STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43844 Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), observation, interview, record review, and policy review, the provider failed to protect residents from neglect by: A. CNA Z who did not provide nighttime cares for one of one sampled resident (425) who was observed the following morning in her clothing from the previous day and incontinent of bowel. Findings include: B. Certified nursing assistant (CNA) (G) who did not provide the appropriate transfer assistance as directed in the care plan for one of one sampled resident (46) who fell . Findings include: A. 1. Review of provider's SD DOH FRI for resident 425 revealed: *At approximately 8:00 a.m. on 8/4/24 resident 425 was in bed, dressed in the same clothes she had on the day before. She was incontinent of stool. -A head to toe skin assessment was completed and reports that all skin is intact, but that her buttocks and peri area are reddened. -Resident 425 was admitted back to us from the hospital this week and her buttocks at that time was [were] very red and sore. *CNA Z and LPN AA were on duty during the night of 8/3/24. -CNA Z received disciplinary action and education to follow resident pocket care plans at all times and ensure that all residents get proper bedtime and nighttime cares they require. -LPN AA received disciplinary action regarding the incident as the charge nurse expectation is to ensure staff follow care plan and ensure residents get proper bedtime and nighttime cares they require. 2. Review of resident 425's electronic medical record (EMR) revealed: (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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 0600 Level of Harm - Actual harm Residents Affected - Few	*Her admitted was 10/27/23. *She was hospitalized from 7/16/24 until 7/30/24 when she returned to the facility. *Her 6/27/24 Brief Interview for Mental Status assessment (BIMS) score was a 14 ehich indicated her cognition was intact. *Her 8/5/24 BIMS score was a 99 which indicated she was unable to complete the evaluation. *Her diagnoses included: depression, macular degeneration (eye disease that cause vision loss), neuropathy (nerve damage), anxiety disorder, post-traumatic stress disorder, lymphedema (swelling of body tissue), reduced mobility, chronic kidney disease, difficulty in walking, need for assistance with personal care, irritable bowel syndrome with diarrhea, and altered mental status. *She had passed away on 8/29/24. 3. Interview on 11/14/24 at 4:36 p.m. with administrator A regarding the above FRI for resident 425 on 8/4/24 revealed: *She confirmed their investigation into the incident validated resident 425 was in her bed the morning of 8/4/24 dressed in the same clothes she had on the day before and was incontinent of stool. *Her expectation was for resident 425's care plan to have been followed. -Resident 425's care plan had been updated and reviewed upon her return from the hospital. *After the above incident, all staff were educated on providing appropriate care to residents, and audits of that were being completed. *FRIs and grievances were reviewed at every QAPI meeting. 4. The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/14/24 after record review revealed the facility had followed their quality assurance process, education was completed, competency of providing care was completed, audits were completed regarding following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics. 5. Based on the above information, non-compliance at F600 was determined occurred on 8/4/24, and based on the provider's implemented corrective actions on 8/4/24 for the deficient practice confirmed on 8/14/24, the non-compliance is considered past non-compliance. 6. Review of the provider's 2/20/24 Abuse and Neglect policy revealed: *It is the policy of the facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, misappropriation of property, exploitation, neglect, or mistreatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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 0600 Level of Harm - Actual harm Residents Affected - Few	*Neglect is the failure to provide necessary and adequate (medical, personal or psychological) care. Neglect is the failure to care for a person in a manner, which would avoid harm and pain, or the failure to react to a situation which may be harmful. Staff may be aware or should have been aware of the service the resident required but fails to provide that service. 50916 B. 1. Review of the provider's submitted SD DOH FRI regarding resident 46 revealed: *Her Brief Interview for Mental Status (BIMS) assessment score was 5 which indicated she had moderate cognitive impairment. *On 10/24/24 at 8:10 p.m. the resident fell during a stand and pivot transfer with CNA G. *The resident had a gait belt on and did not acquire any injuries from the fall. *The resident's power of attorney (POA) and physician were notified of the incident. *The resident's care plan was reviewed and indicated: -She was to perform stand and pivot transfers with the use of a gait belt during the day shift with one staff's assistance. -She was to perform stand-up lift (a mechanical lift used to assist from a seated to a standing position) transfers during the evening and night shift with one staff's assistance. *Interventions included: -Education was provided to all staff regarding the importance of following care plans for all residents. -The resident's pocket care plan wording was updated to lessen confusion to staff. -CNA G as well as four random staff members were to be audited weekly for four weeks to ensure they were following residents care plans. -Interviews with seven random residents were conducted to ensure staff were following their care plans for transfers. 2. Observation and interview on 11/13/24 at 10:41 a.m. with resident 46 in her room revealed: *She was seated in her wheelchair watching TV and her call light was within her reach. *She did not recall any falls that she had recently. *Her room appeared free of environmental hazards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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 0600 Level of Harm - Actual harm Residents Affected - Few	3. Observation and interview on 11/13/24 at 2:10 p.m. with licensed practical nurse (LPN) Q revealed: *There were updated resident care plans located at the nurse's station on each hallway called pocket care plans. *The pocket care plans were updated daily if something changes for a resident. *If a staff member is unsure of how a resident transferred, they could look at the pocket care plans for their assigned hallway. *The pocket care plan located in resident 46's hallway indicated she was to be transferred by standing and pivoting with the use of a gait belt and one person's assistance during the day shift and to be transferred with the use of a stand-up lift and one person's assistance during the evening and night shift. 4. Interview on 11/13/24 at 2:15 p.m. with certified medication aide/CNA X regarding how resident 46 transferred revealed: *She was to be transferred by standing and pivoting with the use of her walker and a gait belt. *She would get weaker in the evening which would be when they would use the stand-up lift. 5. Observation on 11/13/24 at 4:10 p.m. with CNA G and resident 46 in her room revealed: *CNA G transferred resident 46 from the toilet to her wheelchair with the use of her walker and a gait belt. Interview with CNA G immediately following the above observation revealed: *CNA G had been working at the facility since April of 2024. *When she was assigned to a hallway, she would get the pocket care plan so she could reference the residents' care needs if she needed to. *She had been with resident 46 when she fell . -She was assisting the resident to bed with a stand and pivot transfer, a gait belt and her walker when resident 46 said she would not be able to make it. *She lowered the resident to the floor and notified the nurse. *She stated she had misread resident 46's care plan which had indicated she was to be transferred with a stand-up lift during the evening and night shifts. 6. Interview on 11/14/24 at 11:31 a.m. with director of nursing (DON) B revealed education was provided to all staff after resident 46's incident above and audits were being conducted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435020	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Huron	1345 Michigan Avenue SW Huron, SD 57350

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 0600 Level of Harm - Actual harm Residents Affected - Few	The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 11/14/24 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding following resident care plans, and observations and interviews revealed staff understood the education provided regarding those topics. Based on the above information, non-compliance at F600 occurred again on 10/24/24, and based on the provider's implemented corrective action for the deficient practice confirmed on 10/26/24, the non-compliance is considered past non-compliance.