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	09/26/2024

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

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50915 Based on the South Dakota Department of Health (SD DOH) complaint online report, observation, interview, record review, and policy review, the provider failed to ensure that one of one sampled resident (1) had a baseline care plan created that identified her care needs, goals, and interventions within 48 hours of admission. Findings include: 1. Review of SD DOH complaint online report revealed: *Resident 1 was admitted to the facility on [DATE]. *The complainant reported that resident 1 experienced excruciating pain throughout the entire weekend following her admission. *It was also reported that the resident's room was not cleaned. *The complainant reported that resident 1 should have had dressing changes to her legs multiple times per day. -The complainant reported that dressings changes were not completed, and drainage from resident 1's leg wounds would collect on the floor. 2. Observation throughout the facility on 9/25/24 revealed: *Resident rooms appeared to be clean and uncluttered. *Trash cans were empty. *The floors appeared clean. 3. Interview on 9/25/24 at 2:00 p.m. with director of nursing (DON) B revealed: *A member of the management staff performs the admission assessment and care plan when a new resident is admitted . -That could be the charge nurse the day of admission or the DON. (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The resident's admission (baseline) care plan is to be completed within the first 48 hours of admission to the facility. 4. Interview on 9/26/24 at 10:30 a.m. with licensed practical nurse (LPN) E revealed: *She recalled the day resident 1 was admitted to the facility. *She stated the admission care plan should have been completed within 48 hours of admission to the facility. *When asked how staff would know how to provide care for the resident, she stated there are daily care sheets that are printed for staff. -The daily care sheets would have information from the resident's care plan, such as how the resident transferred and other specific care information related to the resident. -She stated this was not part of the resident's electronic medical record (EMR). -She stated the care sheet would have been updated for resident 1 before she left work on 8/30/24, and would have given staff a brief care summary of the resident. -She could not provide a copy of the daily care sheet for resident 1 for 8/30/24. 5. Interview on 9/25/24 at 12:10 p.m. with certified nursing assistant D revealed: *She had worked for two years in the hallway where resident 1 resided. *She recalled resident 1 had resided on her hallway, she was here for just a couple weeks. *She stated she knew how to care for residents because they would have a care plan with that information. -She stated she referred to the residents' care plans to know how much assistance they required. 6. Interview on 9/26/24 at 9:03 a.m. with social services director C revealed: *Resident 1 was admitted to the facility on Friday, 8/30/24 at approximately 3:30 p.m. *On admission, resident 1's son was not happy that his mother had been discharged from another facility, then admitted to this facility. 7. Review of resident 1's EMR revealed: *The resident was admitted on [DATE]. *No care plan had been created to identify and inform staff of resident 1's cares, needs, goals, and interventions within 48 hours of her admission. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*The resident's care plan was initiated on 9/3/24, day five of resident 1's stay. *Her pain medications were administered as ordered. *Her dressing changes were completed as ordered. 8. Review of the facility's September 2019 Care Plans policy revealed: *Page 1, Policy: 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. *Page 1, Policy: 6. The DON will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter. *Page 2, Procedure: 2. A Baseline Care plan is started by nursing staff on the first day of admission to provide guidance to direct care givers as soon as possible after admission and completed no later than 48 hours after admission. Nursing, Dietary, Therapeutic Recreation and Social Services Staff complete formal assessments, interviews and observations and begin formulating the full care plan as soon after admission as possible. (These departments do have areas that need to be completed by the 48-hour deadline).