STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. BUILDING _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 8/29/22 through 8/31/22. Avantara Saint Cloud was found not in compliance with the following requirements: F550, F584, F689, F804, F849, and F880.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	1. No immediate corrective action could be taken for the failure to ensure that residents had been treated with dignity and respect by interacting with them during mealtimes. 2. All residents, regardless of cognitive ability, have been identified to be at risk for lack of staff interaction during mealtimes. 3. The Director of Nursing (DON) or designee will educate all staff that assist with meal service, to include Certified Nursing Assistant (CNA) I, on the Resident Dignity and Privacy policy to ensure that residents are treated with dignity and respect by interacting with them during cares to include mealtimes. Education will occur no later than October 11, 2022, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	10/11/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlotte Penthen	Administrator	09/23/2022

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *15 of 15 randomly observed residents in one of four resident dining rooms (Town Square) had been treated with dignity and respect during one of two observed meals by one of one certified nurse aide (CNA) I. Findings include: 1. Observation on 8/30/22 at 7:50 a.m. of the Town Square dining room revealed CNA I was the only staff person in that dining room assisting 15 residents put their clothing protectors on in preparation for breakfast. Continued observation between 7:58 a.m. and 8:12 a.m. revealed: *At 7:58 a.m. CNA I sat down at an unoccupied dining room table and periodically strummed her fingernails on the tabletop looking around the room. -She exited the dining room for a few minutes, returned with a piece of paper and a pen, and sat back down at that table. -Had not interacted with any residents in that	F 550	4. The DON or designee will audit five meals a week at random times, to include all 4 dining rooms, to ensure staff are engaged with the residents at mealtimes. 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 Quality Assessment Process Improvement (QAPI) meeting with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 550	Continued From page 2	F 550		

dining room.
*One unidentified ambulatory resident tapped on the keys of the piano then attempted to have a conversation with a few of the other residents while he waited for breakfast.
*Another unidentified resident worked on a crossword puzzle book.
*The remaining unidentified residents sat in silence or had their heads down towards their chests with their eyes closed.
*There was no music, television or any other type of stimulation occurring during that time.

Continued observation at 8:12 a.m. revealed:
*Activity director E entered the dining room and asked, "How about some music" to which one unidentified resident responded, "That would be nice."
*She went around to each of the four dining room tables occupied by residents and interacted them.
-They opened their eyes and verbally or non-verbally responded to her.

Continued observation between 8:12 a.m. and 8:20 a.m. of CNA I revealed she:
*Remained seated alone and silent at the same dining room table.
*Got up from that table at 8:20 a.m. and assisted an unidentified resident with a clothing protector who had been brought into the dining room.
*Remained up and assisted residents with their meals after the breakfast cart arrived at 8:23 a.m.

Interview on 8/30/22 at 3:25 p.m. with CNA I regarding the above dining room observation revealed she:
*Had not considered it disrespectful towards residents when she sat herself apart from them and not interacted with them during the

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F 550	Continued From page 3 observation period referred to above. -Was just waiting for breakfast trays to arrive. Interview on 8/31/22 at 11:50 a.m. with director of nursing B and regional nurse consultant D regarding the observation referred to above revealed all staff were expected to create a homelike dining atmosphere for residents that included talking and engaging with residents while they waited for the meal service to begin. Review of the September 2019 Resident Dignity and Privacy policy revealed: *Policy: "-It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment that maintain resident privacy."	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584	1. Residents in semi-private rooms 203, 205 and 211, as well as residents in private rooms 212 and 302, beds were made with fitted sheets and pillow cases at the time of discovery during survey. Residents' 5, 6, 12, 17, 24, 33, 48, 49 and 55 wheelchairs have been cleaned. Resident 19's wheelchair armrests have been replaced. The bifold closet doors in rooms 301, 302, 303, 304, 306, 307, 308, 309, 310, 312, 314 and 316 have been repaired and are connected to the closet track. The various scuff marks on hallway 300 have been repaired and painted. The areas requiring painting in rooms 303, 305, 307 and 310 require a contractor. Facility has contacted a contractor and will have work completed as early as contractor schedule allows.	10/11/22

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F 584	Continued From page 4 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure: *Clean fitted bed sheets and pillow cases had been available in three semi-private residents' rooms (203, 205, 211) and two private residents' rooms (212 and 302). *Routine cleaning and maintenance for ten observed residents' (5, 6, 12, 17, 19, 24, 33, 48, 49, and 55) wheelchairs. *Routine maintenance of one of four dining rooms (Town Square). *Routine maintenance of 12 of 12 rooms (301, 302, 303, 305, 306, 307, 308, 309, 310, 312, 314, and 316) and one of four hallways (300 wing).	F 584	The chipped and peeling paint above the electrical outlet next to the dining room entrance have been repaired and painted. The dining room door with the door gone and gouge in door is being replaced. The door has been ordered. The dining room wall in the barber shop area with a crack in the wall requires a contractor to repair. Facility has contacted a contractor. Repairs will be made as early as possibly as contractor's schedule allows. 2. All residents are at risk to have an environment which is not homelike. The facility will audit all resident room beds to ensure linens are in place and all wheelchairs, resident room walls, dining room walls, bifold closet doors and all doors to ensure that they are clean and in good repair.	

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F 584	Continued From page 5 Findings include: 1. Observation and interview on 8/30/22 at 9:00 a.m. with certified nurse aide (CNA) K assisting resident 17 revealed she: *Completed the resident's peri-care and laid her on the bare mattress on her bed. *Left the room for clean linens, returned to the room, and stated there were no linens in either of the two linen storage closets. *Had informed laundry prior to breakfast there were no linens available to make beds. Observation on 8/30/22 at 9:12 a.m. of the two linen closets referred to above revealed: *In the 300 wing linen closet there were some flat sheets and blankets but no fitted sheets or pillow cases. *In the south wing linen closet there were some blankets but no fitted sheets or pillow cases. Observation on 8/30/22 at 9:28 a.m. of resident rooms on the 200 and 300 wings revealed: *Mattresses on both beds in rooms 203, 205, and 211 were bare. *Mattresses in private rooms 212 and 302 were bare. Observation and interview on 8/30/22 at 9:40 a.m. with resident 23 sitting in the doorway of her room revealed she had wanted to lay in her bed, but her mattress was bare. Interview at that same time with CNA I regarding resident 23 revealed she was unable to help that resident to bed because there was no clean linen to place on her mattress for her to lie on. Observation and interview on 8/30/21 at 9:40	F 584	3. The Administrator will educate Maintenance Director F and all staff on the Homelike Environment policy to ensure the facility is kept clean and in good condition. Additionally, all staff will be educated to report any disrepair noted as soon as it is observed. DON or designee will educate all nursing staff on the newly developed wheelchair cleaning schedule to ensure wheelchairs are cleaned weekly and as needed when visibly soiled. This education will occur no later than October 11, 2022. Those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	

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F 584	Continued From page 6 p.m. with laundry supervisor H revealed: *There were two washing machines and two dryers running with bed linen in them. *"Apparently, today we don't have clean sheets." *The facility had an adequate supply of linen. -Staff were "stashing" clean linen in areas other than the designated storage closets. -Staff were not getting soiled linen to the laundry room for prompt processing. *She often collected linens herself from dirty linen storage and from resident rooms to be laundered. *Lack of clean linen was not a new issue and administrator A, assistant director of nursing/infection control nurse (ADON/ICN) C, and maintenance director F were aware of the problem. Interview on 8/30/22 at 9:50 a.m. with maintenance director F revealed: *Lack of available clean linen had been an issue in the past, but administrator A had told him today it was again a problem. *Staff had been educated at staff meetings and by director of nursing (DON) B about expectations to ensure clean linen was available. *He stated "I don't have a clear fix" for the problem. *He agreed residents not being able to lie down in their beds after breakfast due to not having linen on their beds was not acceptable. Interview on 8/31/22 at 12:01 p.m. with DON B, ADON/ICN C and regional nurse consultant D revealed: *There was a back stock of linen available for staff use so there should not have been unmade beds. *Available flat sheets or blankets both resident linen storage closets should have been used until	F 584	4. Administrator or designee will audit 5 resident rooms to ensure bed is made with appropriate linens, audit 5 wheelchairs to ensure they are clean and in good repair, audit 5 bifold closet doors to ensure they are in good repair and connected to the closet track, audit 5 resident rooms to ensure there are no areas in need of painting, and 5 common areas to ensure there are no scuffs in need of repair and painting to keep the facility clean and in good condition. Audits will be weekly for four weeks and then monthly for two months. Results of audits will be discussed by the Administrator at the monthly QAPI Meeting to identify trends or additional education needs and will include continuation or discontinuation of audits based on the findings.	

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F 584	Continued From page 7	F 584		

fitted sheets had been made secured.
*They agreed some staff may have been "stashing" clean linen, but did not believe staff had not gotten soiled linen to laundry for timely processing.

Review of the undated Laundry Policies and Procedures for Laundry Personnel policy revealed:
*Collection of Soiled Linen:
-"Soiled linen must be removed from the unit for 2 reasons: to keep the area infection free and laundry needs the soiled linen picked up regularly to keep the flow of wash moving through the Laundry Room."
-"The housekeeping/laundry supervisor should check with nursing to coordinate these pickups. The timing of nursing activities such as getting residents up, breakfast feeding, showers, and changing beds will dictate the best times for soiled pickup."

2. Observation on 8/29/22 at 12:53 p.m. in Town Square dining room revealed:
*Resident 12 had brown splattered spots on the spokes of her wheelchair wheels.
*Resident 24 had dried food and residue of sticky fluid on the cushion of the wheelchair.
*Resident 5 had hair bound in the left axle of her wheelchair.

Random observation on 8/29/22 at 5:20 p.m., on 8/30/22 at 11:30 a.m. and on 8/31/22 at 10:00 a.m. revealed:
*Five observed residents' (6, 17, 48, 49, and 55) wheelchairs had hair bound to the axles of their wheelchairs.
*Resident 33 had dried food and residue of sticky fluid on the cushion of her wheelchair.

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F 584	Continued From page 8	F 584		

*The tips of both armrests on resident 19's wheelchair were torn exposing the blue foam padding beneath them.

Interview on 8/31/22 at 9:05 a.m. with administrator A regarding wheel chair cleanliness revealed:
*The quality assurance and performance improvement (QAPI) committee had identified cleaning of high-touch surface areas as a systemic issue.
-This had included wheelchair cleanliness.
*In June of 2022 they had a facility-wide wheelchair cleaning event.
-Each wheelchair was taken outside and was sprayed off with a pressure washer.
*Wheel chair wipe downs were a part of the daily routine and were expected to occur.

On 8/31/22 at 11:45 p.m. a Wheelchair Cleaning policy was requested of administrator A. She stated there was no such policy, but provided a September 2018 Care and Storage of Personal Care items instead. Wheelchair cleaning was not referred to in that policy.

3. Observation on 8/30/22 at 8:09 a.m. of Town Square dining room revealed:
*Chipped and peeling paint above the electrical outlet next to the main dining room door entrance.
*The bottom of the main dining room door had about a seven and a half inch bottom edge of the door protector gone and a big gouge in the door.
*The dining room wall in the barber shop area had a crack in the wall from the floor to the ceiling.

4. Observation on 8/30/22 at 3:00 p.m. of 12 out of 12 residents' rooms revealed the bifold closet

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F 584	Continued From page 9	F 584		

doors (301, 302, 303, 304, 306, 307, 308, 309, 310, 312, 314, and 316) had not been connected to the closet track.
5. Random observations on 8/29/22 between 1:00 p.m. to 4:00 p.m. revealed:
*Hallway 300 had various scuff marks with missing paint measuring approximately twelve inches above the floor that extended down both walls of the entire hallway.
*Room 303:
-The wall under the window had a dry wall repair that was unpainted measuring approximately five inches by twelve inches.
-The wall adjacent to the hallway door had an approximate five by six inch area with two smaller areas above it that were missing paint.
*Room 305:
-The wall adjacent to the hallway door had an approximate four inch by five inch area of missing paint.
-The bathroom wall opposite the toilet had missing paint in various areas.
*Room 307:
-The wall adjacent to the hallway door had vertical lines of missing paint along each edge were the bed's headboard met the wall.
-The bathroom walls had a two inch high strip of missing paint located above the mop boards that encircled the room.
*Room 310:
-The wall under the window had an approximate twelve inch by twelve inch area of missing paint located above the bed.

Interview on 8/30/22 at 3:29 p.m. with maintenance director F revealed he:
*Had a preventative maintenance binder of various topics he monitored on a daily, monthly, quarterly, semi-annual, and annual basis.

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F 584	Continued From page 10 -This binder had not included the monitoring of chipped paint or scuff marks. *Was in charge of senior maintenance for six facilities including two in Montana. -Usually spent about three weeks out of every month at this facility. -Was the only maintenance person for this facility. -Had been cross-trained as a certified nurse's aide (CNA) and medication aide (MA). -Was recently required to work as a CNA and a MA to cover empty shifts. --This had prevented him from performing routine repairs or maintenance. *Walked through the building often, but also depended on staff to place maintenance work orders with any environmental repair issues. -This was done either by paper or through the TELS (electronic work order and building management) system. *Had not received any work orders from staff about chipped paint or scuff marks. -"Staff could improve on notifying me on things that need repaired." *Had crash guard railings he planned on installing in all the hallways to prevent wheelchair scuff marks. -This would require two people to install. -A housekeeper would occasionally help him with projects that required two people, but had not been available to assist him as much as he would have liked. *"Some resident rooms need a good touch-up." Interview on 8/31/22 at 7:50 a.m. with administrator A revealed: *Staff had been educated on maintenance reporting and were encouraged to use the TELS system. *Agreed there were areas in the facility that had	F 584		

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F 584	Continued From page 11 scuff marks and missing paint. *Maintenance had been working on the scuff marks and missing paint in the main corridors. -This had been difficult as resident's would often bang their wheelchairs into the walls and doors. -Had plans to install crash guard railings in all the main corridors. *Lack of staffing had played a part in the general maintenance of the facility. -The maintenance director had been pulled to cover empty CNA and MA shifts three times in the last schedule period. -Filling empty resident care shifts had been her main priority. Review of the provider's October 2019 Homelike Environment policy revealed: *"2. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include:" -"i. Walls and door scuffs/chips repaired with paint/stain when needed." *"3. The facility will have a mechanism for reporting disrepair to Maintenance personnel and staff will be educated on the process."	F 584		
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.	F 689	1. No immediate corrective action could be taken for the failure to transfer resident 59 appropriately or for the failure to leave resident 10 unattended at the edge of her bed during personal care.	10/11/22

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	435060	A. BUILDING _____ B. WING _____	08/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

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F 689	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of two residents (59) had been transferred appropriately and safely by one of one certified nurse aide (CNA) (L). *One of one resident (10) at risk for falls had not been left unattended at the edge of her bed during personal care by one of one CNA (I). Findings include: 1. Observation on 08/30/22 at 9:03 a.m. of resident 59 in her room and being transferred from her wheelchair onto the bed by CNA L revealed: *CNA L stooped over in front of resident 59 and placed the resident's arms up around her neck. -Without using a gait belt, CNA L held the resident around the waist with her arms. -Using a rocking motion, and she lifted the resident up in a "bear hug" type of transfer. -The resident had partially straightened her legs and was not given the opportunity to bear her full weight prior to being turned and lowered down onto her bed. –CNA L had to stoop over while holding resident 59's weight as she placed the resident on the lowered bed. Interview of CNA L immediately following the above observation revealed: *She had been employed at this facility for nine years and this was her first year working as a CNA. *"If they can stand, I have them hug my shoulders and I pivot them." *Physical therapy assistant (PTA) O had provided her education on safe transfer techniques.	F 689	2. All residents are at risk for accident hazard by being transferred inappropriately and by being left unattended at the edge of their bed during personal care. 3. The DON or designee will educate all nursing staff, to include CNA L on the Transfer or Gait Belt Use policy to ensure that residents are transferred appropriately with the use of a gait belt. Additionally, DON or designee will educate all nursing staff, to include CNA I, on the Falls Management policy and fall risk factors to ensure residents are not left unattended at the edge of their bed during personal cares. Education will occur no later than October 11, 2022, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	

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F 689	Continued From page 13 -Had not known she needed to use a gait belt unless they were walking residents with a walker. *All residents should have had gait belts located in their rooms. -Verified resident 59 did not have a gait belt in her room. -"We are in the process of replacing old gait belts, so not all residents have a gait belt." *Agreed there was a possibility of injury to herself or to the resident while transferring using a "bear hug" type of transfer without a gait belt. Interview on 08/31/22 at 8:05 a.m. and again at 9:15 a.m. with director of nursing (DON) B regarding gait belt and transfer training revealed: *There had not been gait belt and transfer training conducted "...in a while." *Staff had received gait belt and transfer training thru CNA classes and from audits following the last survey in 2019. -No recent audits had been conducted. *A prior therapist, who is no longer employed at the facility, used to perform gait belt and transfer training. -Was unsure if the current physical therapist does gait belt and transfer training. *Had a skills fair prior to COVID onset (2020) and this was one of the skills reviewed. -There had been some staff turnover since the skills fair was conducted. *Online training through Relias had recently been implemented in the facility. -Gait belts and transfers were slated to be reviewed sometime this year through Relias. *Agreed transferring a resident without a gait belt and using a "bear hug" technique was an unsafe practice. Interview on 08/31/22 at 8:30 a.m. with PTA O	F 689	4. The DON or designee will audit five CNAs providing cares to ensure that residents are transferred appropriately and that residents are not left unattended at the edge of their bed during personal cares. 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 with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 689	Continued From page 14	F 689		

revealed:
*He had worked for this facility for one and a half years.
*Had not been designated as the facility's trainer for safe transfers and gait belt use.
*Had not provided formal training to staff regarding gait belt use during transfers.
*New staff do not come to him for gait belt or transfer training.
-"They might have told me to provide education, but staff usually do it correctly."
*"Have not seen a transfer done wrong."
-"Ninety-nine percent of the time they do it correctly."
-He would have provided staff correction if he had seen an unsafe transfer.
*He watched new and declining residents and would provide one-on-one education if he saw something done incorrectly.
*Stated a "bear hug" type transfer without a gait belt would not be safe for the resident nor the staff member.
-Had not seen a "bear hug" type transfer "...in a long time."
*Had told administrator A, "It would be great to have an in-service with staff on safe transfers."
-"In a better world we would have this [in-service], but staffing is an issue."

Interview on 8/31/22 at 9:05 a.m. with administrator A regarding the availability of gait belts revealed: *There were plenty of gait belts for every resident in the facility.
*She had recently placed a gait belt in every resident's room.

Review of resident 59's care record revealed:
*She had been placed in the advanced Alzheimer's care unit (AACU) due to severe

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F 689	Continued From page 15	F 689		

cognitive impairment.
*Was at a risk for falls related to a history of falls and psychoactive medication use.
*Required extensive assistance with bed mobility and transfers.
*Had relevant diagnoses of:
-Vascular dementia with behavioral disturbance.
-Muscle wasting and atrophy.
-Low back pain.
-Contracture, right hip.
-Age-related osteoporosis.
-Cognitive communication deficit.
-Expressive language disorder.
-Difficulty in walking.
-Pain in the right hip and right shoulder.

Review of the provider's September 2019 policy on 'Transfer or Gait Belt Use' revealed:
*"Policy: It is the policy of this facility that transfer belts/gait belts will be used with every assisted transfer and assisted ambulation:
-"1. A transfer belt or gait belt must be used with EVERY assisted transfer and assisted ambulation, unless the care plan indicates otherwise. This means unless the resident is INDEPENDENT, a transfer belt/gait belt must be used. If the resident refuses, DO NOT CONTINUE-notify the nursing supervisor or team leader."
-"2. Each resident should have their own gait belt designated and labeled for their individual use."

2. Observation and interview on 8/31/22 between 7:45 a.m. and 8:10 a.m. with CNA I in resident 10's room revealed:
*There was a mat beside the exit side of the resident's bed and the bed was in a low position.
-CNA I confirmed the resident was at risk for falls.

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F 689	Continued From page 16	F 689		

*CNA I proceeded to complete resident 10's bed bath and at the same time change her bed linen.
-The resident's legs were contracted and pulled up towards her chest.
-She used her arms to reach out towards the wall or towards her head when CNA I rolled her onto her side.
-She moaned whenever the position of her limbs and body were moved by CNA I.
*While on her left side with her head and the length of her spine no more than three inches from the outer edge of her mattress, without saying anything CNA I left the room and returned a few moments later with clean linen.
*Stated she had not realized the resident was that close to the edge of the bed when she left the room otherwise would have repositioned her in the center of her bed.

Review of resident 10's care record revealed her:
*Diagnoses included: Alzheimer's disease, chronic atrial fibrillation, age-related osteoporosis with a history of a pathological left femur fracture, anemia, unspecified protein-calorie malnutrition.
*Last fall occurred on 8/20/22.

Review of resident 10's 6/9/22 Minimum Data Set (MDS) assessment revealed:
*Her cognitive skills were severely impaired.
*She required physical assistance of one person for bed mobility.
*She had two or more falls with injury since her previous MDS assessment completed on 3/9/22.

Review of resident 10's care plan last revised on 6/14/22 revealed:
*A goal for the resident to remain free from fall related injury.
-An intervention for frequent monitoring while in

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F 689	Continued From page 17 bed. Interview on 8/31/22 at 12:05 p.m. with DON B, assistant director of nursing/infection control nurse C, and regional nurse consultant D revealed they: *Confirmed resident 10 had a history of and was currently at risk for falls. *Expected CNA I had ensured proper placement of resident 10 on her bed prior to leaving her room to mitigate her risk for additional falls.	F 689		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to ensure food was served at a palatable temperature for two of two sampled residents (8 and 41) during one of two observed meal services in one of four dining rooms (Town Square). Findings include: 1. Observation on 8/29/22 between 12:33 p.m. and 1:10 p.m. of the Town Square dining room revealed: *Three unidentified staff distributed residents' lunch trays both in the dining room and to their rooms.	F 804	1. No immediate corrective action could be taken for the failure to ensure residents 8 and 41 were served food that was at a palatable temperature. 2. All residents are at risk for being served foot that is not at a palatable temperature.	10/11/2022

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F 804	Continued From page 18 *One certified nurse aide (CNA) I remained in the dining room after the trays were passed, sat at a table between two unidentified residents, and fed them. *Resident 8 had sat at a different table away from where CNA I had sat. -During the observation period she had played with her napkin and swirled her index finger in her pureed food occasionally bringing that finger to the inside of her mouth. Continued observation between 1:10 p.m. and 1:39 p.m. revealed: *Assistant director of nursing/infection control nurse (ADON/ICN) C entered the dining room at 1:10 p.m., sat beside resident 8, verbally encouraged and physically assisted her with her meal until 1:25 p.m. *At 1:39 p.m. CNA I asked her if she was finished eating then escorted her out of the dining room. Interview on 8/31/22 at 12:10 p.m. with ADON/ICN C regarding the above dining observation with resident 8 revealed she: *Had not known or asked how long that resident's plate of uncovered food had set out prior to her assisting her with her meal. -Assumed the temperature of her food was palatable. *Agreed after approximately 40 minutes of having sat uncovered it was probably not at a temperature that any reasonable person would have thought was palatable. 2. Observation on that same date at 1:24 p.m. revealed: *Resident 41 had been served her meal tray directly from the food cart that was delivered to the dining room at 12:33 p.m.	F 804	3. The Dietary Manager or designee will educate all staff that assist with meal service, to include CNA I and Assistant Director of Nursing/Infection Control Nurse (ADON/ICN) C, on the Food Temperatures policy to ensure that residents are served food that is at a palatable temperature. The Dietary Manager will educate all cooks on the procedure to ensure that the plate lowerator is turned on and used to heat the plates prior to serving meals to the residents. Education will occur no later than October 11, 2022, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.	

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F 804	Continued From page 19 -Her main dish consisted of spaghetti and was temped at 87.2 degrees Fahrenheit (F) after it had been uncovered and served to her. 3. Observation on 8/30/22 at 8:23 a.m. of the Town Square dining room revealed: *The food cart arrived and breakfast trays had begun to be passed. *At 8:35 a.m. the food tray belonging to an unidentified resident who was no longer in the building was temped. -The bowl of Cream of Wheat type cereal was 112.8 F and the pureed eggs were 97.3 F. Interview on 8/30/22 at 4:30 p.m. with dietary manager G revealed: *Plating for the Town Square dining room was started approximately 15 minutes prior to the scheduled meal time or after plating was completed for another dining room that was served ahead of Town Square. *Sample food temperatures referred to above were not considered to be palatable. *He stated there was a microwave in the Town Square dining room at one time but it had been removed. -Staff would have to walk to the kitchen or the 100 hall dining room to use a microwave to warm a resident's food. *Stated covered plates in the food cart were expected to hold food at an acceptable temperature if they were served and consumed by the resident in a timely manner. *Covered test trays for the 8/30/22 breakfast held their temperature for approximately 30 minutes. Interview on 8/31/22 at 12:10 p.m. with DON B, ADON/ICN C, and regional nurse consultant C revealed they:	F 804	4. The Dietary Manager or designee will audit five meal trays over all 3 meals, to include samples from all 4 dining rooms, to ensure residents are served food that is at a palatable temperature. The Dietary Manager or designee will audit the plate lowerator 5 times a week over 3 meals to ensure that is turned on and being used to heat the plates prior to serving meals to residents. 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 with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 804	Continued From page 20 *Agreed the amount of time that had elapsed between meal tray delivery and resident consumption of that meal in the above observations would have caused food expected to be warm to have cooled to a temperature that would not have been considered palatable to a reasonable person. *Agreed most of their resident population would have been unable to voice dissatisfaction with food temperature and would have to rely on staff to reheat their food when indicated. Review of the undated Food Temperatures policy revealed: *Policy: -"Foods should be served at proper temperature to insure food safety and palatability." *Procedure: -8. Palatability of foods determines appropriate temperature at bedside or tableside food. Generally hot food is palatable between 110 degrees F and 120 degrees F or greater.	F 804		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.	F 849	1. Resident 10's hospice care plan was obtained upon discovery during annual survey. Her care plan was updated with hospice information to include the collaboration of care for the resident between the facility and the hospice provider. 2. All residents receiving hospice services are at risk. All residents on hospice services have hospice care plans in the facility and the facility care plan has been updated to collaborate care for the residents.	10/11/22

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F 849	Continued From page 21 §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the	F 849	3. The DON or designee will educate the Interdisciplinary Team (IDT) on the Hospice Services policy to ensure that the hospice care plan is in the facility and that the facility care plan includes the hospice goals and interventions to outline the collaboration of care for the resident between the facility and the hospice provider. Education will occur no later than October 11, 2022, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit all residents who are on hospice to ensure the facility care plan is collaborative with the hospice care plan. 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 with the IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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

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determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide

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AVANTARA SAINT CLOUD	302 ST CLOUD STREET RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of

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F 849	Continued From page 24 the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on interview, record review, hospice book, and policy review, the provider failed to ensure an integrated plan of care had been developed for one of one resident (10) receiving hospice services. Findings include: 1. Review of resident 10's comprehensive care plan revised on 6/14/22 revealed: *A hospice care plan was initiated at the time of the resident's admission to hospice on 3/3/22. -An intervention: "Refer to Hospice Book kept at the nurse's station for: Hospice Plan of Care, Record of Hospice visits, Brief Hospice Progress	F 849		

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Notes."
*There were no interventions that had identified:
- What types of hospice services were provided for the resident.
- How often hospice services had been expected to assess and provide supportive care for the resident and staff.
- How hospice care was expected to be utilized.

Review of resident 10's hospice book revealed:
*A monthly calendar hospice staff used to initial the date they had visited resident 10,
a copy of resident 10's hospice admission order set, and some hand written progress notes by hospice staff.
*There was no hospice plan of care (POC) behind the POC tab in that hospice book.

Interview on 8/30/22 at 11:59 a.m. with registered nurse/Alzheimer director N revealed she thought resident 10's hospice POC was kept in her hospice book.

Interview on 8/31/22 at 11:50 a.m. with director of nursing B revealed she:
*Was responsible for securing copies of needed hospice agency documentation for residents receiving hospice care.
*Had not known the hospice agency had not provided the facility a copy of their hospice care plan for resident 10.
*Expected information from hospice agency's care plan had been integrated into the hospice care plan the facility had developed for resident 10.

Review of the 5/18/21 revised Hospice Services policy revealed:
*Procedure:

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F 849	Continued From page 26 -"3. When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident' current status."	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at 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	F 880	1. For the identification of lack of: *Appropriate cleaning by CNAs K, L, and M of shared resident equipment that included blood pressure cuff, thermometer, and pulse oximeter. *Appropriate hand hygiene and glove use with care and maintenance of shared resident equipment. *Appropriate procedural technique by CNA I when providing a bed bath *Appropriate procedural technique by CNA J while transporting clean linens. The administrator, DON, ADON/ICN, and/or designee in consultation with the medical director will review the Hand Hygiene, Cleaning and Disinfection, and Standard Precaution policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/ re-educated by September 28, 2022.	09/28/2022

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F 880	Continued From page 27 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §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: A. Based on observation and interview, the	F 880	Identification of Others: 2. ALL residents and staff have the potential to be affected by lack of: *Appropriate cleaning of shared resident equipment. *Appropriate hand hygiene and glove use during care and maintenance of shared resident equipment. *Appropriate procedural technique while providing a bed bath. *Appropriate procedural technique while transporting clean linens. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by September 28, 2022.	

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F 880	Continued From page 28 provider failed to ensure appropriate bed bathing techniques were maintained for one of one sampled resident (10) by one of one certified nurse assistant (CNA) (I) Findings include: 1. Observation and interview on 8/31/22 between 7:45 a.m. and 8:00 a.m. of CNA I as she provided a bed bath to resident 10 revealed: *She filled a basin with soapy water and a clean washcloth then placed it on the night stand in preparation for that resident's bed bath. *After cleaning the resident's body using the soapy water and washcloth she used that now unclean water and same washcloth she used to clean resident 10 to rinse her off. *She stated she had been a CNA for 18 years. Interview on 8/31/22 at 11:50 a.m. with director of nursing B, assistant director of nursing/infection control nurse C and regional nurse consultant D revealed they would have expected CNA I bring two basins and extra washcloths into resident 10's room for her bed bath. One set dedicated to washing the resident and the other dedicated to rinsing her. B. Based on observation, interview, and policy review, the provider failed to ensure appropriate infection prevention and control practices were maintained for: *Cleaning of shared vital sign equipment (blood pressure cuff, thermometer, and pulse oximeter) used by three of three CNAs (K, L, and M) with five of five observed residents (6, 11, 40, 48, and 62). *Appropriate hand hygiene, glove use, and use of cleaned vital sign equipment (thermometer) by	F 880	System Changes: 3. Root cause analysis conducted answered the 5 Whys: After completing the Root Cause Analysis and answering the 5 whys the predominated theme was a sense of quickness or hurriedness. The next why was the feeling of not having enough time to complete all steps. The next why was there are many residents to get taken care of. Administrator, DON, ADON/ICN, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator and DON contacted the South Dakota Quality Improvement (QIN) on September 15, 2022 and scheduled a meeting on September 16, 2022. Topics discussed were the awareness of Great Plains QIN, their website, and the services offered. We were given some tools to help with infection control and prevention resources to include a computer-based, video simulation training program "Create a Culture of Safety with Partnering to Heal"; auditing and tracking tools; COVID-19 scenario based training for new staff or annually; and access to infection control webinars that were recently hosted.	

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F 880	Continued From page 29 one of one CNA (I) with one of one observed resident (16). *Transportation of clean linen by one of one CNA (J). Findings include: 1. Observation and interview on 8/29/22 at 2:30 p.m. of CNA K taking routine vital signs revealed: *She obtained a blood pressure, temperature, and oxygen saturation, on resident 62. -Without sanitizing and using the same shared equipment, she obtained a temperature and oxygen saturation on resident 11. *CNA K stated it was a routine expectation to sanitize the shared equipment between each resident use. -Verified she had not sanitized the equipment between each resident's use. Interview on 8/30/22 at 9:49 a.m. with assistant director of nursing/infection control nurse C revealed: *"They (CNA's) know they are supposed to clean the equipment between each use and it is a constant battle." *The expectation was to disinfect the equipment between each use. *"We have tried to audit this in the past but the focus right now is staffing. We are very staff challenged." -"Management is currently picking up three to four floor shifts per week." *"We know this is a constant issue and realize the potential to spread infection." Further observation on 8/30/22 at 9:57 a.m. of CNA L and CNA M taking routine vital signs revealed: *CNA L had obtained a blood pressure on	F 880	Monitoring: 4. Administrator, DON, ADON/ICN and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 30 resident 6. -Without sanitizing and using the same shared equipment, she obtained a blood pressure on resident 40. -Without sanitizing the equipment she moved the vitals cart into resident 48's room and left for a break. *CNA M took over and without sanitizing the equipment she obtained a blood pressure on resident 48. -Without sanitizing the equipment she placed the vital sign equipment in hallway 300 and walked away to perform another task. Interview on 8/31/22 at 9:05 a.m. with administrator A revealed: *A recent in-house "mock" survey revealed several issues including the cleansing of high touch surface areas. -This had included the use of shared equipment. *They had a current performance improvement project (PIP) on cleaning of high touch surface areas. *It was her expectation the equipment would be cleaned between each resident use. Review of the provider's November 2019 policy on 'Cleaning and Disinfection' revealed: *"Purpose: To provide supplies and equipment that are adequately cleaned and disinfected." *"Policy: I. Cleaning: A. Supplies and equipment will be cleaned immediately after use." 2. Observation and interview on 8/29/22 between 3:11 p.m. and 3:35 p.m. with CNA I revealed she: *Performed hand hygiene prior to entering resident 16's room, put on a pair of gloves then placed a second set of gloves inside her smock pocket. *Cleaned the blood pressure cuff off with a Clorox	F 880		

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wipe and hung it from the vitals cart to dry.
*Cleaned the thermometer with a Clorox wipe and laid it directly on an uncleaned over the bed table to dry.
*Cleaned the pulse oximeter probe and placed it upright in a holder on the cart to dry.
*Removed her gloves. exited then returned to the room, and without performing hand hygiene removed the second set of gloves from inside her smock pocket and put them on.
*Took resident 16's blood pressure, pulse oximeter reading, and temperature.
*Removed her gloves, washed her hands. turned the water off with her wet hand, and wiped her wet hands with paper towel.
*Had not realized the risk for glove contamination when they were stored inside a smock pocket.
*Had not known a barrier should have been placed on the bedside stand before placing the cleaned thermometer on it.
*Knew she should have turned the bathroom faucet off with a clean paper towel but had not done that.

3. Observation on 8/29/22 at 2:30 p.m. of CNA J in the 200 resident hallway revealed:
*She pushed an uncovered wheeled cart containing incontinence briefs, incontinence wipes, and clean resident gowns down that hall.
-Removed contents from that cart to stock resident rooms on that hallway.
*She picked up a gown that had fallen out of the cart onto the hallway floor between rooms 202 and 204 and placed that now unclean gown on top of the clean gowns in that cart.

Interview on 8/29/22 at 2:37 p.m. with CNA J regarding the observation referred to above revealed she:

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*Had not realized she dropped the unclean gown and returned it to the cart on top of the clean gowns.
*Had not known clean laundry was expected to be covered when it was transported.

Observation on 8/30/22 at 7:30 a.m. in the 200 resident hallway revealed an unattended and uncovered cart with resident gowns, incontinence wipes, and incontinence briefs in it.

4. Interview on 8/31/22 between 11:50 a.m. and 11:59 a.m. with director of nursing B, assistant director of nursing/infection control nurse C and regional nurse consultant D revealed they expected:
*Hand hygiene had occurred prior to applying gloves and that extra gloves had not been kept in a potentially unclean smock pocket prior to use.
*A papertowel not cleaned wet hands had been used to turn off the bathroom water.
*The bedside table had been cleaned prior to placing the cleaned thermometer on top of it or that a clean barrier had been between the bedside table and the cleaned thermometer.

5. Review of the May 2021 Standard Precautions policy revealed on page 2: "Hand hygiene should be performed prior to application and after removal of gloves."

Review of the October 2019 Hand Hygiene policy revealed on page 2: "4. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."

A Laundry Transport policy was requested at 4:00 p.m. on 8/30/22 from administrator A. On 8/31/22 at 8:00 a.m. administrator A stated there was no

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such policy but her expectation was that clean laundry was covered during transport and any unclean laundry was placed in a soiled laundry container and not co-mingled with clean laundry.

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E 000	Initial Comments A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 8/29/22 through 8/31/22. Avantara Saint Cloud was found in compliance.	E 000		

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

Charlotte Pentheny | Administrator | 9/28/2022

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.

SEP 29 2022

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	435060	A. BUILDING 01 - MAIN BUILDING B. WING	08/30/2022

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/30/22. Avantara Saint Cloud was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Pinthong | TITLE: Administrator | (X6) DATE: 9/21/2022

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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AVANTARA SAINT CLOUD	302 ST CLOUD ST RAPID CITY, SD 57701

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/29/22 through 8/31/22. Avantara Saint Cloud was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/29/22 through 8/31/22. Avantara Saint Cloud was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charlotte Pankow — TITLE: Administrator — (X6) DATE: 9/21/2022