STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29354 45095 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (4) received personal care promptly during the night. Findings include: 1. Observation and interview on 9/28/21 at 3:10 p.m. with resident 4 in his room revealed he: *Was sitting up in his wheelchair. *A pressure reduction mattress was on his bed and a pressure reduction cushion was on his wheelchair. *Stated he had waited up to one and a half hours during the night for staff assistance with toileting. *Stated call light answering times were a continuous issue during the night, but call lights were answered in a reasonable time during the day. *Had a sore, red bottom due to incontinence that sometimes started to get better but then returned to being sore and red, and felt it was due to his being incontinent and having to wait during the night for long periods for staff to answer his call light. Interview on 9/29/21 at 7:45 a.m. with agency licensed practical nurse (LPN) L regarding resident 4 revealed: *His dressing changes were completed between 6:00 a.m. and 6:30 a.m. prior to getting him up in the morning. *He refused to wait for the surveyor to observe his dressing changes. *He was transported to the veteran's administration (VA) hospital daily for a intravenous (IV) antibiotic infusion related to a Methicillin-Resistant Staphylococcus Aureus infection in his left second toe. (continued on next page)

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.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The call light logs for him were requested from the provider on 9/29/21 at 11:30 a.m. Corporate nurse consultant H stated no call light logs were available as the facility's system was too old to track that. Review of resident 4's medical record revealed: *An admitted [DATE]. *His Brief Interview for Mental Status examination score was eleven indicating moderately impaired cognition. *Diagnoses of lymphedema, body mass index [BMI] 32.0-32.9, muscle wasting and atrophy unspecified site, other forms of dyspnea, abnormal posture, shortness of breath, cellulitis of left lower limb, heart failure, history of falling, low back pain, other dystonia, other recurrent depressive disorders, peripheral vascular disease, diabetes mellitus with diabetic neuropathy, venous insufficiency(chronic)(peripheral). *The 6/11/21 quarterly Minimum Data Set assessment revealed he: -Required extensive assistance of two for bed mobility and toilet use. -Was always incontinent of bowel. -Was at risk of developing pressure ulcer/injuries. -Was not on a turning/repositioning program. -Required limited assistance of one person for personal hygiene. *The 9/10/21 quarterly Braden Scale score was fourteen and revealed he was at high risk for pressure ulcer/injury. *The 9/16/21 skin evaluation revealed he had alteration in skin integrity, with a pressure ulcer to his left and his right buttock. *The 9/23/21 skin evaluation revealed resident without alteration in skin integrity. *Wound assessment details reports dated 8/26/21 revealed the following wounds with wound care being completed for: -Left ankle unstageable pressure ulcer. -Left dorsal vasculitis. -Left second toe venous stasis ulcer. -Left lower extremity lateral vasculitis. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Plan with most recent revision date of 8/12/21 had the following focus areas as follows: *Impairment of skin integrity. *He had extensive care needs and required the support/services of the long-term care setting. *He was at risk for alteration of bowel and bladder functioning related to decreased mobility and weakness. *The goals listed were as follows: -He would not develop signs and symptoms of infection on his pressure ulcer sites and would show improvement of healing through his next review period, and resident's care needs would be provided during the stay at the facility. -He would remain free from skin breakdown due to incontinence through his next review period. *The interventions listed were as follows: -Apply wound treatments as ordered by the physician, see treatment administration record (TAR). -Assess for pain and administer pain medication as ordered, observe feedback, and notify medical doctor as necessary. -Encourage good nutrition and hydration to promote healthier skin. -Heel boots. -Keep air mattress on my bed and pressure reducing cushion in his wheelchair, encourage to lie down for leg elevation. -Lymphedema pumps to bilateral legs twice daily. -Monitor/document location, size, and treatment of skin injury. -Turn and reposition every two hours. -Wound care to left lower extremities. -A thin layer of Zinc to buttock/gluteal cleft area as needed and every shift for maceration. -Barrier cream to inner buttocks and surrounding skin twice a day and as needed. -The facility will provide care to enable the resident to function at their most practical level and support my adjustment towards the residence in a homelike environment. -If incontinent, apply moisture barrier to the peri-area after incontinent episode. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Keep call light within reach. -Remind, offer, and assist with toileting as needed. Will use urinal, keep within his reach, will use bedpan if in bed. -Report to nurse any signs and symptoms of discomfort on urination or defecation and frequency. The provider's orders listed on the treatment administration record (TAR) included: *Barrier cream to inner buttocks and surrounding skin twice daily and as needed. *A thin layer of Zinc to buttock/gluteal cleft area as needed and every shift for maceration. *Skin assessment every Friday. Interview on 9/29/21 at 2:35 p.m. with resident 4 regarding the call light response time during the night revealed: *He had just returned from the VA hospital where he received his IV antibiotic infusion. *He was in his room, lying in bed, and the staff had been in approximately fifteen minutes ago, and had applied his cream for his sore, red bottom. *He denied any history of having had pressure ulcers to his bottom. *His room had a large clock on the wall opposite from his bed. *He knew how long it had taken for his call light to be answered because he looked at his clock on the wall. *Some nights had been worse than others for answering his call light. -It depended on who the charge nurse on duty was. Interview on 9/29/21 at 2:45 p.m. with nurse aide in training N regarding the condition of resident 4's skin revealed: *She had been in his room that afternoon and had assisted another certified nursing assistant (CNA) to put him in his bed. *They had completed a brief change that included skin care and the application of his barrier cream kept in his room. *His bottom had been red, irritated without any opened areas. Interview on 9/29/21 at 3:05 p.m. with CNA O regarding the condition of resident 4's skin revealed: (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She had applied barrier cream to his bottom after they had laid him down and completed a brief change that afternoon. *His bottom had been red and irritated without any opened areas. *She had not reported that to the nurse as it was not new and the red, irritated skin on his bottom had been ongoing. Interview on 9/29/21 at 3:25 p.m. with LPN L regarding the condition of resident 4's skin revealed: *She reported she had applied barrier cream with Zinc on 9/28/21 during the evening part of her shift to his bottom. *His bottom continued with macerated, redness, and irritation, but she stated his skin on his bottom had been improving with the opened areas now closed. *His zinc barrier cream had been kept in his room for the CNAs to apply with brief changes and as needed during the day. *The treatment was signed off on the TAR by nursing when they had confirmed the CNAs had applied the barrier cream. Interview on 9/30/21 at 7:58 a.m. with resident 4 regarding long call light wait times revealed: *He had reported the long call light wait times during the night over and over, multiple times. *He had reported it at resident council meetings stating and I am not the only one. *It would be so nice to get something done about it. *He reported we had lost a lot of good night workers, not just people, but numbers, they had gone from having four workers at night to two workers at night. Interview on 9/30/21 at 8:08 a.m. with social service designee K regarding call light response times during the night revealed: *Her expectations were for call lights to be responded to within fifteen minutes. *She was aware of ten to twelve residents that had complained at resident council about long call light response times at night and one of them had been resident 4. *Residents had verbalized they were aware they had to wait a little longer at night to have call lights answered and were aware there were less staff at night. *She denied being aware of complaints that resident 4 had waited one and a half hours for a call light to be answered during the night. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She reported call light audits had been completed as a follow-up to the complaints for the long waiting at nighttime for the call lights to have been answered. *Call light audit reports were requested by the surveyor. Interview on 9/30/21 at 8:22 a.m. with director of nursing (DON) B, assistant DON I, and corporate nurse consultant H regarding call light response times revealed: *She was aware resident 4 had complained regarding long waits for call light response times during the night. *She had been made aware of the issue through staff reports. *She stated he was not accurate, he exaggerated, and she had attributed that as mood-related and staff-related. *She stated the issue had been due to his not liking black staff and he had chosen to wait for other staff to help him. *Her expectation for call light response times were as soon as staff had seen the call light. *She agreed resident 4 had been at risk for developing a pressure ulcer/skin injury. *His Braden assessment, care plan, and progress notes had been reviewed during the interview and a paper copy of each had been provided. *She agreed: -One and a half hours was too long to wait. -They should have been able to provide accommodations for him and answered his call light. -The resident's choice to wait for a different staff to help him during the night should have been on his care plan. Interview on 9/30/21 at 8:33 a.m. with resident 4 regarding call light response times revealed: *He had chosen to wait for a different staff to help him sometimes. *Not all of the black staff were bad, a few were good. *He would not turn down good help. *He had gotten into a conflict with a few of the staff. Review of the provider's Call Light audit reports dated 6/18/21 and 7/12/21 revealed resident 4 had not been included in the call light audits. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider's resident council minutes dated 7/12/21, 8/9/21, and 9/13/21 revealed: *Call lights were being answered timely, sometimes it had taken a little longer on the weekends or during mealtimes. *All cares were being met. Review of the provider's September 2019 Resident Dignity and Privacy policy revealed: *2. The resident's former lifestyle and personal choices will be considered when providing care and services to meet the resident's needs and preferences. *10. Each resident will be provided equal access to quality care regardless of diagnosis, severity of condition or payment source. Review of the provider's September 2019 Care Planning policy revealed: *1. Each resident is an individual. The personal habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patterns as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins at the moment the resident is admitted to the facility and doesn't end until discharge or death. Review of the provider's April 2021 Skin Program policy revealed: *To provide care and services to prevent injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds. Review of the provider's January 2020 Call Lights policy revealed: It is the policy of the facility that there is prompt response to the resident's call for assistance. 1. Facility shall answer call lights in a timely manner. If immediate assistance cannot be provided and there is not an emergent need, call light may be turned off and resident informed that staff members will be back to assist them shortly.

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents a notice of rights, rules, services and charges. 43021 Based on observation, interview, and document review the provider failed to ensure residents were informed of all of his or her rights prior to or upon admission and during the resident's stay. Findings include: 1. Interview with the resident group on 9/28/21 with ten residents from 1:30 p.m. through 2:00 p.m. revealed when resident rights were discussed and asked if the staff provide ongoing communication to residents about their rights, either orally or in writing, the group's response was no. 2. Interview on 9/29/21 at 8:45 a.m. with the social service designee (SSD) K revealed she was: *Not aware of a poster displaying all of the resident rights of the residents of this facility. *New to coordinating the resident council meetings for the last four months.: 3. Review of the last three months of resident council meeting minutes revealed: *July and September 2021 reviewed the same resident right of dignity. *August 2021 no resident right was reviewed. Review of the documents provided upon admission revealed: *The facility's admission agreement referred to the resident's rights handbook and incorporated it into the admission agreement. *The Long Term Care Facilities Resident's [NAME] of Rights provided by the facility was from the South Dakota Department of Social Services dated September 2012. -The most updated resident's rights handbook was dated August 2019. -The August 2019 handbook contained significant updates from the older, September 2012 version. 4. Interview on 9/29/21 at 1:02 p.m. with administrator A, SSD K, and corporate nurse consultant H revealed and confirmed: *There were significant changes between the September 2012 resident's rights handbook provided by the facility upon admission and the current August 2019 updated resident's rights handbook. *No comprehensive resident's rights poster was posted in the facility. *They would look into getting this information. *The last three months of resident council meeting minutes revealed: (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two months the same resident right of dignity was reviewed. -One month no resident right was reviewed.

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 43021 Based on observation and interview the provider failed to ensure the ombudsman and South Dakota Department of Health (SD DOH) information had been posted in a location accessible to the residents, visitors, and families. Findings include: 1. Interview with the resident group on 9/28/21 from 1:30 p.m. through 2:00 p.m. revealed: *The residents were unaware of where to find contact information for the Ombudsman. *The residents were not aware they could contact the SD DOH directly and/or file a complaint with the SD DOH. 2. Observations on 9/28/21 at 2:00 p.m., following the resident group meeting, 9/29/21 at 8:30 a.m., and 9/30/21 at 1:00 p.m., when exiting the facility, did not find: *The ombudsman's contact information posted. *The SD DOH contact information posted. *A statement that the resident may file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 3. Interview on 9/29/21 at 8:45 a.m. with the social service designee (SSD) K confirmed: *Ombudsman's contact information was not posted. *SD DOH contact information was not posted. *A statement was not posted that the resident may file a complaint with the SD DOH concerning any suspected violation of state or federal facility regulations. 4. Interview on 9/29/21 at 1:02 p.m. with administrator A, SSD K, and corporate nurse consultant H confirmed: *Ombudsman's contact information was not posted. *SD DOH contact information was not posted. *A description of how to file a complaint with the state survey agency, SD DOH, was not posted. *They would look into getting the information posted.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on observation, interview, and record review the provider failed to ensure safe/clean/comfortable/homelike environment had been maintained in two of two wings (West and Center).: *Spider webs had been in multiple areas of the building. *Peeling wallpaper, *Chipped paint on walls. *Numerous water stains on ceiling tiles. Findings include: Observation on 9/29/21 at 3:58 p.m. revealed: 1. Satellite kitchen in the [NAME] wing had spider webs in windows, on the outside, extending the length of the window and extending upwards approximately 4, they were very thick and white in color. Review of contracting pest control company records revealed: *Service was provided on 2/16/21, 3/15/21, 4/19/21, 5/26/21, 6/16/21, 7/13/21, 8/16/21, and 9/21/21. -There had been no record of the interior of the building being treated for spiders. Interview on 9/30/21 at 11:30 a.m. with maintenance director C revealed: *He was aware of spider webs in various locations outside of the facility. -The contracting pest control company had not treated the interior of the building for spider's due to concerns it may cause to resident's health. Interview on 9/30/21 at 8:32 a.m. with administrator A revealed he agreed there were spider webs attached to the outside of the windows in the dining room. 2. Observation on 9/29/21 at 2:55 p.m. revealed there had been: *Multiple areas of peeling wallpaper in the hallway containing rooms 218 to 225, which 12 residents resided in. -A strip of torn and missing wallpaper between rooms [ROOM NUMBERS], measuring approximately 1.5 foot by 2 inches, next to the handrail. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Observation throughout 9/27/21 from 4:03 p.m. to 6:00 p.m. and on 9/28/21 from 8:00 a.m. to 4:00 p.m. revealed: *There had been numerous door frames that had paint chipped and missing. *The white wall board on the bottom half of the walls in the dining room had chipped and missing paint in many areas. Interview on 9/30/21 at 8:42 a.m. with administrator A revealed he had been aware of the environmental concerns. 45383 4. Observation on 9/28/21 at 8:30 a.m. of the walls on the 200 wing of the facility revealed wallpaper peeling in numerous areas down the hallway. *Cobwebs with dead bugs near the ceiling by the dayroom across from room [ROOM NUMBER]. *Dead bugs near the base board next to room [ROOM NUMBER]. *Water stains on the ceiling in the hallway and on the ceiling in resident room [ROOM NUMBER]. Observation on 9/29/21 at 9:00 a.m. of the walls on the 200 wing revealed: *Cobweb with dead bugs and the dead bugs near the base boards were still present. Interview on 9/29/21 at 2:30 p.m. with housekeeping supervisor G revealed: *She had been short-staffed and is finally getting a full staff. *She is planning on stripping the peeling wall paper and painting the walls. *She said she would remove the cobweb with dead bugs and sweep the base board to remove dead bugs before she left work today. Observation on 9/30/21 at 9:30 a.m. of the walls on the 200 wing revealed: *Cobweb with dead bugs and the dead bugs on the base board were still present.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 45383 Based on observation, interview, and record review, the provider failed to ensure two of two sampled residents had comprehensive care plans: Provider failed to ensure two of two sampled residents' (3 and 4) care plans had included: *One resident (3) with a pressure injury. *One resident (4) with concerns with staff assisting him. Findings include: 1. Observation on 9/27/21 at 3:35 p.m. revealed resident 3 lying on his back in his bed. *Resident 3 had an air mattress on his bed. *He was wearing Prevlon boots while in bed. Interview with director of nursing (DON) B on 9/28/21 at 1:10 p.m. revealed: *Resident 3 was admitted [DATE] with a pressure ulcer. *Skin assessment was performed weekly and documented in the electronic medical record (EMR). Interview with resident 3 revealed: *He has a pressure injury, but is not sure where it is located on his body. *Resident's brief interview of mental status (BIMS) on 9/11/21 was 11, meaning he was moderately impaired. Record of resident 3's record review revealed: *On 6/22/21 treatment order received for coccyx/sacral wound care: Cleanse with soap and water. Apply No-Sting around the wound. Apply Medihoney in/in wound, cut white foam to size over wound and around three of four edges, but not cover 6:00. Cover with boarded foam Mepilex. Change every 3 days and as needed for if loose or soiled. *Skin assessment was performed every week and documented in EMR. *Care plan focus for resident 3 stated I am at risk for skin impairment related to immobility. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Goal for resident 3 stated my skin will be intact through next assessment period. *Interventions listed were: -Air mattress on bed. -Monitor skin when providing personal cares. Notify nurse of any skin concerns. *Facility failed to comply with facility's own care plan policy, resident 3's care plan does not include: -Current pressure ulcer and treatment. -Dietary notes for dietary modification for wound healing. -Reposition resident at least every 2 hours. 45095 2. Observation and interview on 9/28/21 at 3:10 p.m. with resident 4 in his room revealed he: *Was sitting up in his wheelchair. *A pressure reduction mattress was on his bed and a pressure reduction cushion was on his wheelchair. *Stated he had waited up to one and a half hours during the night for staff assistance with toileting. *Stated call light answering times were a continuous issue during the night, but call lights were answered in a reasonable time during the day. *Had a sore, red bottom due to incontinence that sometimes started to get better but then returned to being sore and red, and felt it was due to his being incontinent and having to wait during the night for long periods for staff to answer his call light. Interview on 9/29/21 at 2:35 p.m. with resident 4 regarding the call light response time during the night revealed: *He had just returned from the veteran affairs (VA) hospital where he received his intravenous antibiotic infusion. *He was in his room, lying in bed and the staff had been in approximately fifteen minutes ago, and had applied his cream for his sore, red bottom. *He denied any history of having had pressure ulcers to his bottom. *His room had a large clock on the wall opposite from his bed. (continued on next page)

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	435039	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He knew how long it had taken for his call light to be answered because he looked at his clock on the wall. *Some nights had been worse than others for answering his call light. -It depended on who the charge nurse on duty was. Interview on 9/30/21 at 7:58 a.m. with resident 4 regarding long call light wait times revealed: *He had reported the long call light wait times during the night over and over, multiple times. *He had reported it at Resident Council meetings stating and I am not the only one. *It would be so nice to get something done about it. *He reported we had lost a lot of good night workers, not just people, but numbers, they had gone from having four workers at night to two workers at night. Interview on 9/30/21 at 8:22 a.m. with the director of nursing (DON) B, the assistant DON I and the corporate nurse consultant H were present, regarding call light response times revealed: *She was aware resident 4 had complained regarding long waits for call light response times during the night. *She had been made aware of the issue through staff reports. *She stated he was not accurate, he exaggerated, and she had attributed that as mood-related and staff-related. *She stated the issue had been due to his not liking black staff and he had chosen to wait for other staff to help him. *Her expectation for call light response times was as soon as staff had seen the call light. *She agreed: -One and a half hours was too long to wait. -They should have been able to provide accommodations for him and answered his call light. -The resident's choice to wait for a different staff to help him during the night should have been on his care plan. Interview on 9/30/21 at 8:33 a.m. with resident 4 regarding call light response times revealed: *He had chosen to wait for a different staff to help him sometimes. *Not all the black staff were bad, a few were good. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*He would not turn down good help. *He had gotten into a conflict with a few of the staff. Review of resident 4's medical record revealed: *The 6/11/21 quarterly Minimum Data Set assessment for resident 4 revealed he: - Required extensive assistance of two for bed mobility and toilet use. - Was always incontinent of bowel. - Was at risk of developing pressure ulcer/injuries. - Was not on a turning/repositioning program. *Care Plan with most recent revision dated 8/12/21 had the following: -Keep air mattress on my bed and pressure reducing cushion in his wheelchair, encourage to lie down for leg elevation. -Turn and reposition every two hours. -The facility will provide care to enable the resident to function at their most practical level and support my adjustment towards the residence in a homelike environment. -Remind, offer, and assist with toileting as needed. Will use urinal, keep within his reach, will use bedpan if in bed. *It did not include he refused certain staff and did not have interventions for this. Review of the provider's September 2019 Care Planning policy revealed: *1. Each resident is an individual. The personal habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical diagnosis-based care considerations. 2. Each resident has the right to be happy, continue their life-patterns as able, and feel comfortable in their surroundings. 3. Care planning is constantly in process; it begins at the moment the resident is admitted to the facility and doesn't end until discharge or death. Refer to F558

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45383 A. Based on observation, interview, record review and policy review,the provider failed to ensure that professional standards were followed for one of one sampled resident (54) who had fallen and hit her head while taking an anticoagulant. Findings include: 1. Observation and interview on 9/28/21 at 10:58 a.m. Resident 54 revealed she: * Was sitting in her wheelchair with a noticeable yellow and green bruise to her entire face. * Had fallen last Thursday night 9/16/21. *Had felt dizzy while going to the bathroom and she fell and hit her head on the wall in her room. Record review of resident 54 medical medical record revealed she: *She had the potential for bruising and hemorrhage due to anticoagulation use. *On 9/8/21 order for Warfarin 3 milligrams orally to be given at bedtime related to abnormal coagulation. *On 9/17/21 4:49 p.m. Unidentified nurse author identified bruising on her forehead and had reported falling last night. *Management and resident 54's emergency contact were notified of fall and bruise. *Vital signs , neurological assessment and orientation are within the normal limits. *No documentation of notifying E-care or physician at the time of incident. *ON 9/18/21 at 1:23 a.m. Unidentified nurse author documented resident reported falling last [HS] bedtime after being asked about her bruised forehead. Neurological assessment within resident 54's baseline. *On 9/18/21 11:52 a.m. an Unidentified nurse author noted the bruising to her forehead is worse. -She is complaining of feeling dizziness. -E-care was notified and video visit done. -They received orders from the certified nurse practitioner (CNP) to transfer resident 54 to the ER. *She did not have a care plan that addressed risk for falls. Interview on 9/29/21 at 1:10 p.m. with director of nursing (DON) B revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Management was in the facility at the time of the incident, they were not notified. *Risk management form was not completed by nurse for resident 54 fall. *The providers post fall assessment was not completed by nurse. *E-care of resident 54's provider was not notified by nurse at the time of the incident. *Provider via E-care video visit was notified on 9/18/21 at 11:52 a.m. *Providers fall policy was not followed by nurse. *They use Lippincott's Nursing Procedures as their reference for professional standards. 29354 B. Based on observation, interview, and manufacturer's recommendation review, the provider failed to ensure insulin pen preparation and administration for one of one sampled resident (38) by one of one observed registered nurse (RN) (J) had been completed according to the manufacturer's instructions to ensure an accurate dose had been given. Findings include: 1. Observation on 9/27/21 at 5:10 p.m. with RN J in the hallway beside the medication cart revealed: *She removed two insulin pens from the top drawer of the medication cart. -Took the NovoLog Flex Pen, cleansed the end of the pen, inserted a needle, and dialed the gage to 4. -Took the Tresiba Flex Touch, cleansed the end of the pen, inserted a needle, and dialed the gage to 12. *She had not primed the insulin pens before selecting the units to be administered. *She went into resident 38's room and administered both insulin pens. Interview on 9/29/21 at 8:30 a.m. with director of nursing B and corporate nurse consultant H regarding the above observation of RN J not priming the NovoLog Flex Pen and the Tresiba Flex Touch insulin pens before administration revealed their expectations would have been for the insulin pens to have been primed before administration. Review of the manufacturer's NovoLog FlexPen instructions revealed: *Remove the cap. -Pull off the pen cap and wipe the rubber stopper with an alcohol swab. *Attach a new needle. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pull off the paper tab. -Push and twist the needle on until it is tight. -Pull off both needle caps. *Prime your pen. -Turn the dose selector to select 2 units. -Press and hold the dose button. -Make sure a drop appears. *Select your dose. -Turn the dose selector to select the number of units you need to inject. Review of the manufacturer's Tresiba Flextouch insulin pen instructions revealed: *Attach a new needle. -Pull off the paper tab. -Push and twist the needle on until it is tight. -Pull off both needle caps. *Prime your pen. -Turn the dose selector to select 2 units. -Press and hold the dose button. -Make sure a drop appears. *Select your dose. -Turn the dose selector to select the number of units you need to inject.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29354 Based on closed record review, interview, document review, and policy review, the provider failed to ensure one of one sampled resident closed record (107) had: *Her physician's orders for reporting her blood pressure readings followed. *Her care plan reviewed and updated to reflect her current needs. Findings include: 1. Review of resident 107's closed medical record from [name of long-term care facility] revealed: *She had been admitted on [DATE]. *Her diagnoses included hypertension, wedge compression fracture of fourth thoracic vertebra, unsteadiness of feet, low back pain, weakness, anxiety, esophagitis, chronic pain, COPD with acute exacerbation, depression, diverticulitis, fibromyalgia, shortness of breath, and vitamin D deficiency. Review of the 9/13/21 through 10/4/21 medication administration records and physician's orders for resident 107 revealed: *The 9/14/21 physician's order was to: -Increase lisinopril to 20 milligrams (mg) oral every day. -Give an extra dose of lisinopril10 mg orally one time now. -Check vital signs every hour times four hours, report if systolic blood pressure was greater than 150. *There was no documentation her blood pressure had been checked every hour times four hours. *The 9/15/21 physician's order was to: -Do vital signs daily, report systolic blood pressure greater than 150. -Increase lisinopril to 30 mg oral every day. *Her systolic blood pressure had been documented twice on 9/16/21 as 172 and 196. *There was no documentation the physician had been notified on 9/16/21 her systolic blood pressure had been greater than 150 twice. Review of resident 107's care plan with the following date focused areas were initiated revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*9/15/21: Is at risk for altered cardiovascular functioning related to: Hypertension. *Interventions included monitor vital signs as ordered. Report to MD for any changes. Obtain labs and weights as ordered. Review of the provider's December 2019 Notification of Change of Condition policy revealed: *The facility will provide care to residents and provide notification of resident change in status. *Procedures: -1. The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is: --b. A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). 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. *5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' -Physician's orders are referenced in the resident's care plan, but not rewritten into that care plan. *The Resident-Centered Care Plan Format: -5. Interventions act as the means to meet the individual's needs. *Procedure: -9. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. Information received from the provider during the survey regarding the provider's Documentation policy revealed: *They used the [NAME] Nursing Manual, edition 11, copyright 2019, page 15. *The document presented to the surveyor revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5. A deviation from the protocol should be documented in the patient's [resident] chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. -This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29354 Based on closed record review, interview, document review, policy review, and information submitted to the South Dakota Department of Health (SD DOH), the provider failed to ensure one of one sampled closed resident record (107): *The physician's orders to weigh weekly were followed. *The care plan was reviewed and updated to reflect her current needs. Findings include: 1. Review of [name of facility] Healthcare Online Self-Reporting received by the South Dakota Department of Health DOH on 10/6/21 regarding resident 107 revealed an anonymous concern that nursing staff had failed to care for her. Review of documents provided to the SD DOH prior to the 11/16/21 onsite revisit survey regarding resident 107 revealed: *She had been admitted to [name of hospital] from 9/6/21 through 9/13/21. *Diagnoses was T4 compression fracture, and she was found to be underweight. *She had been admitted to [name of long-term care facility] on 9/13/21. *On 10/5/21 her family had removed her from [name of long-term care facility] after they found her dehydrated, hypoxic, and having lost a significant amount of weight. *They had left AMA from the long-term care facility. *She was brought to [name of clinic] by her family. *The clinic recommended they take her to the emergency department due to dehydration, failure to thrive, and worsening from baseline. *She was admitted to [name of hospital] on 10/5/21. *The hospital's nutrition team evaluated her because she was severely underweight. -On 10/6/21 her weight was 69 pounds 4.8 ounces. -They diagnosed her with severe protein-calorie malnutrition at that time and gave her diet recommendations. -She was able to eat and drink in small amounts during her stay. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-She had lost eleven pounds in three weeks. *The palliative team was consulted to discuss pain management, code status, and potential need for hospice referral based on [name of resident] status. They met with the family on 10/9 [21] following permission from [name of resident] daughter. -Resident voiced she did not want cardiopulmonary resuscitation, intubation, or feeding tubes. -Her code status was changed to do not resuscitate. -She did not want further admission to the hospital. -She did not voice interest in hospice. *After discussing her care needs with her family members, they opted to take her home to care for her with home health referrals. *She was discharged on [DATE] to her family in fair condition with home health services. -Her diet on discharge was a gastric bypass diet. *On 10/5/21 both [name of clinic] and [name of hospital] records documented a diagnose of failure to thrive. 2. Review of resident 107's closed medical record from [name of long-term care facility] revealed: *She was admitted on [DATE] to the [NAME]/Rehab Unit. *Multiple diagnoses which included weakness, esophagitis, chronic pain, COPD with acute exacerbation, depression, diverticulitis, shortness of breath, and vitamin D deficiency. *Physician's orders for: -Regular diet, thin liquids consistency. -May follow registered dietitian recommendations. -Ensure three times a day for supplement. Record percentage consumed. -Weekly weight. Review of the 9/16/21 admission/5-day Medicare Minimum Data Set (MDS) assessment revealed: *Her Brief Interview for Mental Status examination score was twelve indicating she was cognitive. *She required extensive assistance of one staff for bed mobility, transfers, locomotion, dressing, toileting use, personal hygiene, and bathing. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was 62 inches tall, and weight was 80 pounds. *She did not have any eating issues. *She was not on a therapeutic diet. Review of resident 107's weight history and review of her 9/13/21 through 10/4/21 medication administration record (MAR) revealed: *On the following dates her weights were: -9/13/21: 80 pounds. -9/25/21: 78 pounds. --That was a 2.5% weight loss in twelve days. -No further weights had been documented at the facility. *The hospital had documented her admit weight on 10/6/21 as 69 pounds. -That was a 13.75% weight loss in twenty-two days. Review of the 9/16/21 registered dietitian (RD) dietary evaluation for resident 107 revealed: *Her most recent weight was 80 pounds on 9/13/21. *She leaves behind a significant proportion of meals, snacks, and supplements daily. *Her intake was less than 25% of meals. *Her overall intake of fluids was less than 1000 milliliters per day. *Ensure three times a day was offered. Review of resident 107's undated MDS Kardex Report for [name of facility] - SNF (skilled nursing facility) revealed: *Her short-term memory was ok. *She was independent in daily decision making. *Her speech was clear. *She was able to understand others and make herself understood. *She required set-up help with eating. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She was not marked for being on a hydration program. *She was not marked for nutritional problems for weight loss, fluid management, or intake and output. Review of resident 107's care plan when the following date focused areas were initiated revealed: *Interventions included assess for pain and encourage good nutrition and hydration. *9/28/21: Will experience no issues with PO [oral] intake through the next review period. -Interventions had not included weekly weights. Interview on 11/16/21 at 8:40 a.m. with CNA II regarding resident 107 revealed: *The resident would tell the staff she could only eat a few bites at a time because she had gastric bypass. *She did not like the Ensure. *They had tried clear Ensure and she did not like that. *She did not like ice cream. -They tried everything. *She had required some assistance with eating when she was on the COVID unit, but by the time she got back to [NAME] Wing she required more assistance with eating. *She took care of her on the [NAME] Wing following the COVID unit. *She would refuse the supplements. --They tried everything, but she had refused. Interview on 11/16/21 at 11:20 a.m. with physician KK regarding resident 107 revealed: *The certified nurse practitioner (CNP) or herself were in the facility a couple times a week. *If the facility had concerns with residents when they were not in the building, they would fax the concerns to their office. -Otherwise they would catch us in the hall. *She could not recall resident 107. -The name sounded familiar. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Her CNP might be able to recall any information from the facility regarding her decline. *She could not remember if there were any concerns brought to her attention regarding resident 107. Interview on 11/16/21 at 1:15 p.m. with RD E regarding resident 107 revealed: *They had weekly nutrition risk meetings. *She: -Checked residents' weekly weights in the computer. -Was aware the weekly weights were not getting done. -Did not know their process for obtaining weekly weights for residents with COVID. -Would leave a list of residents who needed their weights done with the nurses. *She knew resident 107: -Was not eating. -Not taking much of anything in. -Liked the chocolate Ensure. *She did not know what else they could have done for resident 107. 3. Review of the provider's January 2021 Weighing the Resident policy revealed: *The purpose of this procedure is to determine the resident's weight and height, to provide an ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident, and to provide a baseline height in order to determine the ideal weight of the resident. *Procedures: -3. Weight is measured upon admission, weekly for four weeks, and then monthly thereafter. *5. Report significant weight loss/weight gain to the nurse supervisor who will then report to the RD [registered dietitian] and physician. *7. The threshold for significant unplanned and undesired weight loss/gain will be based on the following criteria: -1 month - 5% weight loss is significant; greater than 5% is severe. Review of the provider's September 2019 Care Planning policy revealed: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*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. *5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' -Physician's orders are referenced in the resident's care plan, but not rewritten into that care plan. *The Resident-Centered Care Plan Format: -5. Interventions act as the means to meet the individual's needs. *Procedure: -9. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. Information received from the provider during the survey regarding the provider's Documentation policy revealed: *They used the [NAME] Nursing Manual, Edition 11, Copyright 2019, page 15. *The document presented to the surveyor revealed: -5. A deviation from the protocol should be documented in the patient's [resident] chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. -This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events.

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	435039	A. Building B. Wing	09/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Norton	3600 South Norton Avenue Sioux Falls, SD 57105

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 43844 Based on observation, interview, record review, and policy review, the provider failed to ensure: *Two of three sampled residents (18 and 25) had quarterly safety assessments for bed rail usage. *One of three sampled residents (25) had received risk of use versus benefits of use education and had obtained informed consent for bed rail. Findings include: 1. Observation on 9/28/21 at 11:32 a.m. of resident 18's room revealed: *She had been in her room. *Side rails on the upper half of her bed that were in the up position. *She was not in her bed at this time. Interview on 9/29/21 at 8:20 a.m. with certified nursing assistant (CNA) AA revealed resident 18 does use her side rails to assist in positioning when in bed. Review of resident 18's medical record revealed: *Her care plan had included the use of side rails. *She had safety assessments for the use of side rails completed on 1/25/21 and 4/19/21. -There had been no safety assessments for use of side rails completed after 4/19/21. 45095 2. Observation and interview on 9/28/21 at 9:13 a.m. of resident 25 revealed: *He had been assisted to the bed by CNA BB and CNA CC. *There were side rails on the upper half of his bed that were in the up position. *He was not observed using the side rails. Observation on 9/29/21 at 10:57 a.m. revealed resident 25's bed had side rails in the up position, he was not in the bed at that time. Review of resident 25's medical record revealed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His care plan stated he used side rails to assist with increased independence with bed mobility and repositioning. *There had been side rail/other device assessments completed on 1/23/21 and 7/29/21 which indicated he did not use side rails or other devices. *There had been no risk of use versus benefit of use education provided to him. Interview on 9/29/21 at 1:20 p.m. with corporate nurse consultant (CNC) H regarding side rail use for resident 25 revealed the provider did not have a side rail informed consent or a safety side rail assessment completed for him. Interview on 9/29/21 at 1:55 p.m. with director of nursing (DON) B and CNC H revealed the consent and risk versus benefit of use education had not been completed. Interview on 9/29/21 at 4:25 p.m. with DON B revealed: *She did not know why the consent and risk of use versus benefits of use education had not been completed for resident 25. *She did not know why the safety side rail assessment showed resident 25 did not use side rails. -The nurse manager would have been responsible to complete them. Review of the provider's November 2019 restraint policy revealed: *Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. -Physical restraint may include, but are not limited to: -b. Using bed rails to keep resident from voluntarily getting out of bed. *Resident 25 did not have any side rail assessments completed to determine if the side rails were a restraint or not.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. 43021 Based on observation, interview, and review of posted direct care staffing information, the provider failed to post the daily nurse staffing information. Findings include: 1. Random observations on 9/27/21 from 3:30 p.m. to 6:00 p.m.; 9/28/21 from 7:30 a.m. to 6:00 p.m.; and 9/29/21 from 7:30 a.m. to 1:00 p.m. did not find the daily nurse staffing information posted in the facility. 2. Interview on 9/29/21 at 1:00 p.m. with administrator A revealed that daily nurse staffing information was: *Not posted. *Completed by central supply/scheduler Y. *Kept in the nurse schedule binder. *Discussed with the director of nursing B on 9/29/21. *In process of getting posted in the facility. 3. Interview on 9/29/21 at 1:47 p.m. with central supply/scheduler Y confirmed that the nurse staffing information was kept in the nurse schedule binder and not posted before today. However, she stated that the nurse staffing information was posted today, 9/29/21 by the center nursing station. 4. Observation on 9/29/21 at approximately 2:00 p.m., following the interview with central supply/scheduler Y confirmed that the form Nursing Staff Directly Responsible for Resident Care dated 9/29/21 was posted on the bulletin board beside the activity bulletin board across from the center nursing station.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45383 43844 Based on interviews and job description review, the provider did not employ a full-time qualified registered dietitian (RD), and failed to ensure the dietary manager (DM) met the requirements to serve as a certified dietary manager (CDM). Findings include: 1. Interview on 9/29/21 at 1:40 p.m. with DM D revealed she: *Was not a CDM. *Had registered for the CDM course. -Was not able to start the program until the provider sent a check to pay for the program. *Stated RD E came each week on Tuesday's and was available by phone at all times. Telephone interview on 9/30/21 at 8:04 a.m. with RD E revealed she: *Did not work full-time for the provider, typically worked 5 to 8 hours per week. *Had been available as needed for any questions or concerns. *Had been aware that DM D was not a certified dietary manager. Interview on 9/30/21 at 8:51 a.m. with administrator A revealed: *The dietitian was not full-time. *He needed to mail a check to CDM program in order for the DM to start it. Review of provider's undated DM job description revealed the requirements included Proven experience as a manager and meets all education requirements needed for the position.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 43844 Based on observation, interview, and policy review, the provider failed to ensure: *The kitchen and multiple food storage areas within were maintained in a clean and sanitary manner. *Food was appropriately labeled and stored. *Refrigerators and freezers were appropriately maintained for best temperature control. *Water dispenser was maintained to avoid calcium build up. *Face shields and assorted gloves were appropriately maintained when not being used by staff. *Sanitizing buckets were maintained in good condition and sanitizing solution tested . *Janitor's closet was maintained with an effective drain. Findings include: 1. Observation on [DATE] at 3:45 p.m. during initial tour of the kitchen revealed: *Food particles in crevices of the floor through out the kitchen. *Dishwashing area had: -A metal shelf, measuring approximately three feet by one foot that had: --What appeared to be cardboard dried on to it, measuring approximately five inches by two inches. ---Making the shelf an uncleanable surface. --A salt shaker. --Two boxes of clean gloves, that had been opened. --A pair of obviously dirty yellow rubber gloves. -A dirty vinyl glove on the floor. *Counter near the juice dispenser had a dirty rag laying on it. *A white refrigerator contained: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-An open carton of milk with no open date. -Two boxes of apple juice opened with no open date. -Eight covered glasses of milk and juice with no open date. *The vent above dishwasher had chipped paint on the edges that extended over the clean dish area and the dirty dish area. *Clean dish room had dirty water on the floor. -A fan running, that had accumulated dust on the grill guard. *Main kitchen: -The counter by the juice dispenser had: --A bottle of hand sanitizer with a red spray lid sitting on top of an open box of unused vinyl gloves and next to an open box of drinking straws. --A wet wash cloth lying on the counter. *Microwave had dried spills on the inside of the door, the glass turning plate and the bottom and sides. *Two oranges had been on a gray serving tray that had crumbs of food and clean dessert dishes on it. *Numerous plate warming covers that had worn edges exposing the underlying plastic on them. *A face shield on the counter next to the toaster. *Two additional face shields on the counter, next to a food processor and a visibly dirty blue tooth speaker. -There had been crumbs of food on this area of the counter. Observation and interview on [DATE] at 3:49 p.m. with dietary aide F revealed: *She agreed there had been a wash cloth on the counter, and it should have been in a bucket of sanitizer. -Was not sure why it was there, she had just came to work. -Would have put it in a bucket with sanitizer. -Did not know how to test the sanitizer in the bucket to ensure there was enough. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	--Did not know she would need to verify there was enough sanitizer. -Agreed there had been one red plastic bucket used as a sanitizing bucket that had a crack on the side, approximately one and one-half inches long, and extending from the top downward. Continued observation on [DATE] at 3:51 p.m. revealed: *In the pantry there had been: -Debris on the floor. -Eight cases of food had been sitting on the floor. -Long-grained rice with a date of being opened of ,d+[DATE], inside a blue plastic sack, in a cardboard box, with rice exposed to the air. -Two Ziploc gallon bags of cereal not dated, that had been removed from the original container. -Gallons of mayonnaise and ranch dressing that did not have a use by date or an expiration date on them. -Five packages of grits had been expired on [DATE]. *Janitors closet opposite of the food storage room had a drain that did not work properly and produced a foul odor. *The walk-in cooler had ham in plastic Ziploc bag that had been stored on the same cookie sheet as two rolls of thawed hamburger. *The walk-in freezer had in it: -A plastic bag labeled shepherd's pie, dated [DATE] with ice crystals inside the bag. -A plastic bag labeled 'Chix, with no date on it and ice crystals inside the bag. -Frost on the left side of the circulating fan box measuring approximately one inch thick by eight inches wide. *The ice machine had stored on top of it: -Two face shields stored on top of it. -A pint-size mug with an unwrapped straw in it and no liquid in it. -A salt shaker. *The double door refrigerator had: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-A Rolaids package with one piece left in it was stored on the top shelf. -A package of tortillas with an open date of ,d+[DATE]. *The main dining room had a water and ice dispenser that had: -A white substance, that appeared to be calcium, on the dispensing spouts. -The grill sink area covered in a brown substance, that appeared to be grime. Interview on [DATE] at 4:24 p.m. with dietary manager (DM) D revealed she agreed: *Mayonnaise and ranch dressing did not have a use by or expiration date on them. *Two packages of cereal did not have an open date. -Stated the cereal is normally kept in Ziploc bags with an open date written on them and discarded 7 days after that. *The rice had not been stored safely. *Grits had been outdated. *The walk-in freezer had frost build up the circulating fan box. -Stated the walk-in freezer was defrosted every couple of days. Interview on [DATE] at 4:30 p.m. with DM D revealed: *She agreed the drain in the janitor closet had not been working properly. -They do not normally use the drain and had been disposing of dirty water somewhere else. Interview on [DATE] at 4:45 p.m. with DM D revealed she: *Agreed the ham and hamburger should not have been stored together. *Agreed that the plastic bags containing food in the walk-in freezer had been freezer burnt. *Had been aware one of the sanitizing buckets had a broken handle. -Was not aware one of them had a crack in it. *Staff were to test buckets of sanitizing solution least once a day. -They should be changed every two hours whether or not they had been used. *Agreed the plate covers were worn. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Had been planning on asking the administrator for approval to order new ones. *Agreed the water dispenser had not been cleaned for an unknown amount of time, and that it should have been cleaned at least daily. 2. Observation on [DATE] at 8:45 a.m. of the satellite kitchen revealed: *There had been a refrigerator labeled resident food only. -It had a temperature log taped to the freezer door. --There had been no temperatures taken for the month of September. -It contained the following foods: --A container of grape juice that had been opened and had no open date. --A carton of apple juice that had been opened and had no open date. --A carton of tomato juice with an open date of ,d+[DATE]. --4 individual cartons of chocolate milk that had been outdated on ,d+[DATE]. -The freezer portion of this refrigerator had a white substance that appeared to be ice-cream dried on the bottom shelf towards the back in the middle covering approximately 4 inches by 12 inches. Interview on [DATE] at 4:45 p.m. with DM D revealed the satellite kitchen refrigerators had not been used for months and she had thought housekeeping had been responsible to monitor the temperatures of them. 3. Observation on [DATE] at 9:05 a.m. of the Lounge at the end of the 218 hallway revealed: *There had been two refrigerators labeled resident only, they were labeled #1 and #2. -#1 had been missing temperatures for September on days 2, 6, 8, 12, 21, 22, 24, and 25. -#2 had been missing temperatures for September on days 2, 8, 11, 12, 21, 22, 24, 25, and 26. -There had been a small brown refrigerator with a broken handle that had sharp edges exposed. Interview on [DATE] at 1:40 p.m. with DM D regarding face shields revealed she: *Agreed face shields had been stored on top of the ice machine: -Stated the dietary staff had picked up the face shields when checking in to work, had worn them in the hallway on their way to the kitchen, and put them on top of the ice machine. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Stated, We don't usually wear our masks or face shields when we are in the kitchen, just when we deliver trays in resident care areas. *Agreed face shields had been stored on kitchen counter tops and should not have been. *Agreed face shields had been worn by dietary staff, were contaminated, and had not been stored appropriately. Observation and interview on [DATE] at 2:30 p.m. with housekeeping supervisor (HKS) G revealed: *Refrigerators 1 of 2 labeled resident use in the lounge at the end of 218 hallway findings include: -In refrigerator 2 there were two 2 pack of parboiled eggs dated [DATE]. --Two 4 pack of parboiled eggs dated [DATE]. --Two separate packaged bunches of green grapes that were not labeled or dated. ---All above items were discarded upon finding. *Housekeeping supervisor G agreed that items were outdated and should have been discarded sooner. *She states she thought the CNA's were helping with monitoring refrigerator 1 and 2. Interview on [DATE] at 2:32 p.m. with housekeeping supervisor HKS G revealed she: *Had started monitoring the resident refrigerator in the satellite kitchen on [DATE]. -Thought dietary had been monitoring it until then. *Did take temperatures on the refrigerators in the Lounge. -Was not aware several days had not had temperatures recorded. *Was not aware of the brown refrigerator. Interview on [DATE] at 2:36 p.m. with DM D revealed she thought the brown refrigerator had been in a medication room that had been moved to a new location. 4. Review of provider's ,d+[DATE] food safety requirements policy revealed: *Policy: It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods including those brought to residents by family and other visitors. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-The food service workers, cooks, dietary aides, dishwashers, food prep aides, or any person(s) who are in the kitchen working with any type of food, are responsible for to adhere to the food safety requirements. Review of provider's ,d+[DATE] food storage-dry goods policy revealed: *Policy statement: It is the center policy to insure all dry goods will be appropriately stored in accordance with guidelines of the FDA [Food and Drug Administration] Food Code. Action Steps: Dry Storage 1. The Dining Services Director or designee is responsible to store all items 6 inches above the floor on shelves. 5. The Dining Services Director or designee ensures that all packaged and canned food items shall be kept clean, dry, and properly sealed. 6. The Dining Services Director or designee ensures that the storage will be neat, arranged for easy identification, and date marked as appropriate. Review of the provider's ,d+[DATE] food storage: cold policy revealed: *Policy Statement: It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be appropriately stored in accordance with guidelines of the FDA Food Code. Attachments: 1. Food storage and retention guide. Review of provider's ,d+[DATE] food safety requirements policy (use and storage of food and beverage brought in for residents, food procurement) revealed: *Policy: It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors This includes the storage, preparations, distribution, and serving food in accordance with professional standards for food service safety. *Objective of policy: -(2) Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling process. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Procedure: c. Monitor i. Facility staff will be appointed to check resident refrigerators for proper temperatures, food containment and quality, and disposal of items per facility policy. D. Refrigeration: a .The following are methods to determine the proper working order of the refrigerators and freezers; b. Document the temperature of external and internal refrigerator gauges. Refrigerators must be 41 degrees or less. Freezers must be cold enough to keep foods frozen solid to the touch.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 43844 45383 Based on observation, interview, and policy review, the provider failed to maintain appropriate hand hygiene and glove use as well as procedural technique during: *Provision of personal cares for resident 3 by certified nursing aides (CNAs). *Dressing change for resident 3 by registered nurse (RN) J. Findings include: 1. Observation on 9/28/21 at 9:00 a.m. of personal care for resident 3 who was incontinent of bladder and bowel. Both CNA Z and CNA AA performed hand hygiene and put on clean gloves. CNA Z and CNA AA wear changed an incontinent brief. Resident 3 was incontinent of bowel. CNA Z used peri care cloth to remove BM[bowel movement] CNA Z tucked the soiled incontinent brief under the resident 3, then CNA Z placed a new incontinent brief under resident 3 without performing hand hygiene or changing gloves. CNA Z continued to secure resident 3 incontinent brief and pull his clean clothes up. CNA Z and CNA AA removed soiled items without wearing gloves. No hand hygiene performed. *Reviewed process with CNA Z and CNA AA. They agreed that they had missed hand hygiene and glove changes. *Interview with DON B on 9/28/21 at 10:00 a.m. regarding the step the CNA used. DON B agree that they did not change their gloves and perform hand hygiene while performing resident 3 brief change. *Review of facilities hand hygiene policy revealed CNA Z and CNA AA failed to comply with hand hygiene policy. *CNA Z and CNA AA failed to perform hand hygiene and put on clean gloves before moving from a contaminated body site to a clean body site during resident cares. 2. Observation on 09/30/21 9:40 a.m. of dressing change for resident 3 with a pressure ulcer. RN J prepared a clean surface, putting a clean towel down to lay dressing change supplies. RN J washed her hand prior to procedure and donned clean gloves. *RN J flushed the wound with saline removed gloves and washed hands then put on clean gloves. -Opened package for NO-Sting skin prep. -Applied NO-Sting skin prep to resident's skin. -Grabbed a scissor from a bag with dressing supplies. -Cut foam dressing for wound. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Applied Medihoney with her gloved finger. -Placed foam dressing over wound. -Opened Mepilex dressing, dated dressing with a sharpie marker. -Applied Mepilex dressing to wound all without changing her gloves and performing hand hygiene. Interview on 9/30/21 at 10:00 a.m. RN J following above dressing change revealed: *She stated that is how she performs it. *Review of steps of dressing change with RN J and she agreed she missed gloves changes and hand hygiene. Interview on 9/30/21 at 1:00 p.m. with assistant director of nursing (ADON) RN I and DON B revealed: *Both are working together with Infection Control. *Reviewed steps that RN J used to change resident's dressing. *Both agreed that glove changes had been missed in that procedure. Review of facilities dressing change competency-aseptic technique, RN J failed to comply with hand hygiene and putting on clean gloves after she cleansed the wound. *Did not use a clean gauze or tongue blade to apply medihoney.