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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 9/7/22 through 9/9/22. Avantara Redfield was found not in compliance with the following requirements: F578, F656, F658, F679, F686, F812, and F880. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 9/7/22 through 9/9/22. Areas surveyed included: cleanliness and accommodation of needs. Avantara Redfield was found not in compliance with the following requirement: F558 and F584	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, revealed the provider failed to ensure one of one sampled resident (11) needs had not been met. There was no ability for her to get out of bed or leave her room. Findings include: 1. Observation and interview on 9/7/22 at 12:15 p.m. and 3:16 p.m. with resident 11 revealed she: *Was morbidly obese (over 100 pounds of the recommended weight).	F 558	1. Resident 11's bariatric wheelchair and lift arrived at the facility and are being used as needed. All residents could potentially be at risk. 2. The DON or designee will provide education to all staff on the residents' rights to reside and receive services in the facility with reasonable accommodation of resident needs and preferences by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 3 random residents and all newly admitted residents weekly x 3 months to ensure special equipment has been obtained and present results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/07/22

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

Diane Forgey | Administrator | 10/7/22

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 558	Continued From page 1 *Weighed 427 pounds when she was admitted on 4/5/22. *Was laying in her bed with a bariatric (items made for individuals that are very overweight) air mattress and bed frame. -The mattress and bed frame were larger than a regular mattress. -It measured 48 inches wide and 80 inches long. -A regular hospital mattress measured 36 inches wide and 80 inches long. *Had not gotten out of bed between 4/5/22 and 6/8/22 when she had been admitted to the hospital, she returned on 6/10/22 and had not gotten out of bed since that date. *Stated three to four staff members were required to provide care for her. *Stated the provider did not have a lift that worked for her to get out of bed. *Did not have a wheelchair large enough for her to use. *Would have liked to get out of bed and out of her room. *Has bed baths done weekly. *Stated her hair was only washed with a no-rinse shampoo cap. *Was terribly upset and cursed several times when talking about her hair. Review of resident 11's lift evaluation completed on 4/6/22 revealed she was unable to stand or walk. She was dependent on staff and required a bariatric total body lift. Review of resident 11's electronic medical record revealed: *She was been admitted on 4/5/22. *Her diagnoses included: morbid obesity, chronic kidney failure, heart failure, lymphedema, and diabetes.	F 558		

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F 558	Continued From page 2 Review of resident 11's care plan last reviewed on 6/29/22 revealed: *Focus: "I require assistance with my ADL's [activities of daily living] r/t [related to] my obesity, and inability to get out of bed." *Goal: "My ADL's will be med [met] daily through the review date of 9/13/22." *Interventions included: -Bariatric lift to be ordered. Date initiated 4/15/22. -I have a bariatric bed and bariatric air mattress in place. -"Request MCCMC [Multiple Chronic Complex Medical Conditions] add pay to help off-set the cost of a room without a roommate related to no room for a roommate as well as to compensate for the need of 3-4 staff necessary to provide cares. I have a dx [diagnosis] of morbid obesity and require bariatric equipment which includes bariatric equipment which includes bariatric bed (80" x 48") and mattress." Date revised 6/29/22. -"TRANSFER: Transferring does not occur d/t [due to] my obesity, there is not a lift in house to accommodate me for transfers. I have trialed with the current lift in facility, which does not work for my obesity. I have difficulty breathing when up in lift d/t it not fitting me appropriately. A new lift and w/c [wheelchair] have been requested and awaiting approval." Revised on 6/29/22. Review of resident 11's interdisciplinary progress notes from 5/18/22 through 6/10/22 revealed: *Her physician had ordered lymphedema (large amount of swelling due to fluid) pumps two times a day for thirty minutes, and ace wraps on in morning and off at night. *He was informed a special lift had been ordered to enable safe transfers in and out of her bed. *He had inquired if a lymphedema specialist	F 558		

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F 558	Continued From page 3 could see resident 11 to come up with a treatment plan. *6/8/22 at 3:23 p.m. "Received fax from Dr. at 2:02 p.m. with the following orders: Is oxygen requirement increased? Weight and I+O [intake and output] needed." -"Writer called Dr.'s nurse and explained that we cannot weigh her here d/t not having the appropriate lift in the building yet, but informed her that it has been ordered." -Verbal order was received to send resident to the emergency department by ambulance. -She was required to be hospitalized as the provider was unable to weigh her. *There was no further documentation of the lymphedema pumps, bariatric lift, or bariatric wheelchair in the progress notes after 6/10/22. Review of documentation regarding acquiring a bariatric air mattress, a bariatric lift and a bariatric wheelchair revealed: *On 5/23/22 a certificate of medical necessity had been completed and sent to the South Dakota Department of Social Services. The requests were for the bariatric mattress and the bariatric lift. *On 6/16/22 an email from administrator A had been sent to the long-term care ombudsman. "We have asked the add pay program to purchase an ARJO lift due to her [resident 11] diagnosis of morbid obesity with Alveolar Hypoventilation. The lifts we have are not capable of "sitting her upward when she is transferred". We are still waiting for a decision. I originally sent the request on 5/23/22." *An undated email was sent to the Long Term Services & Supports Nurse Consultant with an attachment with the bid for a bariatric lift." -The nurse consultant replied on 8/31/22 to	F 558		

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F 558	Continued From page 4 administrator A. "Is this the same request you submitted previously? Did [resident] have a therapy evaluation for the lift? Does SD MCD [South Dakota Medicaid]? I don't see an assessment included, HCPCs [Health Care Common Procedure Coding System] code for the equipment you are requesting, or a Certificate of Medical Necessity completed by her physician. Was Avera Home Medical able to assess [resident] and get you the required documentation (letterhead, [resident] name, HCPC codes, prior authorization)?" Interview on 9/8/22 at 4:30 p.m. with administrator A revealed: *When resident 11 had been admitted the previous provider had not supplied them with all the information required to care for her. *They were working with South Dakota Medicaid to purchase the equipment she needed. *She knew the provider was eventually going to have to pay for it. *Stated resident 11 did not want to get out of bed and refused to be repositioned off her back. *She was not sure how much resident 11 would use the special equipment if it had been available.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578	1. Resident 34's Advanced Directive was completed on 8/4/22 and was in the medical record. Resident 40's Advanced Directive was completed on 8/8/22 and was in the medical record. Resident 141's Advanced Directive was completed on 9/8/22. Resident 34's care plan has been updated and residents 40 and 141 have been discharged. All residents could potentially be at risk. 2. The policy was reviewed with no revisions. The DON or designee will provide education to all licensed nurses and socialservices staff on advance directives documentation and direction provided to reflect residents' wishes by 10/7/22. Those not in attendance will be educated prior to their next shiftworked.	

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F 578	Continued From page 5 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the provider failed to ensure three of four residents (34, 40, 141) advance directives had been documented and direction provided to reflect residents wishes. Findings include:	F 578	3. The DON or designee will audit 3 random residents and all newly admitted residents' medical records weekly x 3 months for documented Advanced Directives and will present results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 578	Continued From page 6 1. Review of resident 40's electronic health record (EHR) revealed: *He was admitted on 8/8/22. *His admitting diagnosis included: -Presence of left ariticial hip joint. -Methicillin Resistant Staphylococcus Aureus (MRSA) Infection, unspecified site. -Generalized anxiety disorder. -Anemia, unspecified. *Resident 40 did not have a code status or advance directive listed in his EHR. Further review of resident 40's paper medical record revealed a code status sheet with his name on it and no other information. Interview on 9/8/22 at 3:15 p.m. with administrator A revealed: *The provider had a code status book at the nurses station. *Resident 40's code status was in the code status book. *The provider was working on putting advance directives and code status in the residents EHR. *She agreed the code status advance directives should have been in his EHR but was not. 2. Record review of resident 141's electronic health record revealed: *He was admitted on 8/17/22. *Care plan dated 8/24/22: -Focus: advance directive status pursuant to resident rights, personal choices, and individual's desire to retain control and autonomy over his health care decisions. -Interventions: as indicated, document the code status on the physician's order sheet in the electronic health record. --Continue to educate the resident about his options addressing life sustaining care throughout	F 578		

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F 578	Continued From page 7 the stay as long as the individual remains coherent and able to understand this information. *No mention in his care plan had reflected his code status. *No physician order had been in resident's chart indicating his code status. Interview on 9/8/22 at 10:35 a.m. with social services designee (SSD) H regarding advanced directives revealed: *Agreed that she had not been able to find any advanced directive for resident 141. *She stated that nursing staff would obtain a POLST (physician orders for life-sustaining treatment) from the physician. Interview on 9/8/22 at 2:00 p.m. with administrator A regarding advanced directives revealed the care plan had not been specific regarding his advanced directives. Interview on 9/8/22 at 2:00 p.m. with Minimum Data Set (MDS) K regarding advance directives and locating information revealed: *She would look in the resident's electronic health record to find residents code status. *SSD H had been responsible to ensure that advanced directives had been updated onto the resident's care plan. 3. Review of resident 34's care plan with "last care plan review completed" date of 8/23/22 revealed: *On 9/1/22,: -Focus: "ADVANCE DIRECTIVE STATUS" was initiated and stated, "Pursuant to resident rights, personal choices, and the individual's desire to retain control and autonomy over his health care decisions, I have been educated on Advance Health Care."	F 578		

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F 578	Continued From page 8 -Goal: "The resident's existing Advance Directive will be honored." -Interventions: "As indicated, document the code status on the Physician's Order Sheet... in the [electronic medical record] system. Continue to educate the resident about his/her options addressing life sustaining care throughout the stay as long as the individual remains coherent and able to understand this information." *There was no information in the care plan explaining what the resident's preferences were. Review of resident 34's physician's orders revealed a current order for "Full code, yes to [cardiopulmonary resuscitation], yes to [intravenous antibiotics], no to artificial nutrition." Review of provider's September 2019 advance directive policy revealed: *"It is the policy of the facility for each resident to choose their Advanced Directives upon admission and such may be changed by the resident at any time during thier stay." *"1. Staff will provide the resident and/or representative with information regarding advance care planning which will address types of Advance Directives, treatment opotions and refusal of treatment." *"2. An Advance Directive form (as provided by the healthcare facility) or POLST form shall be completed with resident and/or legal representative to verify treatment opitns as well as code status." *"3. Appropriate information will be added to Physcian Order Sheet (POS)." *"4. The resident's Advance Directive choices/options shall be reviewed with resident/resident representative during quarterly and significant change assessment and care	F 578		

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F 578	Continued From page 9 planning." *"5. Discussion of Advance Directives and treatment options/refusals will be addressed in appropriate chart documentation as well as care planned during the admission process, as indicated." *"6. Staff will initiate a resident choice discussion concerning the DNR option or Full Code." *"7. Staff will request documentation to determine if the residetn has a Power of Attorney for Health Care in place. If the resident has a Power of Attorney for Health Care (POA) a copy of the document will be placed in the medical record (this includes being scanned into a virtual medical record). If the resident does not have Power of Attorney for Health Care, staff will educate the resident on the completion process and the right to choose to assign or not assign a Power of Attorney for Health Care. The POA form itself should be readily retrievable by any facility staff member, according to CMS rule." *"8. If the resident is unable or chooses not to initiate any type of Advance Directive, it is the policy of this facility for the resident to be a Full Code and to receive appropriate life sustaining treatment interventions such as CPR." Review of provider's current admission/readmission checklist revealed: "Nursing was to confirm with the physician within 24 hours of admission the residents code status." *Also within 24 hours: -Certified nursing assistants were to ensure they were completed. -Social services were to make an admission/advance directive note.	F 578		
F 584 SS=F	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		

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F 584	Continued From page 10 §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 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	F 584	1. Residents 6, 11, 14, 26, 33, 34 and 39's rooms have been deep-cleaned. Resident 39's bathroom wall has been repaired. Resident 33's heating coil/element was ordered on 9/30/22 and Hase Plumbing will repair on arrival of part. Resident 34's urinal was replaced. All resident rooms, hallways and public areas have been assessed for odor, clutter and uncleanable surfaces. Lobby furniture has been discarded and lobby is free of odor. Estimate was received on 10/6/22 for Nurses' station countertop repair/replacement, contractor will be here on 10/26/22. Resident room and bathroom doors and handrails in hallways identified as uncleanable will be sanded and refinished by 10/7/22. All residents could potentially be at risk. 2. The policy was reviewed with no revisions needed. The Administrator or designee will educate all staff on the policy including providing a safe, clean, comfortable, and homelike environment and to report areas in need of repair to charge nurse by 10/7/22. Those not in attendancewill be educated prior to their next shift worked. 3. The Administrator or designee will audit 3 random rooms, hallways and public areas weekly x 3 months for odor, clutter and uncleanable surfaces and unreported areas in need of repair and report results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 584	Continued From page 11 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure all areas of the building were maintained in a clean, clutter-free, fresh smelling, and homelike manner for: *Seven of 17 sampled residents (6, 11, 14, 26, 33, 34, and 39) rooms had urine odors and were cluttered. *Five of five hallways (100, 200, 300, and 400) including residents' room doors, hand rails, and public areas had areas which had a strong urine odor and the finish was missing making them uncleanable. Findings include: 1. Observation on 9/7/22 at 7:45 a.m. when entering the facility revealed: *A strong odor of urine. *The armchair in the corner of the entrance sitting room had visible stains on the backrest where a person's head would rest and on each armrest where a person's arms and hands would rest. -The odor of urine grew stronger when standing closer to the furniture. 2. Observation on 9/7/22 from 8:00 a.m. through 11:30 a.m. revealed: *The hallway floors were very sticky and dull looking. *The surfaces of the hall room doors and bathroom doors on the 100, 200, 300, and 400 halls had different sized areas where the finish had worn off. This revealed the bare wood and made those areas uncleanable. *The hand rails throughout the building had areas	F 584		

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F 584	Continued From page 12 where the finish had worn off. This revealed the bare wood and made those areas uncleanable. 3. Observation on 9/7/22 at 8:37 a.m. of resident 33 revealed the guard that covered the heating coils was broken. Those coils were sharp and could have caused injury to a resident. 4. Observation and use of senses on 9/7/22 at 11:24 a.m. in resident 34's room revealed: *There was a strong odor of urine. *A used plastic urinal was on the floor. *The floors were sticky. 5. Observation on 9/7/22 at 11:45 a.m. in resident 26's room revealed: *There was a strong smell of urine. *The floors were sticky. 6. Interview and observation on 9/7/22 at 1:06 p.m. with resident 39 revealed: *He wanted to share an issue he had about a hole he had in his bathroom wall. *After being invited into his room this surveyor observed a soccer ball sized hole in the wall of his bathroom. *He had shared the problem with maintenance director C a month ago. *Maintenance director C informed resident 39 he was trying to gather supplies but the price of lumber was too high to repair it at this time. Interview on 9/8/22 at 3:00 p.m. with maintenance director C revealed he: *Had just transferred to the maintenance department from dietary a couple of weeks earlier. *Was aware of the hole in resident 39's bathroom wall.	F 584		

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F 584	Continued From page 13 *Did not have experience with sheet rock repair. *Was gathering supplies to fix the hole. *Was waiting on a piece of wood to start the project. 7. Observation and interview on 9/7/22 at 2:30 p.m. with resident 11 revealed: *Her room had a moderate smell of urine. *The tile floors appeared to have stains in front of the sink and along the wall by the door. *There were four 12 packs of pop on the floor. *There was an overbed table that had clean linens on it. *She stated there was no place to put all her things. 8. Observation and touch on 9/7/22 at 3:10 p.m. revealed: *Forty-six wood doors had areas of missing finish making them uncleanable. -There were also gouges in the wood. *The handrails throughout the building also had areas of bare wood that could cause splinters. 9. Observation and interview on 9/7/22 at 4:30 p.m. with resident 14 revealed: *Her room was very cluttered. *She had an oxygen concentrator that was against her bedside dresser. -The top drawer of the dresser was extended and was over full with her belongings. It was not able to be closed. -She stated if she moved the oxygen concentrator the dresser would fall over. -She stated she had reported it to the maintenance person but it had not been fixed yet. *The chair between her bedside dresser and her roommates were full of pillows and blankets. -She stated those all belonged to her roommate.	F 584		

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F 584	Continued From page 14 *There was a wheelchair by her bed also. *A narrow path led from her bed to the bathroom. *She used the wheelchair as she was not able to put any weight on her left foot. 10. Observation and use of senses on 9/8/22 at 7:45 a.m. upon entering the building revealed the same strong urine odor as the day prior. 11. Observation and use of senses on 9/8/22 at 10:30 a.m. of the nurses station desk revealed: *A strong odor of urine next to the nurses station. *The laminate trim on the edge of the counter where the nurses did there charting was missing in places. *The laminate counter top had visible finger and hand prints on it. 12. Observation and interview on 9/08/22 at 2:10 p.m. with housekeeping/laundry supervisor N revealed: *She was not aware of the strong urine smell in the front entrance. -The furniture in the front entrance was shampooed several times a month with an upholstery cleaner. -She stated the urine must have gotten trapped in the foam under the fabric. *Residents 6 and 11's rooms were cleaned twice a day due to the increased traffic and strong odors in their rooms. *They use Micro Kill on the doors and the hand rails. That product had taken the finish off of the wood. *Housekeeping did not have access to the online reporting of concerns to the maintenance department. She would leave a note or ask other staff to enter in the online reporting system.	F 584		

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F 584	Continued From page 15 Interview on 9/08/22 at 9:00 a.m. with administrator A and 9/9/22 at 10:30 a.m. with administrator A and director of nursing B revealed: *They had not realized the smell in the front lobby area was so bad. *Agreed the doors and handrails had the finish worn off and bare wood was present. *The maintenance director had just started approximately one month prior. *Had just started an audit of the building after the ombudsman had notified her of some of the above findings. *Those areas had not been included in the prior quality assurance improvement plans. *They were in the process of making housekeeping checklists for cleaning. On 9/7/22 at 2:00 p.m. a copy's of the cleaning and housekeeping policy and procedures and a copy of the provider's preventative maintenance program had been requested from administrator A. Those copies had not been received by the time of the exit on 9/9/22 at 1:00 p.m.	F 584		
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 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 -	F 656		

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F 656	Continued From page 16 (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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider the failed to ensure 5 of 17 sampled (11, 14, 16, 27, and 34) residents had care plans that reflected individual needs had been addressed for: *Activity preferences for residents (11, 14, and 16). *Preventative measures were identified and	F 656	1. Residents 11, 14, and 16 have been again interviewed for individual activity preferences with no changes to their activity preferences. Their care plans were reviewed, and those preferences had been included in their care plans. Resident 34's care plan was revised to reflect lack of teeth, pain when chewing certain foods, and current diet and supplement. Resident 27 has discharged. Activity calendars have been placed in all resident rooms. All residents could potentially be at risk. 2. The policy was reviewed with no revisions. The DON or designee will provide education to all nursing staff on the care planning policy including reflecting individual needs by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 3 random residents' care plans weekly x 3 months for reflection of individual needs and activity preferences and will present results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 656	Continued From page 17 implemented to avoid development of pressure injury(s) for resident 27. *Lack of teeth and pain when chewing certain foods for resident 34. Findings include: 1. Review of resident 11's last reviewed 6/29/22 care plan for activities revealed she: *Was independent with her activity needs. *Was to be offered independent materials as needed. *Should have a copy of the activity calendar provided to her monthly. Review of resident 11's medical record revealed she was dependent on staff for her activities of daily living for bed mobility. She had only been out of her room once since her admission on 4/5/22 for a hospitalization. There was no activities calendar observed in her room. 2. Interview on 9/8/22 at 4:30 p.m. with resident 14 revealed she did not know about the puzzle table. She stated no staff from activities had visited with her about what she liked to do. Review of resident 14's last reviewed 7/20/22 care plan for activities revealed she was new to the facility and may be interested in activity programs offered. She had been admitted on 6/22/22. Interventions included: activity staff to introduce themselves, to become involved with religious programs and events, meet to complete her activity and history assessment, and a puzzle table had been set up for her to work on puzzles. 3. Interview on 9/7/22 at 2:30 p.m. with resident 16 revealed he was laying in his bed with the television on. He stated he did like some of the	F 656		

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F 656	Continued From page 18 activities on the calendar, He stated the activities were listed but never took place. Review of resident 16's last reviewed 7/20/22 care plan for activities revealed he was independent with his activity interests. He preferred independent activities included watching television, reading, and telephone conversations with his family. Interventions included encouraging him to socialize with other residents, invite and encourage him to engage in activities, offer independent materials, and provide him with a copy of the monthly activity calendar. 4. Record review of resident 27's care plan revealed: *He had been identified as having an open area to his right buttock on 8/15/22. *On 8/17/22 measurements and staging of the wound had been completed. -Stage three pressure ulcer to right buttock measuring 4 cm x 1.7 cm x 0.2 cm. *Weekly measurements and wound care had been provided. Interview on 9/8/22 at 2:44 p.m. with director of nursing (DON) B regarding resident 27's care plan related to his pressure ulcer revealed: *She agreed that his care plan had not identified his pressure ulcer to his right buttock. *Stated that interventions to help prevent pressure ulcers would be to reposition residents every two hours. *Agreed that no intervention such as repositioning every 2 hours had been on his care plan. 5. Interview on 9/7/22 at 11:24 a.m. with resident	F 656		

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F 656	Continued From page 19 34 regarding his ability to chew revealed he: *Was admitted to the facility on 8/3/22. *Had no teeth and experienced pain when trying to chew certain food items. *Was not aware if he received a mechanically altered diet or not. Interview on 9/8/22 at 2:54 p.m. with MDS coordinator K about care plans revealed: *A baseline care plan was auto-generated in a resident's electronic medical record based on the data gathered from the admission assessment. *The dietary department was responsible for the nutrition portion of a resident's care plan, which included a resident's diet order, diet textures, supplements, scheduled snacks, food likes and dislikes, etc. *She was not aware that resident 34's care plan did not include the resident's diet order, diet texture, or supplement. Interview on 9/8/22 at 3:25 p.m. with regional registered dietitian (RD) M and dietary manager F about resident 34's diet order and care plan revealed: *Dietary manager F thought she had inserted the nutrition portion into resident 34's care plan. *If dietary manager F required assistance with the clinical aspect of care planning, she would contact RD M. *RD M confirmed there was no nutrition portion in resident 34's care plan. *The nutrition portion of resident care plans included diet order, textures, supplements, and resident preferences. Review of RD M's assessment from 8/8/22 revealed resident 34 had received a regular diet with regular textures and thin liquids, and had	F 656		

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F 656	Continued From page 20 received a supplement of Ensure twice daily. Review of resident 34's 8/23/22 care plan revealed there was nothing related to his diet order. Review of the provider's September 2019 Care Planning policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"Date is the date of onset (or changes) for each section of the care plan." *"Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking pattern identification, and personal information forming the foundation of the care plan." -The care plan was broken down into separate focus areas that included: Psycho-Social, Quality of Life, Nutritional Status, and Hygiene ADL's/Skin. *"Goal for care are directly related to the resident's discharge plan." -Long-term discharge plan focuses on helping the resident feel at home and maintain or improve their overall quality of life. *"Interventions act as the means to meet the individual's needs."	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 658		

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F 658	Continued From page 21 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (4 and 14) had been administered medication correctly by two of two staff (licensed practical nurse (LPN) I and medication aide (MA) J). Professional standards for medication administration had not been followed. Findings include: 1. Record review of resident 14's electronic health record (EHR) regarding a ordered IV (intravenous) antibiotic revealed: *On 9/6/22 at 3:00 p.m. a interdisciplinary progress note stated resident 14 was to receive Vancomycin one gram IV every 24 hours for five days. -Resident had received a dose of IV Vancomycin at the wound clinic on that date. Interview on 9/7/22 at 3:00 p.m. with LPN I regarding the infusion time of resident's IV antibiotic revealed: *She had known the resident received a dose of antibiotic at the wound clinic and returned to the facility on 9/6/22 at 3:00 p.m. *The next dose of IV antibiotic had been scheduled to be administered at 8:00 p.m. on 9/7/22. *She had been asked if giving a medication greater than twenty four hours after last dose had been given would have been considered a medication error. *She confirmed it would have been considered a medication error. *She stated they had received the medication but	F 658	1. Staff I and J were re-educated on appropriate medication administration technique by the DON on 9/7/22. All residents could potentially be at risk. 2. The policy was reviewed with no revisions. The DON or designee will provide re-education to all staff who administer medications on appropriate medication administration procedures including proper dose and all nursing staff on IV administration, flushes and maintenance by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 3 random medication administration passes weekly x 3 months for appropriate medication dose and IV medication and report results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 658	Continued From page 22 did not have an infusion pump to administer the medication. Record review of resident 14's EHR interdisciplinary progress notes revealed: *On 9/7/22 at 4:30 p.m. an entry had been made. The ordering physician had been notified that resident 14's next dose of IV Vancomycin would be given greater than 24 hours since her last dose. It stated they did not have the antibiotic and were waiting for the pharmacy to deliver it. -They were waiting for an infusion pump and once a pump had arrived they discovered they did not have compatible IV tubing for the pump. --It was later discovered that they had the infusion pump tubing in their E-kit. *The medication had been documented as administered at 3:00 p.m. on 9/7/22. Interview on 9/8/22 at 9:30 a.m. with LPN I regarding the procedure was to flush a IV line . She was not sure what the facilities policy was for IV flushes and maintenance. Interview on 9/8/22 at 11:00 a.m. with director of nursing B regarding policies for IV flushes revealed: *They used the Potter and Perry nursing manual as a professional standards for IV medication administration. *She provided a copy of the August 2026 PharMerica Corporation Infusion Therapy procedures. *Agreed the infusion therapy procedure had been outdated. Record review of residents 14's MAR revealed: *Order placed on 9/8/22 to flush IV with 10 cubic centimeter (cc) of normal saline at 7:00 a.m. and	F 658		

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F 658	Continued From page 23 11:00 p.m. and to flush before and after medication administration. 2. Observation and interview on 9/8/22 at 11:00 a.m. with medication aide (MA) J preparing medication for resident 4 revealed: *The medication administration record (MAR) revealed to administer Metamucil 1 teaspoon orally daily. -MA J used a plastic spoon to retrieve the powdered medication from the bottle. -Poured the Metamucil into a medication cup. -She had been asked how many cc's were in a teaspoon. -Stated that she measured to 7.5 grams using a medication cup. -She had been informed that there are 5 cc's in a teaspoon and not grams. *The MAR revealed to administer MiraLax 17 grams and use the medication lid to measure the medication. -MA J poured the MiraLax into a drinking cup without measuring the amount. -Asked how she verified that she was administering the correct amount of medication. -MA J then poured the MiraLax back into the medication lid to verify the amount needed. --Amount had been verified and was poured back into a drinking cup for administration. Attempted interview on 9/9/22 at 11:00 a.m. with director of nursing B regarding professional standards but she was out of the building.	F 658		
F 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		

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F 679	Continued From page 24 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide a activity program that involved three of three sampled (11, 14, and 16) residents individual interests and needs. Findings include: Review of the provider's July 2022, August 2022, and September 2022 activity calendars revealed: *The calendars all said the same thing: -Weekends consisted of family visits, "Find a friend and play a game," and church services. -One-to-one activities were scheduled two times a week. -Group activities that included: Puzzles and music, bingo, trivia, nail care, resident choice, shopping, arts and crafts, resident council, Yahtzee, happy hour, ladder golf, veteran men's group, and fishing to be determined. -There was only one group activity scheduled each weekday. 1. Observation and interview on 9/7/22 at 12:25 p.m. with resident 11 revealed: *No activity calendar in her room. *No one had asked her about what activities she would like to do. *She mostly watched television and had her laptop computer.	F 679	1. Residents 11, 14 and 16 were again interviewed for individual interests. The activity calendar was reviewed and revised to reflect meaningful and regularly scheduled activities. The revised activities have been posted in all resident rooms, including residents 11, 14 and 16. An Activity Director and an Activity Assistant have been newly hired with ongoing education. All residents could potentially be at risk. 2. The policy was reviewed with no revisions needed. The Administrator or designee will provide education to all staff including providing meaningful activities to residents and documentation of such. Education will occur no later than 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The Administrator or designee will audit 3 random residents weekly x 3 months to ensure preferences and activity program supports their choices are being provided and for documented. Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 679	Continued From page 25 *She had not been out of her room, other than one hospital visit, since her 4/5/22 admission. Review of resident 11's activity participation documentation revealed: *June 2022 she had three one-to-one visits. *July 2022 she had two one-to-one visits. *August 2022 she had two one-to-one visits. *September 1st through the 8th she had two one-to-one visits. 2. Interview on 9/8/22 at 2:45 p.m. with resident 16 revealed he: *Would like to have more activities to go to. *He used to have an activity calendar in his room and would know what was done. *Many times, what is listed on the information board for an activity was not held. *It was better in June but had declined since then. Review of resident 16's activity participation document revealed: *June 5th through June 30th revealed he had three one-to one visits, one group outing, and had refused one group activity. *July 2022 revealed he had three one-to-one visits and had refused one group activity, *August 2022 revealed he had two one-to-one visits and had refused on group activity. *September 1st through the 8th revealed he had one one-to-one visit. 3. Interview on 9/8/22 at 5:00 p.m. with resident 14 revealed she: *Stayed in her room most of the time. *Had been invited to some of the group activities. *Did not like any of the activities that were available.	F 679		

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F 679	Continued From page 26 Review of resident 14's activity participation documentation revealed: *June 22nd through June 30th revealed she had refused one group activity and had not been available for another. *July 2022 revealed she had refused activities that had included: puzzles and music, bingo, church services, trivia, and the resident council meeting, she had a one-to-one visit. *August 2022 revealed she had two one-to-one visits. *September 1st through the 8th revealed she not participated in any activities. Interview on 9/9/22 at 9:30 a.m. with administrator A revealed: *The activity coordinator had been out on leave in April and was back for one day in May and decided to not return. *She had hired three staff to assist with activities until a new coordinator was hired. *She agreed the documentation of what the residents had participated in was minimal compared to what the residents had participated in. Review of the provider's January 2020 Activities policy revealed: *"It is the goal to provide meaningful activities for our residents. Individual programming ensures all residents who are unable to participate in group programs have consistent, person centered goal-oriented and individualized recreation opportunities. The activity department will be directed by a qualified professional." *"Regularly scheduled programming will be provided to all residents who are unable or unwilling to attend group activities and will be	F 679		

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F 679	Continued From page 27 developed based on each resident's assessed needs and choices." *"Document the resident's participation in activities provided and whether the resident was engaged in the activity." Refer to F656 findings 1, 2, and 3.	F 679		
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: Based on observation, interview, record review, and policy review the provider failed to ensure interventions were in place to prevent a facility acquired pressure for one of one sampled resident 27. Findings include: Interview on 9/7/22 at 12:07 p.m. with resident 27's daughter while she was visiting her father revealed: *He did not have any skin issues when he moved into the facility. *She had been aware of wounds to his coccyx,	F 686	1. Resident 27 has discharged. All residents could potentially be at risk. 2. The policy was reviewed with no revisions. The DON or designee will provide education to all nursing staff on policy including ensuring interventions are in place to prevent facility acquired pressure ulcers and documentation of such interventions by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The DON or designee will audit 3 random resident's medical records weekly x 3 months for interventions to prevent pressure ulcers and documentation of those interventions and present results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 686	Continued From page 28 legs, and feet. Record review of resident 27's electronic health record revealed: *On 8/15/22 he had a open area to his right gluteal fold. -The area had not been assessed at that time due to resident being seated in his wheelchair. *On 8/17/22 an acquired pressure ulcer to right buttock was discovered. It measured 4 cm (centimeter) x 1.7 cm x 0.2 cm. and was classified as a stage 3 (affect the top two layers of skin as well as fatty tissue). *Measurements and assessments completed weekly revealed: -8/24/22 acquired stage 3 pressure ulcer present to right mid buttock. Area measured 9 cm x 2.6 cm x 0.2 cm. -9/1/22 acquired stage 3 pressure ulcer present to right buttock 5.5 cm x 3.2 cm x 0.1 cm. *Treatment consisted of cleansing the wound, pat dry, apply collagen pad to wound, cover with silicone border foam, and change every day. -9/7/22 acquired stage 3 pressure ulcer present to right mid buttock. Area measured 6.5 cm x 2.9 cm x 0.1 cm. Interview on 9/8/22 at 2:44 p.m. with director of nursing (DON) B regarding resident 27's acquired pressure ulcers revealed: *He had an unstageable ulcer to his left heel. *Would get open areas from his socks. *Stage three on his right buttock which had developed at the facility. *He had been seeing his physician in the wound clinic at the hospital. *He had a history of blood clots and arterial and venous insuffiency. -An air mattress had been placed on his bed.	F 686		

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F 686	Continued From page 29 *Staff should have been turning and repositioning every two hours. *She was unable to provide any documentation that the resident had been repositioned every two hours. Record review of resident 27's care plan dated 8/3/22 revealed: *Had not focused on his pressure ulcer on his right buttock. *Interventions should have indicated repositioning of resident and documentation of repositioning. Review of provider's August 2020 Skin Care Treatment Regimen policy revealed: *Residents who are unable to reposition themselves every two hours unless specified by physicians order, should be repositioned. *Residents with stage three or greater size pressure ulcer will be placed in a specialized air mattress.	F 686		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 812	1. The identified kitchen coolers and fans have been cleaned. Cook G was re-educated on appropriate process to temp foods on 9/7/22 by the dietary manager and the registered dietician. All residents have the potential to be at risk. 2. Kitchen cleaning checklist updated to include cleaning of the coolers and cooler fans monthly and as needed. The RD or designee will provide education to all Dietary staff on routine cleaning of coolers and cooler fans and appropriate practices to measure food temperatures by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 3. The RD or designee will audit for appropriate measuring of food temperatures and cleanliness of coolers and fans weekly x 3 months. The RD or designee will present results at the monthly QAPI meeting for at least 3 months for review and recommendations.	10/7/22

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F 812	Continued From page 30 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and cleaning checklist review, the provider failed to ensure: *Two of two kitchen coolers were maintained in a clean and sanitary condition. *One of one cook (G) had performed appropriate practices to measure the temperature of the food before being served to the residents. Findings include: 1. Observation on 9/7/22 from 8:15 a.m. through 9:23 a.m. in the kitchen revealed: *The milk cooler had a strong rotten milk smell. -A unidentified congealed brown liquid was at the bottom of the milk cooler. *In the three-door cooler the ventilation fans were completely covered with dust. -The ventilation fans were located on the ceiling of the cooler approximately three inches above food storage containers on the top shelf. Interview on 9/8/22 at 3:52 p.m. with dietary manager F about the coolers revealed she: *Was aware of the smell in the milk cooler and had attempted to clean the milk cooler previously but the smell kept coming back. *Was not aware the ventilation fans in the three-door cooler were dirty. *Agreed several items in the kitchen in addition to the two coolers mentioned above needed cleaning and regular maintenance attention. 2. Observation on 9/8/22 at 11:03 a.m. of cook G	F 812		

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F 812	Continued From page 31 during lunch service in the kitchen revealed she: *Removed the thermometer probe from its sheath and did not sanitize the probe before she placed it into the mushroom gravy to measure the temperature. *Used the same alcohol-based thermometer sanitizing wipe between measuring the temperature of multiple food items. *Had only used four alcohol-based thermometer sanitizing wipes for the nine food items that required temperature monitoring. Interview on 9/8/22 at 11:10 a.m. with cook G about the above observation revealed she: *Used one alcohol-based thermometer sanitizing wipe twice by: -Wiping the thermometer probe on one side of the wipe and then wiping the thermometer probe on the other side of the same wipe between food items. *Recalled she was cited on the same issue on the facility's previous survey. Interview on 9/8/22 at 3:52 p.m. with dietary manager F about the above observation and interview with cook G revealed she: *Recalled that had been cited on the facility's previous survey. -Review of facility's recertification survey from 4/29/21 confirmed the above finding. *Had re-educated cook G multiple times regarding using one alcohol-based thermometer sanitizing wipe per food item. *Agreed more oversight of the dietary department was needed. Review of manufacturer's instructions for the alcohol-based thermometer sanitizing wipes revealed the wipes were one-time-use only.	F 812		

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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 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:	F 880		

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F 880	Continued From page 33 (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: Based on observation, interview, record review, and policy review, the provider failed to ensure transmission based precautions had been followed: *For one of one sampled resident (35), by two of two certified nursing assistants (CNA) (D and E) when helping resident 35. *For appropriate signage and supplies for two of two (6 and 14) sampled residents with contact precautions. Findings included:	F 880	Directed Plan of Correction Avantara Redfield F880 Corrective Action: 1. For the identification of lack of: *Appropriate application of personal protective equipment (PPE) by staff while delivering meals to resident(s) in isolation. *Appropriate signage for type of isolation and PPE needs identified for those who enter room. The Administrator, DON and medical director reviewed the policies and procedures for the above identified areas. No revisions were necessary as they are in line with CDC and CMS recommendationsfor the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by the DON/ Infection preventionist or designee by 10/7/22. Those not in attendance will be educated prior to their next shift worked. 2. All residents and staff have the potential to be affected by lack of *Appropriate awareness of isolation type and PPE needs. Policy/education/re-education about roles and responsibilities for the above identified assigned care and service tasks will be provided by the DON/Infection preventionist or designee by 10/7/22. Those not in attendance will be educated prior to their next shift worked. System Changes: 3. Root cause analysis conducted by answering the 5 Whys. The root cause of observed lapses in infection control practices at the time of survey was identified as: Staff did not read posted signage that identified precaution type & the DON/Infection preventionist did not ensure precaution signage was re-posted on one room door following a room change. Administrator, DON, medical director, and nay others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. The Administrator contacted the South Dakota Quality Improvement Organization (QIN) on 9/25/22. The root cause Analysis and this plan of correction were discussed. The QIN agreed with this plan of correction. Monitoring: 4. Administrator, DON 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 of staff compliance with: *Appropriate PPE while delivering meals to residents in isolation. *Appropriate signage and staff awareness of precaution type and PPE needs. 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 the committee.	10/7/22

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F 880	Continued From page 34 1. Observation on 9/7/22 at 8:24 a.m. in the former Alzheimers care unit (ACU) hallway revealed: *CNA D was carrying a room tray in the hall to deliver breakfast to resident 35. She: -Did not put on personal protective equipment (PPE). -Knocked on the door for room 33. -Entered the room with the room tray. -Left the tray in the room for resident 35. -Exited the room. -Used hand sanitizer. Observation on 9/7/22 at 9:00 a.m. of the signs on resident 35's door revealed: *Enhanced droplet precautions. *Visitors were not to enter the room they were to see a nurse. *Hand hygiene: wash hands or perform alcohol hand gel according to standard precautions. *Masks: surgical masks when entering room or N95 respirator, if available, and healthcare personnel have been fit tested. *Eye protection: eye protection when entering room. *Gowns: gowns when entering room. *Gloves: gloves when entering room. *Keep door closed at all times. Observation on 9/7/22 at 12:16 p.m. revealed the door to room 33 was open and resident 35 was eating lunch. Observation on 9/7/22 at 12:57 p.m. revealed the door to room 33 was open and resident 35 was napping. Obseration on 9/8/22 at 9:01 a.m. revealed the	F 880		

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F 880	Continued From page 35 door to room 33 resident 33's room was ajar. Interview on 9/8/22 at 10:57 a.m. with director of nursing (DON) B revealed she: *Knew resident 35 was quarantined due to a rehospitalization and his COVID vaccination status. *Expected CNA D to follow the PPE policy. *Shared resident 35 gets claustrophobic at times so, the door may be open. *Agreed there should be a see-through barrier covering the door if it was going to be open. Observation and interview on 9/8/22 at 11:55 a.m. in the ACU hallway revealed: *CNA E removed a room tray from the lunch tray rack. She: -Did not put on PPE or perform any hand hygiene. -Knocked on resident 35's door. -Entered the room. -Exited the room. -Performed hand hygiene. *When asked why she had not used PPE before entering resident 35's room she stated, "I did put it on and threw it in the garbage can inside the room before I left the room." Review of the provider's revised February 2021 infection prevention program plan revealed: *"Purpose: To determine what resources are necessary to care for our residents competently and to assist with the review and updating of the Infection Prevention and Control Program." *"The goals of the infection prevention and control program are to: A. Decrease the risk of infection to residents/patients and personnel. B. Prevent, to the extent possible, the onset and	F 880		

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F 880	Continued From page 36 spread of infection. C. Monitor for occurences of infection and control outbreaks and cross-contamination. D. Monitor for occurrence of infection and implement appropriate control measures. E. Identify and correct problems relating to infection prevention practices. F. Maintain compliance with state and federal regulations and standards of practice relating to infection prevention and control." *"Prevention of spread of infections is accomplished by use of hand hygiene, standard and transmission precautions and other barriers (PPE-Personal Protective Equipment), appropriate treatment and follow-up, and employee health." *"Staff and resident education focuses on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures, in cleaning/disinfection of equipment, and cleaning and handling linens. Immunizations are offered as appropriate to residents and personnel to decrease the incidence of preventable infectious diseases." 2. Interview on 9/7/22 at 8:15 a.m. with administrator A revealed there was one resident (35) who was on quarantine to rule out COVID-19. She had not indicated any other residents on transmission based precautions. Observation on 9/7/22 at 10:00 a.m. outside of resident 6's room revealed a cart that contained disposable gowns and gloves. There were no signs to indicate if precautions were to have been taken.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	C 09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 37 Interview on 9/7/22 at 10:30 a.m. with director of nursing (DON) B revealed resident 6 was on contact precautions for extended spectrum beta-lactamase (an enzyme made by some bacteria that prevents certain antibiotics from being able to kill the bacteria. The bacteria then become resistant to the antibiotics.) in her urine. She agreed there was no sign to indicate what precautions were to have been used. Resident 6 had moved rooms and the signs had not transferred with her. 3. Review of resident 14's electronic medical record revealed she had been diagnosed with MRSA in a wound on 9/7/22. No signs or preventative equipment had been placed by her room. The wound was on her left foot. It was covered by a dressing. That dressing was changed by the nurses. Interview on 9/9/22 at 9:00 a.m. with DON B confirmed the above findings.	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 9/7/22 through 9/9/22. Avantara Redfield was found in compliance.	E 000		

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

Diane Forgey | Administrator | 9/30/22

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SEP 30 2022

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 9/7/22. Avantara Redfield Building 1 was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K223, and K325 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation, testing, and interview, the provider failed to provide means of egress without obstruction as required at three of four exits easily accessible to facility residents (west facing door closest to Alzheimer's Care Unit (ACU), west facing door in corridor containing boiler room, and north facing door). Findings include: 1. Observation beginning on 9/7/22 at 10:30 a.m. revealed the west facing exit door closest to ACU was obstructed by a heavy transparent barrier	K 211	1. Transparent barriers at three exits were removed on 9/7/22. Allresidents could potentially be at risk. 2. The Regional Maintenance Supervisor or designee will provide education to all staff on means of egress. Education will occur by October 7, 2022. Those not in attendance will be educated prior to their first shift worked. 3. The Administrator or designee will audit TELS monthly x 3 months to ensure means of egress is appropriately monitored. Results of audits will be presented by the Maintenance Supervisor at the monthly QAPI meeting for discussion of effectiveness and recommendations.	10/7/22

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Diane Forgey | Administrator | 9/30/22

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

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K 211	Continued From page 1 with a "STOP" sign. To use the exit door, the barricade had to be moved. 2. Observation beginning on 9/7/22 at 10:50 a.m. revealed the west facing exit door in the corridor also containing the boiler room was obstructed by a heavy transparent barrier with a "STOP" sign. To use the exit door, the barricade had to be moved. 3. Observation beginning on 9/7/22 at 11:15 a.m. revealed the north facing exit door was obstructed by a heavy transparent barrier with a "STOP" sign. To use the exit door, the barricade had to be moved. Interview at the time of the observation with the executive director confirmed those conditions. She stated she was unaware an obstruction meant to slow egress could not be used. Failure to provide an egress path with no obstruction as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants. Ref: 2012 NFPA 101 Section 19.2.3.5, 7.1.3.2.2	K 211		
K 223 SS=E	Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically	K 223		

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	435054	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 223	Continued From page 2 closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power. 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to maintain two of four hazardous areas (laundry and soiled laundry holding) as required. Findings include: 1. Observation on 9/7/22 at 11:00 a.m. revealed the laundry room and clean laundry storage in building one was greater than 100 square feet and contained combustible items. The corridor door would not close without significant pressure applied to the door. 2. Observation on 9/7/22 at 11:05 a.m. revealed the soiled laundry holding room in building one was 100 square feet and contained combustible items. The corridor door would not close without significant pressure applied to the door. Interview with the executive director at the time of the observation confirmed that finding. The deficiency had the potential to affect 100% of the occupants of that smoke compartment.	K 223	1. The clean laundry storage door was adjustedto self-close on 9/27/22. The soiled laundry door was installed on 9/27/22. All residents could potentially be at risk. 2. The Doors with Self-closing devices requirement was reviewed. Education was provided to Maintenance Supervisor on 9/26/22. 3. The Administrator or designee will audit TELS monthly x 3 months to ensure appropriate monitoring of doors requiring self-closing devices close properly. Results of audits will be presented by the Maintenance Supervisor or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	10/7/22
K 325 SS=E	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)	K 325		

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	435054	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	**1015 THIRD STREET EAST** **REDFIELD, SD 57469**

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K 325	Continued From page 3 ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to safely store alcohol based hand rub (ABHR) in one room (personal protective equipment (PPE) storage room adjacent to Alzheimer's Care Unit (ACU) dining room). Findings include: 1. Observation on 9/7/22 at 11:45 a.m. revealed the PPE storage room adjacent to the ACU dining room had a combined total of 22 gallons of boxed ABHR and bottled ABHR stored. The flammable liquids code does not allow over 10 gallons of alcohol in a single smoke compartment.	K 325	1. Excess alcohol-based hand rub was removed from the PPE storage room on 9/7/22. All residents could potentially be at risk. 2. Regulation was reviewed by Administrator and Maintenance Supervisor on 9/26/22. The Administrator educated Central Supply that not more than an aggregate of 10 gallons of fluid ABHR or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room. A posting in PPE storage room indicating the standard above will be posted by 10/7/22. 3. Central Supply or designee will audit PPE storage room weekly x 3 months to ensure no more than 10 gallons of fluid ABHR is stored there. Results of audits will be presented by Central Suppply or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	10/7/22

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	435054	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/07/2022

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K 325	Continued From page 4 Interview with the executive director at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for ABHR use.	K 325		

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	435054	A. BUILDING **02 - BUILDING 02** B. WING _____	**09/07/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 9/7/22. Avantara Redfield Building 2 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 | TITLE | (X6) DATE

Diane Forgey | Administrator | 9/30/22

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South Dakota Department of Health

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	10671	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/7/22 through 9/9/22. Avantara Redfield was found not in compliance with the following requirements: S157, S296, and S301.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, testing, interview and record review, the provider failed to maintain exhaust ventilation in one room (soiled laundry holding) in building one. Findings include: 1. Observation on 9/7/22 at 10:40 a.m. revealed the exhaust ventilation for the soiled laundry holding room adjacent to laundry was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Odors were also evident at the adjacent nurses' station. Interview with the executive director at the time of testing confirmed that finding. She revealed she knew the previous maintenance director had been working with a local contractor for repair, but did not know it was still not working. Record review on 9/7/22 at 4:30 p.m. found notes from the previous maintenance director from April and May 2022. The last note suggested need for	S 157	1. Exhaust ventilation fan for the soiled laundry room was repaired on 9/30/22. All residents could potentially be at risk. 2. The Regional Maintenance Supervisor or designee will provide education regarding ventilation to be provided in all soiled areas, wet areas, toilet rooms and storage rooms by 10/7/22. Facility will add monthly monitoring of ventilation exhaust to ensure proper working order by 10/7/22. 3. The Administrator or designee will audit TELS monthly x 3 months to ensure exhaust ventilation is appropriately monitored. Results of audits will be presented by the Maintenance Supervisor at the monthly QAPI meeting for discussion of effectiveness and recommendations.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Forgey — TITLE: Administrator — (X6) DATE: 9/30/22

South Dakota Department of Health

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S 157	Continued From page 1 a smaller individual to crawl within the ceiling. That room was required to have exhaust ventilation directed to the exterior of the building.	S 157		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.	S 296	1. Dietary Manager position was posted as an open position on 8/10/22. Administrator will screen and interview as appropriate applicants for a full time Dietary Manager. Part time Dietary Manager will complete the ServSafe food protection manager certificate by 10/7/22. All residents could potentially be at risk. 2. The Administrator reviewed the requirement for Director of Dietetic Services. 3. The Administrator or designee will audit dietary staff for the appropriate certifications monthly x 3 months to ensure appropriate certifications. Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.	10/7/22

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S 296	Continued From page 2 This Administrative Rule of South Dakota is not met as evidenced by: Based on interview and certificate review, the provider failed to: *Have a full-time dietary manager to monitor the dietetic service. *Ensure the dietary manager and at least one cook possessed the required food safety certification. Findings include: 1. Interview on 9/7/22 at 10:01 a.m. and 9/8/22 at 10:33 a.m. with dietary manager F regarding her job position revealed: *She had been the full-time dietary manager and recently transitioned to part-time hourly position on 8/29/22. *She had started a different full-time job in June of this year but had continued at the facility, and now worked 20-30 hours per week doing cleaning tasks and assisted with ordering food. *Her ServSafe food protection manager certificate expired in 2021. *No one in the department had a valid ServSafe food protection manager certificate. Interview on 9/9/22 at 8:09 a.m. with administrator A regarding the dietary manager position revealed: *She confirmed dietary manager F had transitioned to a part-time hourly position at the facility on 8/29/22. *She covered cooking shifts, assisted with unloading food deliveries, and handled the dietary schedule. *They had no qualified applicants. Review of dietary manager F's most recent ServSafe food protection manager certificate	S 296		

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	10671	A. BUILDING: _____ B. WING _____	09/09/2022

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S 296	Continued From page 3 revealed it had expired on 9/14/21.	S 296		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on interview, and record review, the provider failed to ensure all required dietary trainings (food safety, food handling/preparation, food-borne illness, serving and distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation) were completed by one of one cook (L). Findings include: Record review of cook L's file revealed: *Cook L had been hired on 8/5/22. *Had completed hand washing training on 8/5/22 with her orientation. Interview on 9/9/22 at 11:00 a.m. with part time dietary manager F regarding record of education revealed: *She only had documentation of cook L completing handwashing on 8/5/22. *The facility had been working on switching education to a computer based education, but had not assigned any learning modules for cook I to complete.	S 301	1. Cook L completed the required dietary trainings (food safety, food handling/preparation, food-borne illness, serving and distribution, leftovers, time/temperature controls, nutrition/hydration and sanitation). All residents could potentially be at risk. 2. The Administrator provided education to Human Resources on required dietary training. 3. The Administrator or designee will audit all dietary staff's employee files for required training monthly x 3 months to ensure required training is complete. Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting for effectiveness and recommendations.	10/7/22

South Dakota Department of Health

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	10671	A. BUILDING: _____ B. WING _____	09/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA REDFIELD	1015 THIRD STREET EAST REDFIELD, SD 57469

(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 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/7/22 through 9/9/22. Avantara Redfield was found in compliance.	S 000		