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 _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	106 BRADDOCK POST OFFICE BOX 489 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: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/10/20 through 2/12/20. Avantara Armour was found not in compliance with the following requirements: F565, F625, F656, F686, F689, F690, F726 and F880.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565	1. Resident Council was held on 3/4/2020. Outstanding issues of privacy, special meals, medical supplies, and missing clothing have been resolved. Residents were encouraged to voice any concerns immediately via the grievance process and they were educated that they do not have to wait until Resident Council meeting to voice concerns or issues. Administrator was present and talked about outstanding issues of call lights, snack cart, salad cart, food temps, and waking at the time of their choosing. Residents were satisfied and in agreeance with the plan to resolve remaining issues. Administrator will provide update to Resident Council at next month's meeting. 2. All residents are at risk for not having their concerns addressed. All grievances will be reviewed during Monday through Friday daily start up meeting to ensure timely follow up with concern. Meeting minutes from Resident Council will be reviewed by administrator and the interdisciplinary team (IDT) to identify and resolve issues and concerns. 3. The Administrator, SSD, social worker consultant, and interdisciplinary team in collaboration with the governing body has reviewed the policies and procedures about follow-up and resolution of resident voiced concerns. The findings cited in the deficiency were reviewed. The Administrator will educate all staff no later than March 13, 2020 about their roles and responsibilities for follow-up and resolution of resident concerns and empowering staff to resolve some concerns promptly and have a method to show what was concern and resolution. Staff not present at education sessions due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. The Administrator or designee will audit resident council minutes monthly to for six months to ensure grievances shared in Resident Council meeting are recorded on a facility grievance form and resolved within three days. Additionally, the Administrator	03/23/2020

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

Stefanie Geigle | Administrator | 03/09/2020

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 565	Continued From page 1 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, record review, and policy review, the provider failed to ensure concerns brought up by the Resident Council were satisfactorily resolved. Findings include: 1. Observation and interview on 2/11/20 at 1:15 p.m. with the Resident Council revealed: *They met monthly and and the social worker helped facilitate the meetings. *The meetings took place in the living room area. -There was nothing to prevent people from coming into the area during the meeting. --It was not private. *During their meetings they were given an opportunity to voice their concerns. *Those concerns had included: -Having to wait a long time for call lights to be answered. -They did not have any privacy during their meetings. -There was no place to meet privately with visitors. -They had requested special meals such as pizza and Indian tacos and were told they could have them, but never had. -They either did not receive an evening snack or the snack cart ran out of certain items by the time they reached a certain point in the snack pass.	F 565	or designee will interview five random residents each week to ensure they know of grievance process and if they have any grievances/concerns they would like to share or any past grievances they felt were not resolved. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be discussed by the Administrator or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 565	Continued From page 2 -The food was cold especially the vegetables. -They only had a limited number of things to choose from if they did not like the entree served. --There was not appropriate alternatives. --It was usually a grilled cheese sandwich. -They felt staff did not know about them as people. --They were always in a hurry, especially in the evening. --Some staff were abrupt. *The above concerns had been brought up many times, but nothing ever happened about their concerns. Review of the following Resident Council meeting minutes revealed: *9/5/19: -Residents had requested pizza and lutefisk. -Call lights were discussed. -Residents voiced concerns about their medical supplies. *10/3/19: -Repeat concern with call lights not being answered timely. -There was no follow-up to the request for pizza or lutefisk or the discussion about the medical supplies. *11/7/19: -Residents requested a salad cart. -Repeat concern with call lights not being answered timely especially in the evening. -There was discussion about getting residents up in the morning when they wanted to get up. -Not all residents were getting evening snacks. *12/5/19: -Food was not always hot. -Repeat request for pizza and Indian tacos along with liver and onions. -Repeat concern with call light response time.	F 565		

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F 565	Continued From page 3 *1/2/20: -Residents commented supper meal was always soup and sandwich, and meat was too tough. -The assistant administrator was checking into a salad cart. -Repeat concern with snacks were not always on time, and there were not enough to make it to the end of the resident hallways. -Repeat concern with call lights. -Residents were missing items in laundry, and laundry was shrinking some items. *2/6/20: -Repeat concern with snacks. -The alternate meal options were limited. -Repeat concern about the temperature of food. -Another concern with missing clothing. Further review of the above meeting minutes revealed: *There was never any representation at the meeting of the department manager's attendance to address the repeated concerns. -There was no evidence the residents were asked if they wanted the managers to attend periodically. *There was no evidence: -They reviewed the plans in place to correct their concerns from month-to-month. -They had assessed if there had been a corrective action, or how resident's felt their concern had improved or been impacted. Interview on 2/11/20 at 2:53 p.m. with social services designee (SSD) Q revealed she: *Had been in that position since October 2019. *Facilitated the Resident Council monthly meeting. *Confirmed the above repeated concerns came up month after month including:	F 565		

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F 565	Continued From page 4 -Not receiving evening snacks. -Wanting more variety with their food. -Food was sometimes cold, especially vegetables. -Not having enough staff and needing to wait for call lights to be answered. *Talked about what she had done to resolve the above concerns, but it was unclear how other department managers were involved in correcting issues related to their department. *She was unaware of a policy regarding the Resident Council. Further interview on 2/11/20 at 4:30 p.m. with SSD Q revealed she had received an April 2018 Resident/ Family Council policy that read: "The facility shall act upon concerns and recommendations of the Council, make attempts to accommodate recommendations to the extent practicable, and communicate its decisions to the Council."	F 565		03
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625	1. The Resident and/or responsible party for residents 1 and 7 have been provided a copy of the bed hold policy. 2. All residents who transfer to the hospital are at risk for not receiving the Bed Hold Policy. 3. All staff will be educated no later than March 13, 2020 on the facility's bed hold policy and the need to document notification the resident and/or responsible party of the bed hold policy and provide a written copy of such upon transfer from the facility. Staff not present at education sessions due to vacation, illness or casual work status will be educated prior to their first shift worked. 4. Administrator or designee will audit all discharges to the hospital each week to ensure resident notification of bed hold policy is documented in the medical record. Audits will be weekly for four weeks and then monthly for three months. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/ revision of audits based on audit findings.	03/23/2020

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F 625	Continued From page 5 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on interview, record review, and policy review, the provider failed to ensure two of two sampled residents (1 and 7) who were transferred to the hospital had received a written notice of the provider's Bed Hold policy at the time of their transfer. Findings include: 1. Review of resident 1's medical record revealed: *She had been admitted on 8/20/19. *Since admission she had been transferred to the hospital three times. *The most recent admission was on 1/26/20. *There was no evidence of a written Bed Hold policy having been given to the resident or her representative at that time. 2. Review of resident 7's medical record revealed: *She had been admitted to the hospital on 1/29/20. *There was no evidence of a written Bed Hold	F 625		

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F 625	Continued From page 6 policy having been given to the resident or her representative at that time. 3. Interview on 2/12/20 at 9:12 a.m. with business office manager G revealed: *When a resident was admitted to the facility the Bed Hold policy was given to the resident or their representative. *When a resident transferred to the hospital they called the family about the Bed Hold policy. -She was unaware if anyone documented that. Interview on 2/12/20 at 9:19 a.m. with administrator A revealed: *The Bed Hold policy was given at the time of admission to the new resident. *They had not given the written policy to them when they were transferred to the hospital. Review of the provider's undated Bed Hold Policy and Notification revealed: *"It is our policy to inform residents/legal representatives upon admission and after leaving the facility for hospitalization, observation or therapeutic leave of our Bed Hold Policy and notification. *Each resident/legal representative will be informed by Avantara Armour staff of the facility's Bed hold Policy and Notification upon admission to the facility and/or when a resident leaves for hospitalization, observation or therapeutic leave." *The form requested a signature indicating acknowledgement of receiving that notice.	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656	1. Resident 16's care plan has been updated to reflect the current care needs. 2. All residents are at risk. All resident care plans have been reviewed to ensure they reflect the current care needs and resident preferences. 3. The Administrator, DON, and interdisciplinary team in collaboration with the medical director and the governing body have reviewed the Care	03/23/2020

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F 656	Continued From page 7 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	Plan policy and have reviewed the example cited in the deficiency. The DON will educate all staff no later than March 13, 2020 on the need to ensure care plan is up to date and reflects resident's current care needs and preferences. Education will include ensuring any changes in care needs or preferences is reported to the charge nurse so that the care plan can be updated as changes occur so that everyone is on the same page and the care is consistent. Those not in attendance at the education session due to vacation, illness, or casual work status will be educated prior to their next shift worked. 4. The DON or designee will audit five random care plans each week to ensure the care plan is accurate and reflects resident's care needs and preferences. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 656	Continued From page 8 This REQUIREMENT is not met as evidenced by: Surveyor: 42593 Surveyor: 40771 Based on observation, interview, and record review, the provider failed to develop and implement a care plan with interventions regarding toileting for one of twelve sampled residents (16). Findings include: 1. Review of resident 16's medical record revealed: *He was admitted on 2/16/16. *He had a Brief Interview for Mental Status assessment score of six indicating he was mildly, cognitively impaired. -He was able to answer all questions appropriately during that interview. *His diagnoses included: chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, myoclonus, osteoarthritis bilateral knees and left shoulder, pain in right and left shoulders, unspecified foot and ankle pain, unsteadiness on feet, difficulty in walking, obesity, and mild cognitive impairment. Observation and interview on 2/10/20 at 2:47 p.m. with resident 16 revealed when he had to wait too long for his call light to be answered he urinated in his brief. He appearred dressed in sweatpants and a button up shirt with pockets, his hair was combed and his room had a commode sitting in it with an overbed table with blankets on top of it. Review of resident 16's dated 2/2/20 at 2:03 p.m. bowel and bladder evaluation revealed he: *Had edema and was on diuretics. *Was not steady without staff assistance when	F 656		

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F 656	Continued From page 9 moving from a seated to a standing position and had a fear a falling. *Had limited range of motion in his right shoulder and bilateral knees. *Required extensive assistance with toilet use requiring two plus staff physical assistance. *Required a mechanical lift for transfers. Interview on 2/12/20 at 3:02 p.m. with director of nursing (DON) C regarding resident 16 revealed: *Toileting was individualized for each resident but was not put in the care plan. *Staff should know how often to check residents based on their handoff reports, orientation to the residents, and shadowing for five, eight hours shifts to learn the routines. Review of the 2/5/20 care plan for resident 16 revealed: *Focus: Alteration in elimination of bowel and bladder: constipation and urinary incontinence, (revised 11/12/19). -No goal for bladder elimination. *Interventions for that focus area revealed non-specific, unclear, and contradictory directions including the following: -"I ask to toilet, but do forget at times. Please ask me regularly throughout each shift, (date initiated 2/12/20). -I choose to use urinal during the day rather than commode. I am able to do this independently at times but may need assist to place. I will need you to empty for me, and my clothing adjustments as needed, (revised 11/12/19). --I use a bariatric commode in my room. I need assist to transfer, cleanse, and adjust my clothing, (stand lift for toileting and needs to be done quickly so not putting too much pressure on shoulder. Be sure to have everything ready	F 656		

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F 656	Continued From page 10 before standing, revised 1/25/20)".	F 656		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on interview, record review, and policy review, the provider failed to a put a plan of care in place to prevent a pressure ulcer from developing and to ensure another pressure ulcer did not develop for one of one sampled resident (18). Findings include: 1. Review of resident 18's medical record revealed: *She was admitted on 10/1/19. *Her Brief Interview for Mental Status assessment score was six indicating her cognition was severely impaired. *Diagnoses included: Alzheimer's disease, anxiety disorder, dementia, delusional disorders, osteoarthritis, repeated falls, other specified disorders of bone density and structure, chronic	F 686	1. Resident 18's care plan has been updated to reflect the current risk level for skin breakdown and interventions are in place for pressure injury prevention. 2. All residents are at risk for missing care plan interventions when identified at risk for pressure injury development. All resident Braden Assessments have been reviewed to ensure if they are identified as at risk for skin breakdown that the care plan is so addressed. 3. The Administrator, DON, and interdisciplinary team in collaboration with the medical director and the governing body have reviewed the Care Plan and Skin Care policy and have reviewed the example cited in the deficiency. The DON will educate all staff no later than March 13, 2020 on adequate assessment and documentation of skin and associated risks - Root Cause helps sort and establish appropriate personalized interventions and don't wait for pressure injury development before implementing interventions. Education will also include the need to ensure care plan is up to date, including pressure injury prevention interventions for anyone identified at risk for skin breakdown. Staff not present at the education session due to vacation, illness, or casual work status will be educated prior to their next shift worked. 4. The DON or designee will audit five random residents and review current Braden Scale, and if assessment indicates resident is at risk for skin breakdown will check care plans to ensure the care plan includes interventions for preventing pressure injury development. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	03/23/2020

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F 686	Continued From page 11 pain, and functional urinary incontinence. *She developed a stage two pressure ulcer to her right ankle on 12/23/19. -The pressure ulcer was healed on 1/8/20. Interview on 2/10/20 at 3:01 p.m. with licensed practical nurse I regarding resident 18 revealed: *The pressure ulcer was on the front of her ankle and had been caused from some short socks she was wearing. *The pressure ulcer was healed, and they were no longer providing any type of treatment to the area. Review of resident 18's 12/23/19 Minimum Data Set assessment revealed: *She was at risk for developing pressure ulcers. *She had a stage II pressure ulcer. *She had a pressure reducing device for her bed. *She was receiving pressure ulcer care. Review of resident 18's 12/22/19 Braden Scale that was used to predict the risk of a resident acquiring a pressure ulcer indicated she was at high risk for developing a pressure ulcer. Review of resident 18's 12/24/19 care plan revealed her pressure ulcer risk had not been addressed. Interview on 2/12/20 at 1:24 p.m. with director of nursing (DON) C regarding resident 18 revealed: *The resident had never had a care plan in place to prevent or treat pressure ulcers. *She would have expected to have a care plan in place for any resident identified to either have a pressure ulcer or be at risk for a pressure ulcer. *The resident's 12/22/19 Braden score was seventeen, and she did not agree that score	F 686		

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F 686	Continued From page 12 would indicate the resident was at risk for a pressure ulcer. -At a score of sixteen she would expect a plan of care be put in place regarding pressure ulcers. *She would have expected a resident with a pressure ulcer to have a plan of care in place. *After a pressure ulcer was healed she would expect the resident to continue to have a plan of care in place. *She agreed the resident could be at risk for a pressure ulcer in the future. Review of the provider's 7/30/19 Care Plan policy revealed care plans would be reviewed and revised after each assessment. The DON was asked for a pressure ulcer policy on 2/13/20 and she provided a 8/2/19 Skin Care Treatment Regimen policy. That policy had not addressed care planning for a resident with a pressure ulcer or for a resident at risk for a pressure ulcer.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review, the provider failed to follow the	F 689	1. Residents #28 and #32 will be evaluated by Skilled Therapy for safe transfer status. Resident #28 requires and is receiving safe transfer with the sit to stand lift and two staff assist. Resident #32 requires and is receiving safe transfers with the sit to stand and two staff assist. The Lift Evaluation was amended on 03/05/2020 to reflect the current policy and standard of practice of using one staff assist with Sit-to-Stand mechanical lifts. Care plan has been updated for specific lift required on resident 28 and 32. Education was provided to staff member I, on 3/5/2020 by DON regarding thorough and accuracy of Lift Evaluations. Staff Member J was educated on 3/5/2020 by DON regarding following care planned mobilizations for safety of residents and staff and educated on process to communicate resident changes of condition (declines and improvements) to charge nurse for	03/23/2020

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F 689	Continued From page 13 plan of care to ensure safe transfers for two of four sampled residents (28 and 32) who required mechanical lift transfers. Findings include: 1. Review of resident 32's medical record revealed: *He was admitted on 9/16/19. *His long and short term memory were intact. *His diagnoses included: cerebral infarction, type two diabetes, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, muscle wasting and atrophy, and flaccid hemiplegia affecting left non-dominant side. Observation and interview on 2/11/20 at 1:25 p.m. of certified nurse assistant (CNA) J assisting resident 32 revealed: *She had used the sit-to-stand mechanical lift by herself to transfer him from his wheelchair (w/c) to his recliner. *She stated when he was first admitted he had two staff assist him with the lift to transfer. *He was stronger now, so he only needed one staff person to assist with the mechanical lift. *She was able to access his care plan on the Kiosk to look at it. Review of resident 32's 1/18/20 Lift Evaluation assessment revealed he required a sit-to-stand mechanical lift. *There had been a statement in bold print that stated: "Number of Staff Required for Lift/Transfer: LEGACY HEALTHCARE Policy REQUIRES 2 or more PERSON ASSIST when using a lift for transfers." -It did not specify what type of lift. Review of resident 32's 1/21/20 Minimum Data	F 689	evaluation. Mechanical lift competency was completed with staff member J on 03/05/2020 by DON. 2. A baseline audit of all residents who require transfer with a Sit-to-Stand Mechanical Lift was completed. All residents who require transfer with a Sit-to-Stand Mechanical Lift have the potential to be affected by this practice. All residents who currently utilize a Sit-to-Stand Mechanical Lift will have a new Lift Evaluation completed by 03/12/2020. 3. Administrator, DON, and interdisciplinary team in collaboration with the medical director and the governing body to review, revise, create as necessary the policies and procedures about ensuring: • Adequate assessment and documentation of resident transfer capability and/or needs. Education on Root Cause Analysis provided. Care Plan development and updating for resident specific interventions. Staff competency to meet Standards of Practice, State and Federal requirements. All facility staff will be educated by March 13, 2020 on their roles and responsibilities for expected tasks; included skills competencies. All Nursing Department Staff will be educated by March 13, 2020 by the DON/designee, regarding safe transfers using a Sit-to-Stand Mechanical Lift, Lift Evaluation accuracy, MDS accuracy for transfer status, and resident-centered care plan accuracy for safe transfers. Sit-to-Stand Mechanical Lift Competencies will be completed at that time with return demonstration. Nursing Department Staff not present at the education session due to vacation, illness, or casual work status will be educated prior to their next shift worked. 4. The DON or designee will complete safe Sit-to-Stand Mechanical Lift audits weekly x 4 weeks, then monthly x 3 months. Results of audits will be discussed by the DON or designee at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for	

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F 689	Continued From page 14 Set (MDS) assessment revealed he: *Required extensive assistance of two staff with transfers. *Was only able to stabilize himself with staff assistance for surface-to-surface transfers. *Had impaired range of motion to one side of his upper and lower extremities. Review of resident 32's 1/23/20 care plan revealed he required the assistance of two staff: *To get in and out of bed with the sit-to-stand mechanical lift. *For transfers with the sit-to-stand mechanical lift: -"Be aware two assist needed at all times due to his left side being flaccid so needs extra help to ensure he doesn't loose his balance while moving and fall to the left." 2. Record review of resident 28 revealed: *He was admitted on 6/21/19. *He had a Brief Interview for Mental Status assessment score of fifteen indicating his cognition was intact. *His diagnoses included: type two diabetes, bilateral primary osteoarthritis of hip, bilateral primary osteoarthritis of knee, low back pain, other abnormalities of gait and mobility, muscle wasting and atrophy, pain in right shoulder, pain in left shoulder, and unsteadiness on feet. Observation on 2/11/20 at 11:04 a.m. of CNA J assisting resident 28 revealed she had used the sit-to-stand mechanical lift by herself to transfer him from his w/c to the toilet. Observation on 2/11/20 at 11:16 a.m. of CNA J assisting resident 28 revealed she had used the sit-to-stand mechanical lift by herself to transfer him from the toilet to his recliner.	F 689	analysis and recommendation for of audits based on audit findings.	

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F 689	Continued From page 15 Interview on 2/11/20 at 1:52 p.m. with CNA J regarding the above revealed: *When she assisted him out of the bed she would use two staff to assist him. *At times she did use two staff to assist with the sit-to-stand lift if another staff member was available to help. Review of resident 28's 10/12/19 and 1/13/20 Lift Evaluation assessment revealed: *He was unable to bear at least 50% weight on at least one leg. -That indicated he was not a candidate for a sit-to-stand lift. *It had also been marked that he required a sit-to-stand lift. *There had been a statement in bold print that stated: "Number of Staff Required for Lift/Transfer: LEGACY HEALTHCARE Policy REQUIRES 2 or more PERSON ASSIST when using a lift for transfers." -It did not specify what type of lift. Review of resident 28's 1/14/20 MDS assessment revealed he: *Required extensive assistance of two staff with transfers. *Was only able to stabilize with staff assistance for surface-to-surface transfers. *Had impaired range of motion to bilateral upper and lower extremities. Review of resident 28's 2/6/20 care plan revealed: *He required extensive assistance of two staff with the sit-to-stand mechanical lift for all transfers. *Full body lift could be used if necessary with	F 689		

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F 689	Continued From page 16 assist of two staff. 3. Interview on 2/11/20 at 4:54 p.m. with MDS coordinator F revealed: *Lift assessments were performed quarterly. *She was not sure if the policy was to have two staff assist with all lifts. *Residents 28 and 32 were to have two staff assist with sit-to-stand lift for transfers per their care plans. Interview on 2/12/20 at 10:57 a.m. with CNA U revealed: *She used two staff assist with the sit-to-stand lift to transfer resident 28. *She usually was the only one assisting him when she used the stand lift to transfer resident 32. *She used the care plan in the Kiosk to see how a resident was to be transferred. *She had thought she had been told resident 32 could be transferred with one staff person. Interview on 2/12/20 at 12:59 p.m. with director of nursing C and assistant director of nursing D revealed: *They would have expected the CNAs to follow residents' care plans for transfers. *Per the provider's policy the sit-to-stand lift could be used with one or two staff. -The lift assessment they used needed to be updated to reflect the current policy. *The last two lift assessments on resident 28 were incorrect. He had always required the assistance of two staff with the sit-to-stand lift with transfers. Review of the provider's September 2019 Mechanical Lifts policy revealed sit-to-stand lifts could be used by one staff member to assist a	F 689		

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F 689	Continued From page 17 resident. Review of the provider's 7/30/19 Care Plan policy revealed residents would have a person centered care plan in place, and it would be reviewed after each MDS assessment.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's	F 690	1. Resident #2 and #16 have been evaluated for Bowel and Bladder needs to determine resident specific needs. Care plans for resident #2 and #16 have been updated to reflect the resident's current bowel and bladder needs. Documentation for bowel and bladder are being documented appropriately for residents #2 and #16. 2. Residents with bladder incontinence and cognitive impairment have a potential to be affected. The facility completed a call light audit to determine timely answering of all call lights. Residents were interviewed to determine if there were concerns with timely call light response. All residents have the potential to be affected by call light response times. 3. Administrator, DON, and interdisciplinary team in collaboration with the medical director and the governing body to review, revise, create as necessary the policies and procedures about ensuring: • Adequate assessment of needs and documentation for toileting of all residents. Care plan implementation and updates with changes in resident toileting needs. Responding to resident call lights. Provide education and training for ALL facility staff about their roles and responsibilities for the assigned task(s); including return demonstration for skills. The facility will review all resident care plans for bladder or bowel incontinence and will update bowel and bladder care plans for resident individualized needs no later than March 23, 2020. All Nursing Department Staff will be educated by March 13, 2020 by the DON or designee to promote continence of the residents, regarding individualized resident	03/23/2020

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F 690	Continued From page 18 comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 40771 Surveyor: 42593 Based on observation, interview, record review, and policy review, the provider failed to provide services for two of two residents (2 and 16) who required assistance with toileting from staff. Findings include: 1. Review of resident 16's medical record revealed: *He was admitted on 2/16/16. *He had a Brief Interview for Mental Status assessment score of six indicating he was mildly, cognitively impaired. -He was able to answer all questions appropriately during the assessment. *His diagnoses included: chronic kidney disease, benign prostatic hyperplasia with lower urinary tract symptoms, myoclonus, osteoarthritis bilateral knees and left shoulder, pain in right and left shoulders, unspecified foot and ankle pain, unsteadiness on feet, difficulty in walking, obesity, and mild cognitive impairment. Interview on 2/10/20 at 2:47 p.m. with resident 16 revealed: *He stated that when he had to wait too long for his call light to be answered he urinated in his brief. *He felt he had developed worsening tremors which he believed caused a prior fall. *He had worsening bilateral shoulder pain and	F 690	resident needs in bowel and bladder continence, accuracy in Bowel and Bladder evaluations and updating bowel and bladder care plans. All Nursing Department Staff will also be educated on facility expectation of answering resident call lights. CNA education regarding documentation each time a resident is toileted ensures we are capturing the care provided. Nursing Department Staff not present at the education session due to vacation, illness or casual work status will be educated prior to their next shift worked. 4. The DON/designee will complete bowel and bladder management audits weekly x 4 weeks and then monthly x 3 months to determine resident centered care planning for bowel and bladder management; accurate bowel and bladder evaluations, consistent bowel and bladder documentation, and timely call light response to the resident's needs. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	

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F 690	Continued From page 19 stiffness. Review of resident 16's 2/2/20 at 2:03 p.m. bowel and bladder evaluation revealed he: *Could identify the need or urge to void or defecate and was able to ask to go to the toilet. *Was able to use a call light. *Was not continent of bladder and would awake at night to void some of the time. *Had edema and was on diuretic medication. *Was on opiod medication. *Was not steady without staff assistance when moving from a seated to a standing position and had a fear a falling. *Had limited range of motion in his right shoulder and bilateral knees. *Required extensive assistance with toilet use requiring two or more staff. *Required a mechanical lift for transfers. Review of resident 16's 2/5/20 care plan revealed: *An intervention initiated on 11/20/19 for toilet use: He did not always remember to ask for everything, and staff should have checked in with him throughout each shift. *Focus area: urinary incontinence revised on 11/12/19. -Intervention initiated 2/12/20: "I ask to toilet, but do forget at times. Please ask me regularly throughout each shift." -"I choose to use urinal during the day. I will need you to empty for me, and my clothing adjustments as needed (revised 11/12/19)." Review resident 16's 1/14/20 to 2/12/20 bowel and bladder task documentation revealed: *For ten of the thirty days there was no continence documentation after 3:00 p.m.	F 690		

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F 690	Continued From page 20 *For seven of the remaining twenty days there was documentation after 5:00 p.m. *None of the days had two hour documentation. Interview on 2/12/20 at 3:02 p.m. with director of nursing (DON) C regarding resident 16 revealed: *Since he had a pacemaker placement he had decreased cognition with more incontinent episodes. *He had periodically complained of late responses to call lights that she had investigated. -She had determined the delays were because he needed two staff to assist with toileting. *Toileting was individualized for each resident but was not put in the care plan. *Staff should have known how often to check residents based on their handoff reports, orientation to the residents, and shadowing for five, eight hours shifts to learn the routines. Review of the provider's Toileting Interventions policy revised on 8/2/19 revealed: *"Incontinent care every 2 hours/after each involuntary episode to help keep patient clean and dry. *Assist patient to the toilet as indicated consistent to established bladder pattern. *Offer bedpan/urinal every 2 hours and as needed. Resident's plan of care for toileting interventions will be consistent to the resident continence status assessment." Surveyor: 26180 2. Observation on 2/11/20 at 9:58 a.m. of resident 2 and certified nursing assistant (CNA) J revealed she: *Used the EZ stand lift to transfer the resident from her wheelchair to her bed.	F 690		

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F 690	Continued From page 21 *After the resident was laying down she hung her catheter bag on the side of the bed. *Covered the resident with a blanket. *She left the room without attempting to toilet the resident or checking the resident to see if she had a bowel movement (BM). -An odor indicating the resident could have had a BM was noted during the above time. Immediately after exiting resident 2's room CNA J: *Was asked about when she would check the resident for a BM. *She indicated she would normally have done it when she laid her down. *She confirmed she had not done that; maybe because she was nervous. -She immediately returned to the resident's room where she confirmed the resident had a BM in her disposable brief. Review of resident 2's 9/5/19 care plan revealed: *Focus: Alteration in elimination of bowel and bladder r/t (related to) constipation, diarrhea. -Was incontinent of bowel frequently. *Goal:" I will have a soft formed bowel movement at least every three days." *Interventions: Bowel medication as ordered. -There were no interventions that addressed her actual toileting managing bowel management. Interview on 2/12/20 at 9:30 a.m. with director of nurses C regarding resident 2 revealed: *Staff should have taken her to the bathroom after breakfast. *She would sometimes start to have a BM but could continue to have more if placed on the toilet. *She thought the CNA might have been nervous	F 690		

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F 690	Continued From page 22 when she was being observed. *She confirmed the resident should have been checked for a BM.	F 690		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services 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). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by:	F 726	1) LPN I and CNA L have verification of their competence related to infection control concerns identified during the survey related to transmission-based precautions. Completed all the South Dakota required training topics during their orientation for: • Accident prevention and safety. • Proper use of restraints. • Confidentiality of resident information. • Incidents and diseases subject to mandatory reporting. • Care of residents with unique needs. • Dining assistance, nutritional risks, and hydration. • Abuse, neglect, misappropriation, and mistreatment. • Facility identified needs. CNA J received training and return demonstration competency on safe Mechanical Lift transfers. 2) The facility completed a review of all employee files to determine that required orientation, annual education, and competencies are current. All residents have the potential to be affected by this practice. 3) Administrator, DON, and interdisciplinary team in collaboration with the medical director and the governing body to review, revise, create as necessary the policies and procedures about ensuring: • Staff are competent in the required skillset and understand their roles and responsibilities. • All Staff education will be completed by the administrator, DON, or designee by March 13, 2020 regarding staff roles and responsibilities, required annual education, skill competencies, and ongoing educational needs based on the individualized needs of the resident population. Nursing Department Staff not present at the education session due to vacation,	03/23/2020

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	435057	A. BUILDING _____ B. WING _____	02/12/2020

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F 726	Continued From page 23 Surveyor: 35237 Based on observation, interview, record review, and facility assessment review, the provider failed to ensure an orientation program and nursing staff competencies had been completed for three of four sampled nursing staff (I, J, and L) to ensure the residents' health and safety needs were met. Findings include: 1. Observations during the survey on 2/10/20 from 2:15 p.m. through 5:15 p.m, on 2/11/20 from 8:30 a.m. through 5:30 p.m., and on 2/12/20 from 8:30 a.m. through 5:00 p.m. identified concerns with staff training and competencies related to infection control practices for transmission-based precautions and residents' safety with transfers. Refer to F880 and F689. Interview on 2/12/20 at 11:22 a.m. with medical director E regarding concerns identified during the survey revealed: *She confirmed staff should have been trained and were competent to complete the tasks they were performing. *Competence with nursing tasks should have been verified. Personnel file review and interview on 2/12/20 at 1:45 p.m. with human resources (HR) coordinator G revealed: *Licensed practical nurse (LPN) I had been hired on 8/19/19. *Certified nursing assistant (CNA) L had been hired on 11/4/19. *CNA J had had been hired on 7/26/19. -All three of them were working independently with the residents and were not currently in orientation. *LPN I and CNA L had not:	F 726	illness, or casual work status will be educated prior to their next shift worked. 4) The Administrator, DON, or designee will complete audits weekly x4 and then monthly x3 on new hire orientation completions and staff competencies. Audits will be reported quarterly to the QAPI Committee meeting for analysis and recommendation for continuation discontinuation/revision of audits based on audit findings.	

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F 726	Continued From page 24 -Had verification of their competence related to infection control concerns identified during the survey related to transmission-based precautions. -Completed all the South Dakota required training topics during their orientation for: --Accident prevention and safety. --Proper use of restraints. --Confidentiality of resident information. --Incidents and diseases subject to mandatory reporting. --Care of residents with unique needs. --Dining assistance, nutritional risks, and hydration. --Abuse, neglect, misappropriation, and mistreatment. --Facility identified needs. *Certified nursing assistant J had not had verficiation of her competence with the mechanical lift. *HR coordinator G indicated the files should have contained all their training and competency records. -She confirmed the above concerns with the incomplete orientation and competencies. Interviews on 2/12/20 at 10:15 a.m. and at 2:00 p.m. with director of nursing C regarding the above revealed: *She agreed all staff should have completed an orientation program and received training on the required topics within thirty days of being hired. *She confirmed there were no competencies of the nursing staff related to the concerns with transmission-based precautions and mechanical lifts. *Staff had completed several training topics in the past with verification of their attendance. -Those trainings had not supported the staff were competent with performing those tasks.	F 726		

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F 726	Continued From page 25 Review of the provider's last reviewed 2/11/20 Facility Assessment revealed: *They accepted and cared for residents with infectious diseases and who required assistance with activities of daily living. *For staff training,education, and competencies: -"All employees complete training and competencies on the following upon hire (*and completed annually): --"Clinical services:...*infection control, prevention and state reportable disease list; hand hygiene;...*dietary and hydration needs of residents; resident rights; reduction and alternatives to restraint use; and *HIPAA and confidentiality; *activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, *procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property;..." *"Nurses are required to maintain a valid license plus CPR and AED certification. Annual in-service training for nurses is designed to ensure continued competencies based upon the following: -Care for cardiac disorders (CPR, DNR, AED), identification, assessments and documentation of medical issues appropriately,...wound care..." *"Nurse aides are required to complete an approved training and licensure program within 4-months of employment and maintain a valid license. Annual in-service training for nurse aides is a minimum of 12 hours per year and sufficient to ensure continuing competencies. At a minimum, the following competencies are evaluated for topic selection: -Activities of daily living - ...transfers, using gait belt, using mechanical lifts, hand washing and infection control (hand hygiene, isolation,	F 726		

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F 726	Continued From page 26 standard universal precautions including use of personal protective equipment, MRSA/VRE/CDI precautions, environmental cleaning)..."	F 726		
F 880 SS=F	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 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	F 880	1. Resident 26 is no longer on transmission-based precautions. CNAs L and J, LPN I, Social Services Director Q, Registered Nurses D and K, PTA H were educated and showed competency on transmission-based precautions and hand hygiene including hand washing and glove use as well as donning and doffing of PPE. CNA L and PTA H were educated and showed competency on proper cleaning and disinfecting of resident care equipment. Laundry worker M was educated and showed competency on proper laundering of clothing and linens of residents on transmission-based precautions. Housekeeper O has been educated and showed competency on identifying type of precautions residents may be placed on. 2. An audit of all residents was completed, and no other residents have been identified with transmission-based precautions. 3. Facility interdisciplinary team in collaboration with the governing board will review and revise, if necessary, the Transmission Based Precaution policy. For all new residents identified with transmission-based precautions; immediate initiation of Legacy policy for transmission-based precautions will be done. Type of precautions required will be identified by the DNS, Infection preventionist or designee (charge nurse) and implemented promptly to reduce the risk of transmission to other residents. Equipment for transmission-based precautions is easily accessible in the main floor of the building. A list of equipment needed in an isolation room will be compiled and staff educated on this. Appendix A from the CDC: Type and Duration of Precautions Recommended for Selected Infections and Conditions will be posted in Infection Prevention Binder	03/23/2020

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F 880	Continued From page 27 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. §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: 35237 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control practices had been utilized for: *One of one sampled resident (26) on	F 880	at the Nurses Station. The infection control binder will include all current and up-to-date Legacy Healthcare infection control policies. This will be placed at the nursing desk. Education of all staff will include transmission-based precautions, hand hygiene, donning and doffing of PPE, and identification of different transmission-based precautions and their needs. Each will have test or performance competency. Staff not present at the education session due to vacation, illness, or casual work status will be educated prior to their next shift worked. 4. DON or designee will complete audits on proper transmission-based precautions to include hand hygiene, donning and doffing of PPE, and identification of different transmission-based precautions and their needs. Audits on transmission-based precautions will be audited twice weekly for two weeks and then once weekly for two weeks and then monthly x 3 months. Results of audits will be discussed by the DON or designee at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 880	Continued From page 28 transmission-based precautions for a methicillin staphylococcus aureus (MRSA) wound infection related to: -A lack of appropriate signage with guidance for visitors and staff prior to entering the room to ensure their safety and the safety of other residents. -Seven of seven randomly observed staff (physical therapy assistant [PTA] H, certified nursing assistants [CNA] L and P, licensed practical nurse [LPN] I, social services director Q, and registered nurses [RN] D and K) had not followed the transmission-based precautions while in the resident's room, prior to leaving his room, and while assisting him with personal care. -A lack of supplies including paper towels and disposal containers to ensure precautions were followed by staff. -Resident care equipment had not been cleaned and disinfected following use by one of one CNA (L) and one of one PTA (H). -Staff competencies for transmission-based precautions and infection control had not been verified to ensure they were able to perform those tasks. -An overall inconsistency with the staffs' knowledge of transmission-based precautions and infection control practices. -Incomplete documentation in the resident's record related to his active infection including: --When the MRSA was identified and when precautions had been initiated. --A care plan goal and interventions related to his MRSA infection. *Handwashing and glove use during four of four randomly observed residents' (16, 28, 32, and 34) care by four of four nursing staff (CNA J, certified medication assistant [CMA] T, and LPN J and S). Findings include:	F 880		

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F 880	Continued From page 29 Surveyor: 42477 1. Observation and interview on 2/10/20 at 2:50 p.m. with CNA L regarding resident 26 and his room revealed: *There was an isolation box hanging on the door containing personal protective equipment (PPE) and a sign that stated: -"Droplet precautions-everyone must: clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry or Remove of face protection before room exit." *The box of PPE contained the following items: -Two boxes of gloves. -Yellow disposable gowns. -Red biohazard bags. -Yellow biohazard bags. -Disposable masks. -Shoe covers. --There was no eye protection supplies. *CNA L came out of the room wearing a gown and gloves. -She was not wearing a mask. *She was not sure why the resident was on isolation precautions. -She thought it was related to his foot. *When CNA L removed her PPE she did not perform hand hygiene. *She placed the gown and gloves in a red bio-hazard bag. -She indicated she was not sure what to do with the bag, as there was not a garbage can in the resident's room. --She took the bag down to the soiled utility room. *When she came back to the resident's room she: -Had not put any PPE on and came back out with a vitals/blood pressure cart.	F 880		

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F 880	Continued From page 30 -She had not cleaned or disinfected that cart before bringing it into another resident's room. Further observation on 2/10/20 at 3:31 p.m. of resident 26's room revealed: *An unidentified staff member was in the room: -Was wearing no PPE. -Used hand sanitizer when they left. *Resident 26 and his roommate were sitting in their side-by-side recliners. Continued observation on 2/10/20 at 3:38 p.m. of LPN I in resident 26's room revealed: *She was in his room and was wearing gloves only. -She had a non-isolation stethoscope around her neck. *She washed her hands for approximately five seconds. *She shut the water off by touching the faucet handles without using a barrier. *She dried her hands on a towel that was hanging on the resident's sink. -There were no paper towels in the resident's room. Brief interview on 2/10/20 at 3:52 p.m. with LPN I and RN K revealed: *LPN I was training RN K. *They indicated the resident had an infected wound that grew MRSA. -They were informed of the culture results last week. *The resident's heel wound was covered with a dressing and a protective boot. *He was on contact precautions and was not isolated to his room. -He came out for meals, activities, and whatever else he wanted to do.	F 880		

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F 880	Continued From page 31 *Since he was on contact precautions staff were supposed to wear a gown and gloves anytime they went into his room. *They had not realized the sign on the door stated "droplet precautions." -That was not the type of infection he had. Interview on 2/10/20 at 3:52 p.m. with resident 26 and his roommate revealed: *Resident 26 was sitting in his recliner and had a protective boot on his right foot. *Resident 26 thought he had been on precautions a couple of days for the infection in his right foot wound. -His roommate stated it had been at least a week. *When asked if staff wore protection when they came in the resident replied "yes." -The roommate looked away. *The roommate indicated he was not aware of what was going on in regards to the precautions for resident 26. Observation on 2/10/20 at 4:07 p.m. regarding resident 26's room revealed: *Social services director Q was in his room. -She had a gown on, no mask. --She removed her PPE. *When she removed her PPE and left the room she did not perform hand hygiene. Observation on 2/10/20 at 4:24 p.m. of PTA H in resident 26's room revealed: *He was holding physical therapy equipment while sitting in the resident's wheelchair doing exercises with the resident who was sitting in his recliner. *The only PPE he was wearing was gloves. *He put the physical therapy weights on the resident's legs.	F 880		

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F 880	Continued From page 32 Observation and interview on 2/10/20 at 4:48 p.m. of LPN I in resident 26's room revealed: *She was not wearing PPE. *She was carrying a box of laboratory supplies out of the room and stated she was drawing labs on his roommate. *She was observed with a red biohazard bag in her hand. Further interview on 2/10/20 at 4:30 p.m. with LPN I and RN K revealed: *The resident had an infected wound on his right heel. *LPN I and RN K stated they educated therapy about wearing PPE in resident 26's room. *They acknowledged the sign on the door was wrong. *Everyone should have been wearing a gown and gloves in his room. *LPN I confirmed staff would have been referred to the sign on the door for direction. -LPN I believed the sign was left on the box from a previous resident. *Asked LPN I about policies and guidelines for contact precautions, she was not able to find them. *They: -Agreed staff needed to know what to do regarding precautions. -Confirmed there was a lack of consistency regarding communication between the staff about the infection. -Did not think anyone had talked to resident 26's roommate about the change in his environment. -Confirmed staff communication should have been better to ensure appropriate infection control practices had been followed.	F 880		

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F 880	Continued From page 33 Interview on 2/10/20 at 5:04 p.m. with PTA H regarding the above observation revealed: *He had just completed his exercises with resident 26 in his room and was heading back to the therapy room. *He placed the weights he had used on the nurses counter while talking to the surveyors. -He stated he would have cleaned them off when he got down to the therapy room. *He was aware the resident had an MRSA infection and had also worked with him the week before. *He had just found out today they wanted him to wear a gown other than just gloves when he worked with the resident in his room. Interview on 2/10/20 at 4:52 p.m. with CNA N regarding resident 26 revealed: *They had found out his wound had MRSA two weeks ago. *She stated people should have been wearing gowns and gloves in his room. On 2/10/20 at 4:57 p.m. policies were requested from director of nursing (DON) C regarding infection control practices including standard, contact, and droplet precautions and isolation/transmission-based precautions. Observation on 2/10/20 at 4:59 p.m. of resident 26 revealed: *He wheeled himself independently in his wheelchair into the hallway and outside to smoke with other residents and staff. *His right foot continued to have the boot in place. Observation on 2/10/20 at 5:09 p.m. revealed there was now a contact precautions sign up on resident 26's door instead of the droplet	F 880		

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F 880	Continued From page 34 precautions sign. Review of the provider's October 2019 Transmission Based Precautions policy received on 2/10/20 at 5:26 p.m. revealed: *The policy appeared to be incomplete. *It had un-numbered pages, a donning PPE page, and then pages 5 through 7. *It was not comprehensive and had not covered all of the areas that had been requested from the DON. Interview on 2/11/20 at 9:28 a.m. with laundry worker M revealed: *Laundry for any resident on contact precautions should have been double-bagged with a clear plastic bag and a yellow bag on the outside. *The laundry would then be laundered in a separate isolation load. *She stated those precautions would be taken for someone who had clostridium difficile (C-diff) or MRSA. -She thought there was no one currently on any precautions. -They had not been doing any isolation loads. Interview on 2/11/20 at 9:54 a.m. with housekeeper O revealed she referred to the precautions signs on the doors to know what type of precautions a resident was on. The signs also informed her of what type of PPE she should have used when cleaning/disinfecting the resident's room. 2. Observation and interview on 2/11/20 at 12:01 p.m. of resident 26's wound and dressing change revealed: *There were four staff members in the tub room with resident 26, including:	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	106 BRADDOCK POST OFFICE BOX 489 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 880	Continued From page 35 -Bath aide/CNA P. -LPN I. -RN K. -Assistant director of nursing (ADON)/wound care RN D. *The resident was sitting in the shower chair, and he was covered by a towel and wearing a t-shirt. *The wound on his right foot was currently open, and his foot was resting on a towel. *The staff members were only wearing gloves. *No one had any gowns on or other PPE on. *RN K wrapped gauze around his infected right heel wound. *Without performing hand hygiene or removing her gloves she: -Reached in her pocket to get a roll of tape. -Tapped the gauze onto his right foot and put the used tape back in her pocket. -Touched her face and moved her glasses to the top of her head. *When the staff members were asked what they should be wearing when doing wound care for resident 26 they indicated they should have been wearing gowns. *After the wound care was done they placed the soiled towels in a yellow bag without double-bagging it. -There was confusion on whether they should have used a red bag or a yellow bag for those soiled linens and garbage. *Once outside the tub room RN K was asked what she was going to do with the used tape in her pocket. -She took out the roll of tape with her bare hand and asked, "What should I do with it?" -She had not recognized it as being potentially contaminated from working with the wound and soiled gloves. *With further questioning as to wearing	F 880	SRG 3/9/20	

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F 880	Continued From page 36 appropriate PPE when doing wound care, they indicated they had not worn it since they had been in the tub room and not the resident's room. *They confirmed they had been performing direct wound care and should have been wearing a gown and gloves due to potential contact and contamination with the infected wound. Interview and record review on 2/11/20 at 3:13 p.m. with LPN I regarding resident 26 revealed: *She was unable to find the laboratory result to indicate the exact date of his MRSA infection. *She found a faxed order from a physician when they changed his antibiotic from one antibiotic to another that was probably when it had occurred. *She thought she had worked the day of the notification of his MRSA, and her and another nurse had implemented the precautions. *There should have been documentation in his progress notes to support when they were aware of the MRSA infections, when the precautions had been implemented, and what type of precautions should have been used. *The charge nurse was responsible for getting the PPE, signage, and precautions started if needed. Review of resident 26's medical record revealed: *He was admitted on 12/31/19. *He had an open wound on his right heel at the time of admission. *On 1/30/20 at his clinic appointment cultures of the wound were obtained, and he was started on ciprofloxain (Cipro) 750mg BID (twice a day) for a possible infection. *On 2/3/20 his cultures were positive for MRSA. *He was receiving wound care twice daily by the nurses. *His progress notes were not clear as to when the contact precautions had been initiated and were	F 880	at the Nurses Station. The infection control binder will include all cu 4. DON or designee will complete audits on proper transmission-ba	

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F 880	Continued From page 37 being used. Interview and record review on 2/11/20 at 4:32 p.m. and again on 2/12/20 at 10:15 a.m. with ADON/wound care RN D and DON C regarding infection control and observations of resident 26 revealed: *They were going to look for other policies relating to infection control. -They confirmed the above received policy appeared to have been missing information and was not comprehensive. *Discussion of resident 26 and his roommate sharing a room and bathroom revealed: -They were originally roommates. -Their determination of who could share a room with someone who was on contact precautions would have been documented in the residents' progress notes. -They acknowledged resident 26 and his roommate were sitting in side-by-side recliners with only a curtain in between the two residents. --They did not have any documentation to show they had determined that resident 26 could have shared a room with another resident. *Cultures of resident 26's wound were obtained on 1/30/20 at a clinic appointment and finalized 2/3/20. -The wound grew moderate amounts of MRSA and streptococcus A. -RN D had a copy of the lab result, but it was not in his record at that time. *Contact precautions for resident 26 should have been started on 2/1/20, and his care plan should have been updated. *Documentation should have supported the timeline of events relating to his wound infection, and what had been being done related to it. -His care plan had not been updated and should	F 880		

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F 880	Continued From page 38 have been. *RN D agreed that infection control with resident 26's wound care was "not great." *DON C confirmed there were no competencies of the nursing staff related to the concerns with transmission-based precautions. *They confirmed staff had not: -Followed appropriate infection control practices and transmission-based precautions and should have. -Been knowledgeable relating to resident 26's infection and contact precautions. -Completed hand hygiene, glove usage, and appropriate PPE use in the above observations. -Appropriately cleaned and disinfected resident care items that were shared with other residents after becoming potentially contaminated. -Ensured appropriate signage to protect other residents and staff from entering the room without the appropriate PPE. -Ensured supplies had been available to promote good infection control practices. Review of resident 26's 1/14/20 care plan revealed: *That was his most current care plan. *The care plan had not been updated to reveal he was currently on contact precautions. -The precautions were added on 2/11/20 after interview with DON C and ADON D. Surveyor: 41895 3. Observation on 2/11/20 at 11:16 a.m. of CNA J providing care to resident 28 revealed: *She had entered the resident's room and put on gloves. -No hand hygiene was performed prior to putting those gloves on. *She had assisted him off the toilet with the mechanical sit-to-stand lift and cleaned his	F 880		

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F 880	Continued From page 39 bottom with wet wipes. *She removed her gloves, reached into her pocket, pulled out two new gloves, and put them on. -No hand hygiene was performed between glove use. *She applied protective ointment to his bottom, put an incontinent brief on him, and pulled up his pants. *She then removed her gloves and put him in his recliner. *She put on new gloves, cleaned a spot of feces off the floor with a wet wipe, went to the bathroom to empty the urinal he had used while sitting on the toilet, and removed those gloves. -She then performed hand hygiene. *She then took the mechanical sit-to-stand lift and left it in the hallway after touching it with her contaminated gloves and with out sanitizing it. Interview on 2/11/20 at 11:26 a.m. with CNA J following the above observation of resident 28 revealed she agreed she should have performed hand hygiene each time she removed her gloves. 4. Observation on 2/11/20 at 2:39 p.m. of LPN I after suprapubic catheter care with resident 32 in his room revealed: *She had removed her right glove, reached into her pocket, took out her keys, and then went into the hallway. -She had soiled linens in her left gloved hand. *She opened the closet door with the keys and put the dirty linen in a bin. *She went back to the resident's room and removed her left glove. *Then she performed hand hygiene and put on new gloves. *Put a Betadine wipe on a paper towel next to	F 880		

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F 880	Continued From page 42 been clear and consistent to ensure infection control had been maintained. *She was aware there were concerns with policies being available and comprehensive. *She confirmed policies should have been available for staff to use as references and guidelines in their care. Review of the provider's July 2019 Infection Prevention and Control policy revealed: *"A transmission-based precaution set up will be provided outside the resident's room to provide Personal Protective Equipment (PPE) like gown and gloves to staff and visitors entering the resident's room." *"A sign will be provided outside the room for residents on transmission-based precautions indication the type of the precaution (Contact or Droplet). As long as the type of infection is not included in the signage..." *"Residents on Contact or Droplet isolation cannot share bathroom with residents who are not on isolation." *"A disposable thermometer, BP cuff, and stethoscope will be provided inside the room to provide personal equipment for residents who are on transmission-based precaution. *"Handwashing for 15 to 20 seconds will be required for all staff after direct patient contact and after each situation that necessitates handwashing. Alcohol-based rubs may also be used in place of handwashing, unless in cases of contact with residents with C. Difficile [C. Diff] and prior to leaving their isolation rooms." *"Staff will be education about current infection control practices and procedures through inservices." *"No colored coded bags or double bagging is required in handling isolation linens if the facility	F 880		

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F 880	Continued From page 43 considers all soiled linens as contaminated." *"Contact precautions- intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment. a. Single room is required. If not available, cohorting with a resident with the same organism may be done. If no room is available, the resident may share a room with a resident who is not at risk to develop infection from the affected resident. Examples of these residents are those who are not immunocompromised and those who has no wounds and gastrostomy tube. Consultation with physician might be done to assess various risk factors. b. Use of Gown and gloves is necessary for all interactions." Review of the provider's August 2019 Medical Care Equipment, Instruments and Health IT Devices Infection Control Plan revealed: *"Facility personnel must wear appropriate PPE (e.g., gloves, gown), if contamination is anticipated or when handling patient-care equipment and instruments/devices that is visibly soiled or may had been in contact with blood or body fluids." *"Reusable equipment will not be used for the care of another resident until it has been properly cleaned and reprocessed and that single-use/disposable items are properly discarded after use." *"Nursing personnel shall wipe down/clean reusable equipment between residents using a facility approved cleaner/disinfectant." Review of the provider's September 2019 Hand Hygiene policy revealed: *Hand hygiene should be done during the following situations: -"Before and after direct resident contact."	F 880		

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F 880	Continued From page 44 -"Before and after entering isolation precaution settings unless the infectious organism is C. Difficle or Norovirus." -"Before and after changing a wound dressing." -"After removing gloves including during wound dressing change." Review of October 2019 infection control education revealed they reviewed and posted the following items: *Laundry handling: -"All linen from an isolation room should be handled with regular laundering procedures unless heavily soilage is noted." -"Yellow outside bagging is used to indicate it is from and isolation room; this may be sent down the chute." -"Heavily contaminated items with body substances will need yellow bag and special dissolving bag for laundering process-this must be hand carried to laundry." -"Special washable bags are not required for a basic isolation room linens." *Other PPE was to go into regular garbage. *Bloody or soiled items would be bagged in a red bio-hazard bag.	F 880		

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E 000	Initial Comments Surveyor: 26180 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 2/10/20 through 2/12/20. Avantara Armour was found in compliance.	E 000		

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

Stefanie Geigle | Administrator | 03/08/2020

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
	435057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	**106 BRADDOCK POST OFFICE BOX 489** **ARMOUR, SD 57313**

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/11/20. Avantara Armour was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K916 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 | TITLE | (X6) DATE

Stefanie Geigle | Administrator | 03/08/2020

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 435057	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **2/11/2020**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	**106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
K 916	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation, interview, and testing, the provider failed to maintain the generator remote annunciator at one of one locations (nurses station). Findings include: 1. Observation at 1:20 p.m. on 2/11/20 revealed the annunciator for the generator was mounted at the nurses station. Interview with the maintenance supervisor at the time of the observation revealed there was not any documentation showing the functions on the annunciator had been tested on a periodic schedule. Further interview with the maintenance supervisor revealed there was not a preventive maintenance test in place to confirm the annunciator's monitoring of the various generator functions. This deficiency has the potential to affect 100% of the occupants of the building.

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
	10593	A. BUILDING: _____ B. WING _____	02/12/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARMOUR	106 BRADDOCK POST OFFICE BOX 489 ARMOUR, SD 57313

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S 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/10/20 through 2/12/20. Avantara Armour was found not in compliance with the following requirements: S121, S206, S210 and S236.	S 000		
S 121	44:73:02:01 Sanitation The facility shall be designed, constructed, maintained, and operated to minimize the sources and transmission of infectious diseases and ensure the safety and well-being of residents, personnel, visitors, and the community at large. This requirement shall be accomplished by providing the physical resources, personnel, and technical expertise necessary to ensure good public health practices for institutional sanitation. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain a clean surface in the kitchen above a food preparation area (range hood overhead grease filters). Findings include: 1. Observation at 1:30 p.m. on 2/11/20 revealed the four grease filters situated above the cooking range in the exhaust ductwork had a large amount of lint and grease buildup on them. Interview with the maintenance supervisor at the time of the observation confirmed that condition. He revealed a former employee had been in charge of cleaning the grease filters.	S 121	1. The four grease filters situated above the cooking range in the exhaust ductwork were cleaned of all lint and grease build up on 2/11/2020. An audit was completed, and no other areas were identified. 2. Cleaning of the grease filters was added to TELS for monthly SRG 3/9/20 cleaning and preventative maintenance. Every six months the ductwork and SRG 3/9/20 filters will be professionally cleaned and inspected. Environmental and dietary staff will be educated by March 13, 2020 on cleaning schedules and the importance of cleaning filters monthly. 3. Administrator or designee will audit the cleaning of the filters monthly for three months and then quarterly for three quarters to ensure compliance. Results of audits will be discussed by the Administrator at the monthly Quality Assessment Process Improvement (QAPI) meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	03/23/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stefanie Geigle — TITLE: Administrator — (X6) DATE: 03/09/2020

STATE FORM 6899 GM8F11 If continuation sheet 1 of 10

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 206	Continued From page 1	S 206		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section. Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on interview and record review, the provider failed to ensure five of six recently hired sampled employees (D, I, L, Q, and R) had	S 206	1. Employees D, I, L, Q, and R have completed all required orientation training topics. An audit will be completed of all current staff to identify any others who have not completed all required orientation topics. 2. Administrator, DON, and Human Resources Director with collaboration from governing board will review the standard of practice on personnel training. The facility will follow the general orientation checklist to ensure all mandatory topics are covered. All staff will be educated by March 13, 2020 on the requirement of completing all required orientation and training topics. 3. Administrator or designee will audit all new hire files for completed general orientation checklists for one month, then three files monthly for three months to ensure compliance. Results of audits will be discussed by the Administrator at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	03/23/2020

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S 206	Continued From page 2 completed all of the required orientation training topics. Findings include: 1. Review of registered nurse D's personnel file revealed: *She had been hired on 5/15/19. *There was no evidence to support she had completed the following required training topics: -Proper use of restraints. -Care of residents with unique needs. 2. Review of licensed practical nurse I's personnel file revealed: *She had been hired on 8/19/19. *There was no evidence to support she had completed the following required training topics: -Accident prevention and safety procedures. -Proper use of restraints. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment. 3. Review of certified nursing assistant L's personnel file revealed: *She had been hired on 11/4/19. *There was no evidence to support she had completed the following required training topics: -Accident prevention and safety procedures. -Proper use of restraints. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration.	S 206		

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S 206	Continued From page 3 4. Review of social services director Q's personnel file revealed: *She had been hired on 10/10/19. *There was no evidence to support she had completed the following required training topics: -Fire prevention and response. -Emergency procedures and preparedness. -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting. -Care of residents with unique needs. -Dining assistance, nutritional risks, and hydration. -Abuse, neglect, misappropriation, and mistreatment. 5. Review of dietary aide R's personnel file revealed: *She had been hired on 11/20/19. *There was no evidence to support she had completed the following required training topics: -Infection control and prevention. -Accident prevention and safety procedures. -Proper use of restraints. -Resident rights. -Confidentiality of resident information. -Incidents and diseases subject to mandatory reporting. -Care of resident with unique needs. -Dining assistance, nutritional risks, and hydration. 6. Personnel file review and interview on 2/12/2020 at 1:45 p.m. with human resources (HR) coordinator G revealed: *All of the above staff were working independently	S 206		

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S 206	Continued From page 4 with the residents and were not currently in orientation. *She confirmed: -The personnel files should have contained all their training records. -There was incomplete orientation and lack of documentation to support the required training topics had been completed for the above employees. *A policy on staff training and education was requested at that time. Interview on 2/12/2020 at 2:00 p.m. with the director of nursing regarding the above revealed: *She agreed all staff should have completed an orientation program and received training on the required topics within thirty days of being hired. *There should have been documentation to support the required training had been completed. Interview on 2/12/2020 at 3:30 p.m. with administrator A confirmed the above concerns with the staff training. As of the end of survey on 2/12/2020 at 5:45 p.m. no policy on staff training and education was received.	S 206		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests.	S 210	1. Employees D, J, Q, R have had a health evaluation completed by a licensed health professional. An audit on all current employees was completed to identify any others who have not completed the required health evaluation. 2. Administrator, DON, and Human Resources Director with collaboration from governing board will review the New Hire Pre-Screening Procedure. The facility will follow the New Hire Pre-Screening Procedure to ensure the health evaluations are completed. All staff will be educated by March 13, 2020 on the requirement of completing a health evaluation by a licensed health professional upon hire. 3. Administrator or designee will audit all new hire files for completed health evaluations for one month, then three files monthly for three months to ensure compliance. Results of audits will be discussed by the Administrator	03/23/2020 SRG 3/9/20

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S 210	Continued From page 5 The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and procedure review, the provider failed to ensure four of six recently hired sampled employees (D, J, Q, and R) had a health evaluation by a licensed health professional completed within fourteen days of being hired. Findings include: 1. Interview and review on 2/12/2020 at 1:45 p.m. of employees' personnel records with human resources coordinator G revealed: *The following employees were hired on the following dates: *Employee D: 5/15/19. *Employee J: 7/26/19. *Employee Q: 10/10/19. *Employee R: 11/20/19. *The above employees' files had no evidence of health evaluations by a health care professional to determine they were free of communicable diseases. -Employees J and Q's forms were signed by the employees themselves. -There was no documentation at all for employees D and R.	S 210	or designee at the monthly QAPI meeting for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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S 210	Continued From page 6 Interview on 2/12/2020 at 3:30 p.m. with the administrator revealed: *She confirmed health evaluations had not been completed by a licensed health professional for the above employees. *Health evaluations should have been completed within fourteen days of an employee being hired to determine they were free of communicable diseases. *Her expectation was to follow the regulation for health evaluations. Review of the provider's undated Pending New Hire Pre-Screening procedure revealed: "8. Have the individual complete the Health Questionnaire that is to be reviewed and signed off by the Director of Nursing or Designee (R.N.)."	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the	S 236	1. Employees D, I and J have completed a two-step TB test. Employees Q, R have had the first step of their two-step TB test completed and will complete their second step within the required timeframe. An audit of all current employees will be completed to identify any others who have not completed the required TB test. 2. Administrator, DON, and Human Resources Director with collaboration from governing board have reviewed the policy and procedure for TB Screening of Employees. The facility will follow the policy to ensure all required TB tests are completed. All staff will be educated by March 13, 2020 on the requirement of completing the TB Screening as required. 3. Administrator or designee will audit all new hire files for completed TB tests for one month, then three files monthly for three months, then one file quarterly for three quarters to ensure compliance. Results of audits will be discussed by the Administrator or designee at the monthly QAPI meeting for analysis and recommendation for continuation/ discontinuation/revision of audits based on audit findings.	03/23/2020

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S 236	Continued From page 7 state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 35237 Based on record review, interview, and procedure review, the provider failed to ensure five of six recently hired sampled employees (D, I, J, Q, and R) had completed the two-step method for the tuberculin (TB) skin test or TB screenings within fourteen days of employment. Findings include: 1. Review of staff member D's personnel file revealed: *She had been hired on 5/15/19. *There were no documented TB skin tests. 2. Review of staff member I's personnel file revealed: *She had been hired on 8/19/19. *There were no documented TB skin tests 3. Review of staff member J's personnel file revealed: *She had been hired on 7/26/19. *There was only one TB skin test completed on 8/7/19. -There was no evidence to support a second step had been done or proof of a previously completed TB skin test.	S 236		

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S 236	Continued From page 8 4. Review of staff member Q's personnel file revealed: *She had been hired on 10/10/19. *There were no documented TB skin tests. 5. Review of staff member R's personnel file revealed: *She had been hired on 11/20/19. *There were no documented TB skin tests. 6. Interview and personnel file review on 2/12/20 at 1:45 p.m. with human resources director/business office manager G revealed: *She confirmed the above findings. *Those above TB skin tests had not followed the state guidelines for TB screenings of new employees within fourteen days of being hired. *A policy on TB screening was requested at that time. Interview on 2/12/20 at 3:30 p.m. with administrator A confirmed the above findings. TB skin tests had not been completed and documented to support they had been done. As of the end of survey on 2/12/2020 at 5:45 p.m. no policy on TB screening was received. Review of the provider's January 2020 Pending New Hire Pre-Screening Procedure revealed there was no mention of a process to ensure TB skin tests were completed and documented.	S 236		
S 000	Compliance/Noncompliance Statement Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide	S 000		

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S 000	Continued From page 9 training programs, was conducted from 2/10/20 through 2/12/20. Avantara Armour was found in compliance.	S 000		