STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435040	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Mountain View	916 Mountain View Road Rapid City, SD 57702

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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43844 Based on the South Dakota Department of Health (SD DOH) facility reported incident (FRI), interview, record review, and policy review, the provider failed to ensure adequate pain management for one of one sampled resident (1) who inflicted harm to himself that required surgical treatment at a hospital. Failure to assess and provide adequate pain control may have contributed to resident 1's action of self-harm. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include: 1. Review of the SD DOH FRI regarding resident 1 revealed: *He had inflicted a stab-wound to his abdomen on 5/4/24. *He stated, I do not want to be here, and I am not getting what I want so I stabbed myself with a piece of that picture I broke. *He was transferred to the hospital and had surgery to his self-inflected stab wound to his abdomen. Interview on 5/13/24 at 3:22 p.m. with administrator (ADM) A and director of nursing (DON) B regarding the incident involving resident 1 above revealed: *During the provider's investigation into the incident involving they found non-compliance in the pain management process including: -Pain documentation. -Providing pain medication without documenting it. -Accurate completion of pain assessments. Review of Resident 1's electronic medical record (EMR) revealed: *He was admitted on [DATE]. (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 0697 Level of Harm - Actual harm Residents Affected - Few	*On 5/4/24 he discharged to the hospital for surgical treatment of his self-inflicted wound. *His 5/1/24 Brief Interview of Mental Status score was a 14, which meant he was cognitively intact. *His 5/1/24 PHQ-9 score was a 00, which meant he had no signs or symptoms of depression. *His diagnosis included: Systemic Inflammatory Response Syndrome of Non Infectious Origin, Cerebral Infarction, Retention of Urine, Rheumatoid Arthritis, Arterial Embolism and Thrombosis of Abdominal Aorta, Contusion of Left Front Wall of Thorax, Obstruction and Reflux Uropathy, and hemorrhoids. *He had physician orders for the following pain medications: aspirin, clopidogrel bisulfate, hydrocortisone acetate rectal suppository, Plaquenil, prednisone, and Tamsulosin. *An order for 625 milligrams (mg) of Tylenol, as needed, every six hours for pain in his back and legs was added on 5/4/24. -There was no documentation that the Tylenol had been administered. Interview on 5/15/24 at 9:16 a.m. with DON B regarding standing orders and resident 1's pain revealed: *Standing orders for pain control were not always put in a resident's EMR when they were admitted . *A standing order for Tylenol for pain control for resident 1 was implemented prior to 5/4/24 by a licensed nurse. -That nurse had not entered the standing order for Tylenol in his electronic medical record (EMR). -The nurse that implemented the order should have entered the standing order into his EMR and documented the Tylenol she had given him. *Their medical director had reviewed their process and changed it to include: -The admitting nurse would enter standing orders for pain upon each resident admission. -On day two of a resident admission, a physician assistant would visit the resident and ask the resident which pain medication worked best for them. --That pain medication would then be ordered for the resident. *Staff were educated on the new process for standing orders on 5/5/24. *The Pain Assessment was updated on 5/1/24. -The previous medication administration (MAR) pain assessment included Pain Assessment: Numeric Scale (0=no pain; 1 to 3 = mild pain; 4-7 = moderate pain; 8-10 severe pain) or PAIN AD [scale to assess pain for people with advanced dementia] every shift. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	--There was an area to document the pain level and if it was on the day or evening shift. -The current MAR pain assessment included Pain Eval or PAINAD q [every] shift (0=no pain; 1 to 3 = mild pain; 4-6 = moderate pain; 7-9 severe pain; 10 excruciating. Ask if pain is acceptable, if yes, then no further action, if no provide non-harm interventions (cold/warm wash cloth, massage, distractive activities, reposition, etc.) or ordered analgesic medications. If interventions not effective, then notify MD [medical doctor]. --There was an area to document the pain level and if it was the day or evening shift. *She was unable to determine if the nursing staff understood the question on the revised 5/1/24 Pain Assessment and was documenting a resident's pain level correctly. -She provided education on the assessment of pain and documentation of pain after the incident. Review of resident 1's pain level documentation revealed his pain level score using a scale of 1-10 with 10 being excruciating pain revealed: *On 5/1/24 the score was a 5. *On 5/2/24 the score was an 8. *On 5/3/24 at 8:30 a.m. the score was a 0, there was no score recorded for the second (evening/night) shift. *On 5/4/24 at 2023, the score was an 8. *On 5/4/24 at 22:27, and 5/4/24 at 22:53 the score was a 10. *There was no documentation to support any interventions were provided to relieve his pain. Review of resident 1's 5/1/24 MAR revealed there was no documentation of Tylenol given from 5/1/24 through 5/4/24. Review of resident 1's 5/1/24 registered nurse assessment revealed: *He had pain or hurting at anytime in the past 5 days. *His pain was almost constantly and included stomach pain, bruised ribs, and rheumatoid arthritis, and he had no pain with therapy. *He rated his pain as a score of 5 out of 10. Review of resident 1's nurses progress notes revealed: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	*On 5/1/24 he was having pain at a score of 9 or 10, and He is seeking percocet [Percocet, a pain medication] and that he is leaving this facility is he is not given a Percocet immediately .Resident became frustrated with our policy and procedure and states that he is going to call 911 and possibly discharge asap [as soon as possible] .APAP [an abbreviation referring to acetaminophen, a very common pain-relieving - drug] administered per prescription orders. *On 5/2/24 After speaking with resident and his family, they remembered that the pain medication he takes for his arthritis is prednisone, not Percocet. Prednisone is already scheduled per order. Review of resident 1's 4/30/24 care plan revealed: *A focus that he was at risk for pain. *The goal for this focus, states that level of pain is tolerable or has relief with interventions. *The interventions included: -Evaluate efficacy of pain management. -Notify MD if inadequate pain relief. -Provide analgesic as ordered. -Utilize non-pharmacological intervention [specify e.g. massage, repositioning, distractive activities, cold/warm wash cloth, music, snacks, journaling, other, etc. --The interventions did not specify which of those non-pharmacological interventions worked for him. Interview on 5/15/24 at 10:15 a.m. with certified nursing assistant (CNA) D regarding residents' pain revealed: *When a resident would report they had pain to her, she would: -Notify the nurse. -Offer the resident a warm towel or ice pack. Interview on 5/15/24 at 10:22 a.m. with CNA E regarding residents' pain revealed: *When a resident would report they had pain to her, she would: -Ask where the pain is and the level of pain they are having. -Notify the nurse and provide her this information. -Offer to reposition the resident. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Interview on 5/15/24 at 10:30 a.m. with registered nurse (RN) C regarding residents' pain revealed: *She assessed residents for pain, including asking where the pain was and how often the pain occurred. -She then checked their MAR to see what medication the physician might have ordered. -When they did not have an order for pain medication, she would administer the standing order for Tylenol. --When the standing order for Tylenol was not pre-loaded into a residents' MAR she would have to add it. *There had been lots of education on pain recently. *Resident 1 had not volunteered information regarding his health, she had to pull it from him. -She thought he had a flat effect. Review of the provider's 3/23/23 Pain Management Policy revealed: *The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. *'Pain Management' is defined as the process that includes the following: -a. Assessing the potential for pain; -b. Effectively recognizing the presence of pain; -c. Identifying the characteristics of pain; -d. Addressing the underlying causes of pain; -e. Developing and implementing approaches to pain management; -f. Identifying and using specific strategies for different levels and sources of pain; -g. Monitoring for effectiveness of interventions; and -h. Modifying approaches as necessary. *Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including: -Rheumatoid arthritis (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Constipation *Pain management interventions shall be consistent with the resident's goals for treatment. Such goals will be specifically defined and documented. *Pain management interventions shall reflect the sources, type and severity of pain. *Strategies that may be employed when establishing the medication regimen include: -Combining long-acting medications with PRNs [as needed] for breakthrough pain. *Implement the medication regimen as ordered, carefully documenting the results of the interventions. *Report the following information to the physician or practitioner: -Significant changes in the level of the resident's pain. Review of the provider's 5/18/21 Following Physician Orders policy revealed: *If the order is for a medication or treatment, it should be entered in the MAR/TAR [medication administration record/treatment administration record]. Review of the provider's Standing Orders policy revealed the following: *Only licensed nurses implement standing orders. Professional judgment is used in the initiation and administration of standing orders. *Documentation of the situation requiring the use of standing order is placed in the nursing notes section of the resident's medical record prior to initiation of the order. Interview on 5/15/24 9:57 a.m. DON B regarding a documentation policy revealed: *They used nursing standards which included if something was not documented [it was] not done. *The reference source for nursing standards was The standard of Fundamental of nursing 10th edition [NAME]. Continued interview on 5/15/24 at 11:39 a.m. with DON B revealed: *The provider did not have a policy specific to entering standing orders upon admission. -She stated this was an internal process and no policy was required. The provider implemented systemic changes to ensure the deficient practice does not recur by having: *Provided education for all nursing staff that included: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	-Assessing a resident for pain, including pain level, location of pain and to do full pain assessment. -Documenting this assessment, give pain meds as ordered and notify the residents physician. -Tylenol was a standing order and must be put into PCC [the electronic medical records system] if not already there, after ensuring no allergy to Tylenol. -If Tylenol did not relieve pain the nurse MUST call the provider and notify them. -All interventions must be documented in the electronic medical record and Progress Notes. --Non-pharmacological interventions need to be attempted and documented. -Pain management policy. -Pain Numeric Rating Scale or PAINAD Order Directions. -Following Physician Orders. -Standing Orders policy and process. *Initiated audits for newly admitted residents to ensure they had pain medication ordered or a standing order for Tylenol entered into their MAR, documentation of PRN (as needed) medication and follow-up completed for those PRN medications. *Initiated a performance improvement project (a concentrated effort to improve care or services in a facility area that needs improvement). *Initiated the above items into their Quality Assurance Program Improvement. Based on the above information, non-compliance at F697 was determined, and based on the provider's implemented corrective actions for the deficient practice, the non-compliance is considered past non-compliance.