STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/06/2022
NAME OF PROVIDER OR SUPPLIER: Avantara Norton		STREET ADDRESS, CITY, STATE, ZIP CODE: 3600 South Norton Avenue Sioux Falls, SD 57105	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32332 Based on observation, interview, and record review, the provider failed to ensure: *Diets were followed as ordered resulting in a choking episode for one of one resident (4). *A care plan had been updated to identify goals and interventions to prevent further choking episodes for one of one resident (4). *A resident (4) was supervised for potential of choking during one of three observed meal services. *A process was in place for meal delivery to identify the correct diet for each resident who received their meals in the dining room. *A documentation process was in place to accurately capture meal and oral intake for residents. Findings include: 1. Review of the provider's online self-report to the SD DOH on 3/15/22 revealed: *On 3/14/22 resident 1 had a choking episode during the supper meal. *The resident was able to expel the food on his own and had not required outside treatment. *The resident had a piece of regular bread on his plate. *The resident had not been given the correct diet. *The resident had a diet order for a regular diet, dysphagia [difficulty swallowing] mechanically altered (level 2) texture, thin liquids. *Educated staff on duty on 3/15/22 at 10:00 a.m. need to look at diet card prior to serving trays, to ensure correct diets are being given, to all residents. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A conclusionary summary to the provider's self-report had indicated:*Resident 4 had been evaluated by the speech therapist (ST) last on 7/22/21 and a NDD (National Dysphagia Diet) 2/IDDSI (International Dysphagia Diet Standardisation Initiative) 5 (a mechanical diet that altered the texture - chopped, very soft foods, ground meat, and minced/moist food. Breads were to have been pureed.) His liquids could remain thin. *The dietitian had audited all the diet textures on 3/15/22 and her audit indicated: -Resident 4 had a correct diet on the meal ticket (a diet card specific to what diet he was to have). --His care plan had not been updated with his current diet but had been updated on 3/15/22. -All other residents with altered textures had matching diet and care plan on their meal ticket and care plan. *The dietitian was to have provided mandatory education on diets for all staff on 3/24/22. *A binder had been placed at the serving window in the kitchen for all staff to reference. It lists all current residents, diets, textures, thickened fluids, supplements, serving sized and descriptions of what the meals should look like. This binder will be updated every Tuesday and the nutrition risk meeting. Staff are being provided education on the binder at the beginning of each meal service and additional education be provided at the all staff on 3/24/22 by DON [director of nursing]. Review of the 3/14/22 at 8:11 p.m. interdisciplinary progress note by licensed practical nurse (LPN) I revealed:*Resident 4 had a choking episode at the evening meal. *The kitchen aide had noticed the resident with his head laid back in his wheelchair and trying to clear his throat. She leaned him forward and he began to clear his throat. *LPN I was summoned to the dining room to assist and noted a regular piece of bread on his plate. *Resident 4 was not given the correct diet. *The kitchen staff and CNA's [certified nursing assistants] were counseled to ensure correct diet is given. *He was taken to the nurses station and monitored. Observation of the noon meal on 4/5/22 at 12:00 p.m. revealed: *Dietary manager F was plating food and handing the plate to a CNA to deliver to the residents. *The CNA would pick up the plate and place the meal ticket upside down in a pile of meal tickets. -That CNA would then take the plate to a resident in the dining room and set it down in front of the resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*There were no binders at the serving window for staff to review as stated in the provider's self-report. *Dietary manager F had picked up a black binder from the kitchen table behind him one time and then placed it behind him again. Interview on 4/5/22 at 12:15 p.m. with registered dietitian (RD) D regarding resident 4's choking episode on 3/14/22. RD D stated: *The kitchen staff have had a large staff turnover over the last several months. *The provider has had difficulty maintaining a dietary manager. *The previous dietary manager had resigned and she did not think the new dietary manager F had started working. *On the day of the choking episode the person cooking and dishing up plates had been a temporary CNA. *RD D stated there had been times there were no cooks to fill empty slots. *The DON and others filled in when there was no cook. *On the day of the choking episode CNA J's focus was making sure every resident had food. -The focus was not on diets. *The current dietary manager had no experience in healthcare when he started but he was learning the diets. *When asked about the meal tickets RD D stated the provider stopped placing each resident's meal on the ticket because residents became upset when they were not served what was on the ticket. -The staff did not want to bring the meal ticket to the table because the residents became upset. -The fill-in staff had chosen easy foods to cook rather than follow the menu. -She confirmed the provider now had the menu on their meal ticket with the diet to be served and the amount and type of food to be served. -She was not sure why the ticket was not brought to each resident to confirm accuracy of the diet. *When asked about the binder for staff to reference she stated all questions about the binder needed to go to the DON because she was the one to put the binder together. I had nothing to do with that. *When asked if the binder was for the cooks or the CNA servers she stated it was probably for the cooks. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Observation on 4/6/22 at 8:25 to 9:00 a.m. of the center dining room revealed: *Resident 4 was sitting in a wheelchair facing the far west wall. -He had slid down in the chair and held an empty glass of water. No food or other drinks had been present. He was the only resident at the table. *CNA E sat on the east wall with three other residents who were receiving supervision or assistance. *CNA E would not have been able to see resident 4's face from where she was sitting. *This surveyor approached resident 4 and asked if he had already eaten. *The resident stated he had not and wondered if he was going to get breakfast. *This surveyor approached CNA E asked and if resident 4 could get his breakfast. -CNA E approached cook G and asked about his breakfast: *Cook G placed corned beef hash and scrambled eggs on a plate (that was part of his mechanical soft diet). *CNA E told the cook the resident was at risk for choking. *Cook G dished up two bowls of oatmeal and this was brought to the table. *A meal ticket had not been brought to the resident's table. *CNA E returned to the residents across the room and resident 4 sat alone facing the wall, and holding the oatmeal bowl to his chest to eat. He remained slightly slumped down in the wheelchair. *This surveyor questioned CNA E about resident 4's need for assistance with his meal. She stated: -He was capable of feeding himself. -He did not allow staff to feed him. -There were no available staff to sit with him. -She could see him from across the room. -She did not know why he was not given the plate of food that was dished up for him. *CNA E then sat with resident 4 and supervised him. Further interview with CNA E regarding resident 4 and the dining process revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*The CNAs did not bring meal tickets to the residents with their meal. *Only those residents who received meals eaten in their room received the meal tickets. *When asked about documenting the meal intakes after each meal she stated: -CNAs were supposed to document the meals of the residents down the halls they were assigned to but they did not come to the dining room to check their intakes because they were busy cleaning, removing garbage, and making beds on the unit. Interview on 4/6/22 at 9:00 a.m. with cook G revealed:*He did not know why resident 4's plate of food had not been given. *When asked what happened to the meal tickets after he dished up the residents' food he stated: -He threw them away. -Confirmed the meal tickets had an area to document meal intakes, but they had not been filled out. -He was not sure who was supposed to document the meal intakes. *When asked about a binder that was supposed to have been placed at the serving window, he brought this surveyor a menu book. Interview on 4/6/22 at 12:25 through 1:10 p.m. with assistant dietary manager H revealed: *She had: -Been an employee for approximately one year. -Worked as the dietary manager for approximately two months. *On the day of resident 4's choking event he had been served a french dip sandwich on regular bread. -The diets were not followed. *The binder: -Was supposed to be kept on the serving window. -Had been developed for the CNA's to refer to regarding each residents diet order and what foods were allowed and not allowed in each diet order. *The cooks were to have referred to the diet menu book for information. *The CNA's were supposed to bring the residents' meal tickets to their tables with their food to make sure the meal and diet were correct. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*She did not know who was supposed to be documenting meal intakes. *The dietitian had updated the CNA binder on 4/5/22 and it was to be updated weekly with dietary orders for the residents. *She was not sure who was to have updated the dietary care plans. Review of resident 4's medical record revealed:*A current order summary indicated: -A 7/22/21 diet order for: 'Regular diet, dysphagia [difficulty swallowing] mechanically altered (level 2) texture, thin liquids consistency. -A 3/16/22 order for ST to evaluate and treat. *A previous 5/18/21 therapy note by speech language pathology (SLP) K for a swallowing screen referral indicated resident 4 had been found cheeking 10+ peanuts in mouth over the weekend. Pt [patient] unable to chew. Resident 4 refused to participate in an assessment. SLP K recommended the use of universal swallow precautions for decreased pocketing episodes:-To sit upright in his wheelchair for all oral intake. -Cueing to eat and swallow at a slow rate. -Cueing to take small bites and sips. -Encouraging alternating liquids and solids. -Assessing the oral cavity following oral intake to ensure his mouth had been cleared. -Oral care following meals. *A 7/22/21 SLP K evaluation provided recommendations for: -IDDSI 5/0 thin liquids (minced moist foods with thin liquids). -Oral care following all meals. -Caregiver assistance/supervision as needed with feeding. The SLP indicated he required supervision/assistance due to significant history of food pocketing twenty-six to forty-nine percent of the time. -Caregivers were to provide cueing for using small bites, slow rate of intake, alteration of foods and liquids, and use of a mouth sweep to monitor for clearing food. -There was a diagnosis of dysphagia, oral phase. Dietitian notes had been requested from the DON on 4/6/22. This surveyor received only a 1/11/22 Dietary Evaluation. That evaluation indicated his diet: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Was a concentrated carbohydrate diet with regular consistency and thin liquids. -The resident did not have functional problems that affect his ability to eat. -He had no behavioral problems. -He was independent with set-up and eating. Review of resident 4's revised 4/1/22 care plan related to his swallowing problems and choking event revealed:*He had dementia which resulted in the need for an altered texture diet due to swallowing problems related to dementia progression. -A 12/6/19 Activities of Daily Living (ADL) care plan indicated he required assistance with eating. *The goal was that he would not experience weight changes. *He could choose his own food choices at meal and snack times. *There were no interventions on the care plan to guide the staff for prevention of safe eating as recommended by the SLP. Interview on 4/6/22 at 2:20 p.m. with DON B and occupational therapist registered (OTR)/director of rehabilitation (DOR) L and regional nurse consultant C revealed:*Resident 4 had a 3/16/22 order for speech therapy but it was decided that the choking episode was not a resident problem but a staff issue due to the resident receiving the wrong diet. -He will be receiving SLP therapy to work on communication due to his verbal outbursts including at mealtime. *They: -Stated the previous SLP recommendations for assisting the resident with eating safely were just universal guidelines and not specific for the resident. -Confirmed: --Those guidelines had not been added to his care plan. --The care plan was not specific and did not address interventions to prevent choking. --Education was provided for use of the binder for the aides to use, but had not been utilized by the staff. *Regarding the lack of consistent meal intake documentation the DON stated before the pandemic the dietary aides were documenting the meals but that had stopped when residents were not eating in the dining rooms. -The provider planned to have the dietary aides document intakes again. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*Regarding dietitian evaluations for resident 4 the DON stated she was unable to locate further documentation. *Head of therapy L stated resident 4 could be observed for choking from across the room. *Nurse consultant confirmed: -The meal tickets should have been brought to each resident during meals to monitor for correct diets. -The diets had not been followed on 3/14/22, but should have been followed. Review of the provider's September 2019 clinical management policy revealed:*Care planning was to have been constantly in process. *The physicians' orders in conjunction with the care plans constitute the total plan of care. *The DON would be responsible for holding the team accountable to initiating and updating the care plan. *Each staff member working with the individual resident is responsible to read, utilize, and offer input to improve the care plan. *Care plans were to have been updated between care conferences as changes occur. Requests for policies regarding safe feeding, monitoring for choking, documentation of oral intakes, and the use of the new binder protocol had been made to the DON. No policies had been provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45383 Based on interview, record review, and policy review the provider failed to ensure medication destruction and accountability had been properly completed by one registered nurse (RN) and a witness to prevent diversion for: *Two of two closed sampled resident records (1 and 2). *One of one current sampled resident record (3). Findings include: Review of report submitted by the provider to the SD Department of Health on 4/1/22 at 11:06 a.m. revealed this investigation. Findings include: *The facility had not been aware of any medication improperly removed from the facility until a detective arrived on 3/14/22. *The following medication had been in possession of licensed practical nurse (LPN) D. *Medication belonging to resident 1 included: -Duloxetine 60 mg: 21 capsules remaining out of a 30 in the blister pack. *Medication belonging to resident 2 included: -Seroquel 25 mg. None remaining in the blister pack. *Medication belonging to resident 3 included: -Levothyroxine 50 mcg: 11 remaining out of 30 in the blister packs. *Gabapentin 600 mg: 6 remaining out of a unknown amount. Interview on 4/5/22 at 3:30 p.m. with director of nursing (DON) B revealed: *Discontinued medication provided by PharMerica Pharmacy were scanned and returned to the pharmacy. *They did not keep a log count of discontinued/returned medication to PharMerica pharmacy. *They had been keeping a log count of discontinued/returned medication since 3/14/22. *Medication that were not provided by PharMerica are logged and counted and destroyed upon discontinuation. -Those log sheets are scanned into the resident's medical record. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The facility does not keep a copy of any log sheets for medication that had been returned to PharMerica. *If DON B was not working at the time of discontinuation of any medication, the medication would be kept in the medication cart until she removed it. *She had been trying to remove discontinued medication and destroy medication every day. *She had been doing this since October 2021. Interview on 4/5/22 at 3:40 p.m. with regional nurse consultant C revealed: *She had conducted the investigation for the diverted medication. *She had provided information from PharMerica manifests of medication dispensed to the provider. Interview on 4/6/22 at 7:45 a.m. with DON B regarding logs for destroyed medication revealed she: *Did not have a log for medication that were returned to PharMerica or destroyed prior to 3/14/22. *Stated that PharMerica had been keeping track of that. *Stated the provider received a daily audit of medication administered and medication count. Interview on 4/6/22 at 12:45 p.m. with regional nurse consultant C regarding her investigation report revealed: *Her report was submitted to the SD Department of Health. *Staff had been made aware of the investigation. Review of policy for Disposal of Medication by PharMerica dated 2007 utilized by the provider revealed: *A non-controlled medication disposition log or form shall be used for documentation and shall be retained as per federal privacy and state regulations. The log would contain: *Resident's name, medication name and strength, prescription number, quantity/amount disposed, date of disposition, signatures of required witnesses. *DON B stated they did not use that policy since there was no regulation for non-controlled medication.