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
	435068	A. BUILDING _____ B. WING _____	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA CLARK CITY	201 8TH AVENUE NW CLARK, SD 57225

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 6/12/23 through 6/15/23. Avantara Clark City was found not in compliance with the following requirements: F657 and F700.	F 000		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Morehouse Rachel Morehouse	Administrator	7/6/23

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	435058	A. BUILDING _____ B. WING _____	06/15/2023

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F 657	Continued From page 1 by: Based on record review, interview and policy review the provider failed to ensure the 48 hour nutritional care plans for two of four sampled residents (11 and 22) were updated in their comprehensive care plan. Findings include: 1. Review of resident 11's medical record revealed he: *Was admitted on 5/11/23. *Had diagnoses that included: Anemia secondary to blood loss, type 2 diabetes mellitus with hyperglycemia and pneumonitis due to inhalation of other solids and liquids. *Was on a consistent carbohydrate (CCHO) diet. Review of resident 11's care plan problems initiated on 5/12/23 revealed: *Altered cardiovascular functioning related to post-op blood loss anemia. -The goal was to be free from signs and symptoms of complications of cardiac problems through the next review window. -The intervention was to give the diet as ordered. *Resident 11 was at risk for fluctuating blood sugars due to diabetes mellitus with hyperglycemia. -The goal was blood sugars would remain within parameters set forth by the physician through the next review window. -The intervention was to provide the diet per physician's order. 2. Interview on 6/13/23 at 1:47 p.m. with resident 22 revealed she: *Was in her room sitting in her recliner. *Knew she was on a ground meat diet because of her Barrett's esophagus diagnosis. *Had been dealing with acid reflux.	F 657	1. Residents 11 and 22's baseline (48-hour) care plans can not be changed. Their comprehensive care plans will be reviewed and updated to reflect their current nutritional needs by dietary manager H or designee by 7/30/23. All newly admitted residents are potentially at risk. The IDT will review and update applicable baseline and comprehensive care plans for all residents admitted from 5/1/23 forward to reflect their current nutritional needs by 7/30/23. 2. Policy was reviewed with no revisions needed. The DON or designee will educate the IDT, including dietary manager H, by 7/30/23 on the need to ensure newly admitted residents' baseline and comprehensive care plans reflect their nutritional needs in a timely manner. Applicable staff not in attendance will be educated prior to their next shift worked. 3. The dietary manager H or designee will audit all newly admitted resident's baseline and comprehensive care plans to ensure they reflect their current nutritional needs weeklyx 1 month; then 3 newly admitted residents weekly x 2 months. Results of audits will be presented by dietary manager H or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	7/30/23

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F 657	Continued From page 2	F 657		

*Had lost over 100 pounds in the last two years.
-Due to a loss of appetite.
-Dealing with her acid reflux.

Review of resident 22's medical record revealed she:
*Was admitted on 4/12/23.
*Had diagnoses that included: dysphagia, unspecified, gastroesophageal reflux disease without esophagitis and Barrett's esophagus without dysplasia.
*Was on the provider's nutrition at-risk list for weight loss.
-Weighed 133.6 pounds on 4/15/23.
-Weighed 127.8 pounds on 6/8/23.

Review of resident 22's care plan problems initiated on 4/13/23 revealed:
*{Name} is at risk for altered cardiovascular functioning related to hyperlipidemia, anemia, obesity hypertension, peripheral vascular disease (PVD).
-The goal was to have been free from cardiac overload through the next review period.
-The intervention was to give the diet as ordered.
*{Name of the resident} has an actual impairment to skin integrity to bilateral lower extremities (BLE) classified as unhealing leg ulcers. These were present upon admission.
-The goal was not to develop signs and symptoms of infection on the wound site through the next review.
-The intervention was to encourage good nutrition and hydration in order to promote healthier skin.

Interview on 6/14/23 at 1:39 p.m. with dietary manager H revealed:
*She completed the dietary portion of the initial care plan upon the resident's admission within 48

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F 657	Continued From page 3	F 657		

hours.
*The comprehensive care plan should have been completed by the 21st day after admission.
-She thought the comprehensive care plans had been updated for residents 11 and 22.
-She agreed the comprehensive care plans were not updated in a timely manner.

Interview on 6/14/23 at 3:35 p.m. with director of nursing (DON) A regarding resident 11 and 22's care plans revealed:
*The interdisciplinary team (IDT):
-Implemented the 48-hour resident care plans for all new admissions.
-Completed the comprehensive care plan within 21 days after admission.
*She agreed that the dietary portion of the comprehensive care plan was not updated for residents 11 and 22.
*It was her expectation the resident care plans would have been completed in a timely manner.

Review of the provider's September 2019 Care Planning policy revealed:
*"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. In doing so, the following considerations are made:
1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care consideration...
3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death...
6. The DON will be responsible for holding the

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F 657	Continued From page 4 team accountable to intitiating and completing the admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter."	F 657		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the provider failed to ensure quarterly side rail assessments were completed for three of seven residents (4, 5, and 19). 1.Observation on 6/14/23 at 9:00 a.m. of	F 700	1. Residents 4, 5, and 19 have been assessed for safe use of side rails by DON. All residents with side rails have the potential to be at risk. All residents with side rails will have assessments completed by the DON or designee by 7/30. 2. The Restraint Free Environment Policy provided during survey was reviewed with no revisions required. The DON or designee will educate the nursing staff on timely and accurate completion of side rail assessments by 7/30. Applicable staff not in attedance will be educated prior to the start of their next shift. 3.The DON or designee will audit all residents with side rails to ensure the side rail assessment has been completed. The DON or designee will audit all new admissions for side rail use and assessment completion weekly x3 months as well as 3 random residents weekly x4 weeks, then 2 residents weekly x2 months for completed side rail assessments at least quarterly. Results of audits will be presented by DON or designee at monthly QAPI meeting for discussion of effectiveness and recommendations for 3 months.	7/30/23

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F 700	Continued From page 5	F 700		

resident 5's room revealed she had a one-half side rail on the left side of her bed.

Interview on 6/14/23 at 9:30 a.m. with maintenance director E revealed:
*He stated the assessments had been completed in the four months since he began working at this facility.
*He provided documentation of a side rail audit with one bed rail audit conducted on 5/30/23 for room 10 which was not resident 5's room.
*He admitted that he had not done as many assessments as he thought.

Interview on 6/14/23 at 3:34 p.m. with director of nursing A and Minimum Data Set coordinator F regarding resident 5's side rails revealed:
*There were no assessments completed for residents who use side rails.
*Resident 5 had no assessment for side rails.
*Their expectation would have been that the assessments had been completed.

Review on 6/14/23 at 3:45 p.m. of resident 5's electronic medical record revealed:
*She had no assessment completed for the use of a side rail.
*There were no physician's order for the use of the side rail.
*She had a signed side rail consent form on her admission on 2/14/20.

2. Observation and interview on 6/12/23 at 4:01 p.m. with resident 4 revealed:
*She was in her room seated in her wheelchair.

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F 700	Continued From page 6	F 700		

*A u-shaped side rail was elevated on the upper half of her bed.
*She used her side rail to reposition in bed and to assist herself to sit up on the edge of the bed.

Review of resident 4's medical record revealed:
*She was admitted on 5/26/22.
*She had diagnoses of symptomatic epilepsy and epileptic syndrome with complex partial seizures.
*Her most recent Brief Interview of Mental Status (BIMS) of 13 revealed no cognitive impairment.
*Quarterly side rail/other device evaluation forms were completed on 8/18/22 and on 1/25/23.

3. Observation and interview on 6/13/23 at 10:02 a.m. with resident 19 revealed:
*She was in her room sitting in her recliner with the footrest elevated.
*A u-shaped side rail was elevated on the upper half of her bed.
*She used the side rail to reposition in bed and to transfer to her recliner or wheelchair.

Review of resident 19's medical record revealed:
*She was admitted on 4/16/19.
*She had diagnoses of epileptic seizures related to external causes, a mild neurocognitive disorder due to known physiological conditions without behavior disturbance, type two diabetes mellitus with unspecified complications and Parkinson's disease.
*Quarterly side rail/other device evaluations were completed on 9/29/21 and on 11/13/22.

A side rail policy was requested from the director of nursing but was not recieved by the end of the survey.

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care facilities was conducted from 6/12/23 through 6/15/23. Avantara Clark City was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Morehouse — TITLE: Administrator — (X6) DATE: 7/6/23

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South Dakota Department of Health

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	10607	A. BUILDING: _____ B. WING _____	06/15/2023

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/12/23 through 6/15/23. Avantara Clark City was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Morehouse

TITLE: Administrator

(X6) DATE: 7/6/23

STATE FORM 6899 I4QV11 If continuation sheet 1 of 1

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	435058	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/14/2023

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 6/14/23. Avantara Clark City was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K226, K271, K321, K325, K355, K712, and K914 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 226 SS=E	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain the two-hour fire resistive rating of horizontal exits. The bottom latching hardware on both leaves of the cross-corridor doors separating the addition from the original building were not functioning properly, and the two-hour wall above the doors was not fire sealed. Findings include:	K 226	1. Flooring and door company contacted 7/6/23 to schedule repair to floor. Fire rated spray foam was purchased on 6/29 and applied on 7/3/23. Will inspect repairs after they are made to ensure life safety code is met. All staff, visitors and residents have potential to be at risk. 2. All doors will have bottom latching hardware on both leaves of the cross corridor doors. All future flooring or door repairs done by third parties will be inspected for appropriate hardware. All penetrated areas will be filled with fire rated spray foam. 3. All doors will be inspected for appropriate door latches. All walls will be inspected for fire and smoke protection. All inspections will be logged through TELS by maintenance director or administrator.	7/30/23

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Rachel Morehouse Rachel Morehouse | Administrator | 7/3/23

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K 226	Continued From page 1 1. Observation on 6/14/23 at 11:05 a.m. revealed the bottom latching hardware installed on both leaves of the of ninety-minute fire-rated cross-corridor doors separating the addition from the original building did not have a second latch. New flooring was installed over the floor latching points Interview with the maintenance director at the time of the observation confirmed the missing floor latches. 2. Observation on 6/14/23 at 11:15 a.m. revealed an unfilled penetration of the two-hour wall separating the addition from the original building above the ceiling. The maintenance director acknowledged the missing fire sealant. The deficiencies had the potential to affect all residents of the facility.	K 226		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to provide a level walking surface without abrupt changes in elevation at three exit discharges (north wing, east wing, and front entrance). Findings include: 1. Observation on 6/14/23 at 10:05 a.m. revealed	K 271		

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K 271	Continued From page 2 the exit discharge from the north wing did not meet the change in elevation requirements. The difference in elevation from the threshold of the exit door to the first sidewalk panel was greater than one-inch, while the Life Safety Code (LSC) requires a change no greater than one-fourth inch. 2. Observation on 6/14/23 at 10:30 a.m. revealed the exit discharge from the east wing did not meet change in elevation requirements. The concrete sidewalk which extended to the public way was deteriorated and had many elevation changes that were greater than the one-fourth inch requirement. 3. Observation on 6/14/23 at 10:40 a.m. revealed the exit discharge from front entry did not meet change in elevation requirements. The concrete sidewalk which extended to the public way was marked with orange paint where it intersected with the sidewalk at the front of the parking lot. The elevation change marked was approximately one-half inch. Ref: 2012 NFPA 101 Section 19.2.7, 7.7.4, 7.1.6.2 The maintenance director was present and acknowledged all of the deficiences. He had previously asked for quotes for concrete repair. Failure to keep level exit discharge as required increases the risk of death or injury due to fire.	K 271	1. Concrete contracters contacted 6/29, 6/30, and 7/5 to obtain bids for repair. Pictures of concrete sent on 7/5 to local contractor.Areas will be inspected after repairs completed by third party vendor to ensure repairs meet code requirements.Will continue with weekly attempts to complete repairs needed. All visitors, staff and residents have potential to be at risk. 2. Concrete affected by frost heave, areas impacted by ice melt and age will be replaced and all sidewalk panels will be elevated by contractor to adhere to LSC of no greater than 1/4 inch difference between sidewalk and first sidewalk panel. 3. Concrete elevation and overall condition will be evaluated quarterly by maintenance director or designee with findings discussed in safety committee meetings to review findings and make plan for repair if needed.	7/30/23
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		

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K 321	Continued From page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed protect a hazardous area (boiler room) as required. Findings include: 1. Observation on 6/14/23 at 11:15 a.m. revealed the boiler room was over one hundred square feet, contained combustible items and fuel fired equipment and did not maintain corridor separation. The concrete wall separating the	K 321	1.Fire rated spray foam was purchased 6/29/23 and used to fill gaps in concrete corridor wall on 7/3/23. All staff and residents have potential to be at risk. 2. Maintenance director or administrator will inspect all third party contractor work to ensure life safety codes are met and ensure any penetrated corridor walls, if any future repairs require penetration,are filled with fire rated spray foam. 3. All hazardous areas will be protected by fire barriers and smoke resisting partitions and doors. Maintenance Director will inspect areas monthly and upload logs in TELS. Logs will be reviewed quarterly by safety committee to review findings and any future repairs that will require penetration.	7/30/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435058	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/14/2023

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K 321	Continued From page 4 boiler room had been penetrated for piping and cabling, and a three-inch by four-inch opening was not fire sealed. Interview with the maintenance director at the times of the observations confirmed those findings. The deficiency affected one of numerous requirements for hazardous rooms.	K 321		
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485	K 325	1. Excess ABHR was removed from the housekeeping closet on 7/3. All staff educted 7/6/23. All residents could potentially be affected. 2. The administrator, housekeeping staff and maintenance director reviewed the regulation and educated all staff on 7/6/23 that not more than an aggregate of 10 gallons of fluid ABHR or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room and no more than 5 gallons are stored in a single smoke compartment. 3. Housekeeping Director or designee will audit ABHR storage monthly x 3 months to ensure no more than 5 gals of ABHR is stored there. Results of audits will be presented at monthly QAPI meeting for discussion of effectiveness and recommendations.	7/30/23

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K 325	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to safely store alcohol-based hand rub (ABHR) in one room (east wing housekeeping closet). Findings include: 1. Observation on 6/14/23 at 11:00 a.m. revealed the east wing housekeeping closet had a combined total of approximately ten gallons of boxed ABHR stored. The flammable liquid code does not allow over five gallons of alcohol in a single smoke compartment. Interview with the maintenance director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for ABHR use.	K 325		
K 355 SS=E	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to properly maintain fire extinguishers. Findings include: 1. Observation on 6/14/23 beginning at 9:50 a.m. and extending through 3 p.m. revealed none of the fire extinguishers had received monthly checks since the contract maintenance was	K 355	1. Portable fire extinguisher in maintenance area was secured 7/5. Maintenance director was educated by regional plant operations by 7/30 on requirements for fire extinguishers. All residents and staff potentially at risk. 2. Fire extinguisher checks will be completed monthly by maintenance or designee and logged into TELS. 3. TELS information will be audited by administrator or designee monthly x3 months and will findings will be reviewed by QAPI for recommendations and effectiveness.	7/30/23

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K 355	Continued From page 6 performed in January 2023. That observation included all general-purpose (ABC) extinguishers as well as the kitchen (K) extinguisher. 2. Observation on 6/14/23 at 11:45 a.m. revealed the fire extinguisher on the maintenance cart in the boiler room had not received monthly checks and was not secured. Interview with the maintenance director at the time of the observations confirmed the findings. He stated he was unaware of the maximum height requirement for fire extinguishers. The deficiency has the potential to affect the entire facility.	K 355		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills 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. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the provider failed to conduct fire drills at appropriate intervals and failed to ensure staff were familiar with the provider's fire drill procedures. Findings include:	K 712	1. Fire Drills will be completed on all three shifts monthly x3 months. All staff and residents have potential to be at risk. Type text here 2. Regional Plant Operations will provide inservicing to all staff by 7/30. Those not in attendance will be inserviced before the start of their next shift. All fire drills will be loaded into TELS. 3. Maintenance Director, admin or designee will complete and log fire drills on all three shifts monthly and logs will be entered into TELS. Logs will be reviewed monthly by QAPI and quarterly by safety committee.	7/30/23

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K 712	Continued From page 7 1. Observation on 6/14/23 at 12:45 p.m. record review revealed only one fire drill was completed in the past 12 months. The fire drill was during the day shift in March 2023 when the maintenance director was training. Prior to that date the maintenance position was vacant for 9 months. 2. Observation on 6/14/23 at 2:15 p.m. revealed three staff members declined to participate in a simulated fire drill in the cafeteria. After those refusals the maintenance director activated the alarm with a pull station. The staff performance revealed a lack of experience. Doors remained open. The use of a fire extinguisher had to be explained to the staff. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 712		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6,	K 914	1.Weekly generator logs updated by 7/7/23. Generator maintenance contractor contracted 7/5/23 to obtain service paperwork. All staff and residents at potential for risk. 2. Generator will be tested under load weekly and logged into TELS weekly. 3. Maintenance Director will log generator test logs weekly. TELS will be audited weekly x3 weeks, monthly x3 months and findings will be reviewed at monthly QAPI meeting for recommendations and effectiveness.	7/30/23

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K 914	Continued From page 8 which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to document weekly or monthly generator inspections for the past twelve months. Findings include: 1. Observation on 6/14/23 at 1:45 p.m. during record review revealed no documentation of the required weekly generator preventive maintenance inspections or any documentation of monthly required load testing. Interview with the maintenance supervisor at the time of the record review revealed he was completing the inspections when he was working on his shift. The deficiency affected two of numerous generator maintenance requirements.	K 914		

South Dakota Department of Health

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	10607	A. BUILDING: _____ B. WING _____	06/15/2023

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 6/12/23 through 6/15/23. Avantara Clark City was found in compliance.	S 000		

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

Rachel Morehouse | Administrator | 7/6/23

STATE FORM 6899 I4QV11 If continuation sheet 1 of 1