top of stairwell from basement to kitchen to be replaced. Door ordered 03/24/2020.<br><br>2. All residents, staff, and visitors have the potential to be affected.<br><br>3. Audit to be completed by Maintenance or designee on door to ensure closure functioning appropriately. Audits to be completed weekly x4 weeks, monthly x3 months. Audit results will be brought to QAPI committee by Maintenance supervisor or designee for further review, and recommendations. | 04/23/2020 |

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

Ashley Nickel | LNHA | 03/24/2020

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 |
|---|---|---|---|
| | 435049 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **03/03/2020** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **AVANTARA SALEM** | **500 COLONIAL DRIVE**<br>**SALEM, SD 57058** |

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| K 311 | Continued From page 1<br><br>1. Observation at 11:57 a.m. on 3/3/20 revealed the door at the top of the stairwell to the basement from the kitchen receiving area was not latching into the door frame. That door was a 1.5 hour fire rated door and would not maintain the fire rating of the vertical opening when not latched into the door frame.<br><br>Interview with the maintenance director at the time of the above observation confirmed that finding. He stated he was unaware that fire door was not latching into the door frame.<br><br>The deficiency had the potential to affect 100% of the residents in that smoke compartment. | K 311 | | |
| K 712<br>SS=D | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 27198<br>Based on record review and interview, the provider failed to ensure staff were familiar with the provider's fire drill procedures (inadequate number of required fire drills) for two of four | K 712 | 1. Education provided to Maintenance Director to test Fire Alarm monthly to ensure functioning equipment on 03/16/2020. Fire Alarm Sounding Documentation Log Implemented.<br><br>2. All Residents, Staff, Visitors are identified to be potentially affected. Fire Alarm Sounding Documentation Log to be completed monthly by Maintenance Director or designee.<br><br>3. Fire Alarm Sounding Documentation Log will be Audited monthly by Administrator or designee for 6 months to ensure completion. Administrator or designee will report findings to QAPI committee for further recommendations and review. | 04/23/2020 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435049 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **03/03/2020** |

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| **AVANTARA SALEM** | **500 COLONIAL DRIVE**<br>**SALEM, SD 57058** |

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| K 712 | Continued From page 2<br>yearly quarters from January through December 2019. Findings include:<br><br>1. Record review at 1:15 p.m. on 3/3/20 revealed there was no documentation for third shift fire drills for quarter two (June) in 2019. There also was no documentation of fire drills for the third shift for quarter three (September) in 2019.<br><br>Interview with the maintenance director at the time of the record review confirmed those findings. He stated he was a new employee within the last year. He added he was unaware the minimum number of fire drills per the required frequency had not been met for each shift for 2019.<br><br>The deficiency had the potential to affect 100% of the occupants of the building. | K 712 | | |

South Dakota Department of Health

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|---|---|---|---|
| | 10674 S | A. BUILDING: _____ B. WING _____ | 03/04/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA SALEM | 500 COLONIAL DR SALEM, SD 57058 |

| (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 |
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| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 27198<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/2/20 through 3/4/20. Avantara Salem was found not in compliance with the following requirement: S195. | S 000 | | |
| S 195 | 44:73:03:02 General Fire Safety<br><br>Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Surveyor: 27198<br>Based on record review and interview, the provider failed to sound the fire alarm monthly for three out of twelve months (June, September, and December) for calendar year 2019. Findings include:<br><br>1. Record review of fire drill documentation at 1:15 p.m. on 3/3/20 revealed the fire alarm had not been sounded for June, September, and December for calendar year 2019. The fire alarm was required to be sounded monthly.<br><br>Interview with the maintenance director at the time of the record review confirmed that finding. He revealed he was unaware the alarm was required to be sounded monthly. | S 195 | 1. Education provided to Maintenance Director to test Fire Alarm monthly to ensure functioning equipment on 03/16/2020. Fire Alarm Sounding Documentation Log Implemented.<br>2. All Residents, Staff, Visitors are identified to be potentially affected. Fire Alarm Sounding Documentation Log to be completed monthly by Maintenance Director or designee.<br>3. Fire Alarm Sounding Documentation Log will be Audited monthly by Administrator or designee for 6 months to ensure completion. Administrator or designee will report findings to QAPI committee for further recommendations and review. | 04/23/2020 |

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

Ashley Nickel | LNHA | 03/26/2020

South Dakota Department of Health

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| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 26632<br>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 3/2/20 through 3/4/20. Avantara Salem was found not in compliance with the following requirement: S060. | S 000 | | |
| S 060 | 44:74:02:15(1-2) Nurse Aide Curriculum<br><br>The curriculum of the nurse aide training program shall address the medical, psychosocial, physical, and environmental needs of the residents served by the nursing facility. Each unit of instruction shall include behaviorally stated objectives with measurable performance criteria. The nurse aide training program shall consist of at least 75 hours of classroom and clinical instruction, including the following:<br>(1) Sixteen hours of training in the following areas before the nurse aide has any direct contact with a resident;<br>(a) Communication and interpersonal skills;<br>(b) Infection control;<br>(c) Safety/emergency procedures, including the Heimlich maneuver;<br>(d) Promoting residents' independence;<br>(e) Respecting residents' rights; and<br>(f) Abuse, neglect, and misappropriation of resident property;<br><br>(2) Sixteen hours of supervised practical training, with enough instructors to ensure that nursing care is provided with effective assistance and supervision. The ratio may not be less than one instructor for each eight students in the clinical setting; and | S 060 | 1. Education provided to PRN Staff Development Nurse, and Nurse Management. Checklist developed and implemented to meet regulation standards for 16 hours of nurse aide training.<br><br>2. All residents and staff have potential to be affected. Implemented checklist, and program return demonstration competencies to ensure completion of 16 hours of practical training completed.<br><br>3. Audits of Checklist, and Competencies to be completed monthly x 6 months. Administrator or Designee to bring audit findings to QAPI committee for further recommendations, and review. | 04/23/2020 |

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| AVANTARA SALEM | 500 COLONIAL DR SALEM, SD 57058 |

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| S 060 | Continued From page 2<br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Surveyor: 41895<br>Based on interview, the provider failed to ensure the appropriate training had been documented before the nurse aides in the training program had any direct contact with a resident. Findings include:<br><br>1. Interview on 3/4/20 at 5:55 p.m. with the director of nursing B regarding the nurse aide training program revealed there had not been documentation related to the sixteen hours of training needed prior to a nurse aid having contact with a resident.<br><br>Interview on 3/4/20 at 5:55 p.m. with director of nursing B revealed:<br>*The primary instructor was employed on an as needed basis.<br>-She was not present during the survey.<br>*She had called the instructor and the instructor did not have documentation that the required training had been completed. | S 060 | | |