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

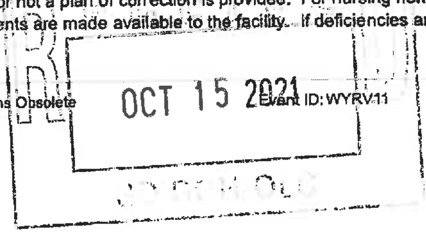
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435057	A. BUILDING ______ B. WING ______	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	106 BRADDOCK ARMOUR, SD 57313

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 25107 A COVID-19 Focused Infection Control survey was conducted by the South Dakota Department of Health Office of Licensure and Certification on 9/15/21. Avantara Armour was found not in compliance with 42 CFR Part 483.80 infection control regulation: F880. Avantara Armour was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations F550, F562, F563, F583, F882, F885, and F886. A COVID-19 Focused Emergency Preparedness survey was conducted by the South Dakota Department of Health Office of Licensure and Certification on 9/15/21. Avantara Armour was found in compliance with 42 CFR Part 482, Subpart B, Subsection 483.73 related to E-0024(b)(6). Total residents: 30	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880	Corrective Action: 1.Time Cannot be turned back to a time prior to the identification of lack of: *Appropriate observation of negative air flow to keep aerosolized COVID in room. *Appropriate application and wearing of N95 masks. The administrator and DON in consultation with the medical director and infection control nurse and whomever else identified will review,	10/12/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karrie Doty
TITLE: LNHA
(X6) DATE: 10/08/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.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F 880	Continued From page 1 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 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880	assigned tasks have potentialrevise, and create as necessary policies and procedures about: *The need to maintain negative airflow in COVID positive areas. *Appropriate application and wearing of N95 masks. *Necessary infection control and prevention plan that includes effective compliance. All staff who provide above care and services to residents will be educated/ re-educated by 9/15/21 by DON. Activity Director B was educated on 9/15/21 on appropriate application and wearing of N95. All staff were educated on appropriate application and wearing of N95 on 9/15/21 by Acting Administrator and Clinical Care Coordinator. As new admissions come into receiving rooms or positive rooms they will be educated on maintaining negative airflow to keep aerosolized COVID in room. Current resident in isolation was educated on 10/8/21 by DON negative air flow and open windows to keep aerosolized COVID in room. Identification of Others: 2. All residents have the potential to be affected if staff do not adhere to: *Appropriate observation of barriers to ensure negative airflow is maintained in COVID positive rooms. *Appropriate application and wearing of N95 masks. All staff completing the care and/or	

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 25107 A. Based on observation and interview, the provider failed to prevent the potential spread of aerosolized COVID from one of five COVID positive resident rooms (7A). Findings include: 1. Observation and interview on 9/15/21 from 12:30 to 12:45 with the director of nursing (DON) A in the north resident hallway revealed: *The north resident wing had both positive and negative resident rooms. *The positive resident rooms had plastic barriers installed over the outside of the resident room doors. -The barriers were clear plastic with a zipper running vertically through the middle. -They had installed the clear plastic over the door to provide a barrier to keep the aerosolized COVID in the room while allowing staff to see and communicate with the residents when the resident door was open. *The window in resident room 7A was open. The air pressure from the open window was pushing the plastic barrier outward into the hall.	F 880	education/training with demonstrated competency. DON contacted the South Dakota Quality Improvement Organization (QIN) on 9/22/21 and again on 10/7/21. Discussion included: Performance trackers done weekly on proper disinfection of equipment, hand hygiene, and PPE audits. The 5 Whys of RCA. Education for staff on the Root Cause Analysis. to be affected. Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by Administrator and DON. Policy education/re-education about assigned tasks was completed on 9/15/21 to Activity Director B and all staff on Respiratory Protection For COVID-19-N95 Use. Policy education/ re-education done for all staff by DON by 10/12/21 on negative air flow to keep aerosolized COVID in room to include no open windows. System Changes: 3. Root cause analysis conducted answered the 5 Whys: Communal dining we learned that COVID is easily passes from resident to resident of vaccinated residents with no symptoms. Residents with no symptoms can easily spread the virus without us knowing until we have an outbreak. Staff turnover leads to lapse education. Leadership turnover leads to lapse in education. Improper notification from hospital of COVID positive resident diagnosis	

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F 880	Continued From page 3 *Air was escaping from the COVID positive room into the hallway by going under the plastic barrier and through the zipper when it was opened. *The escape of aerosolized COVID into the hall could potentially expose staff and residents who were not wearing N95 respirators. *DON A agreed and sent a staff member into the room to close the window. *She had not considered the possibility that opening a widow could increase the potential spread of COVID. B. Based on observation, interview, and policy review, activities director B failed to properly apply and wear an N95 mask while in a room of a resident who was COVID positive. Findings include: 1. Observation and interview on 9/15/21 at 1:45 p.m. in the north resident hallway with the DON revealed: *Staff were delivering snacks to residents in that hallway. *Activities director B was observed coming out of a COVID positive resident room. *Activities director B was wearing an N95 respirator over the top of a surgical mask. *The DON talked to activities director B and made sure she discarded both the N95 and the surgical mask. *The DON was not for sure why activities director B had done that. -It was the first time she had ever seen a staff member putting an N95 over the top of a surgical mask. -Activities director B had just returned to work on 9/13/21 from an extended leave of absence. -Activities director B usually did not provide direct resident care.	F 880	leads to lack of knowledge causing resident to not be placed in appropriate isolation on admission. Administrator, DON and medical director identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency. DON contacted the South Dakota Quality Improvement Organization (QIN) on 9/22/21 and again on 10/7/21. Discussion included: Performance trackers done weekly on proper disinfection of equipment, hand hygiene, and PPE audits. The 5 Whys of RCA. Education for staff on the Root Cause Analysis. Monitoring: 4. Administrator, DON, infection control nurse, and whomever else determined necessary will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum 3-5 times weekly for 4 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with: *Necessary infection control and prevention plan that includes compliance in the above identified areas. *Any other areas identified by the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month.	

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F 880	Continued From page 4 *She agreed activities director B had not properly applied and worn the N95 mask while in a room of a resident who was COVID positive. Review of the May 12, 2021, Universal Mask/Respirator - eye protection on COVID-19 unit/area Policy revealed: "Fit check to ensure there is a good fit on face, must be completed with each donning of the respirator."	F 880	Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or infection control person, or whomever else is determined necessary, to the QAPI committee and continued until the facility demonstrates sustained compliance then as determined by the committee and medical director.	