

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435040	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2024
NAME OF PROVIDER OR SUPPLIER Avantara Mountain View		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43844</p> <p>Based on South Dakota Department of Health (SD DOH) facility-reported incidents (FRI), interview, record review, and policy review, the provider failed to ensure one of two facility operated buses had functional straps to safely secure one of one sampled resident's (26) wheelchair while being transported from another location. Failure to ensure the straps were functional and the wheelchair was safely secured potentially placed the resident at risk for harm or injury. This citation is considered past-non-compliance based on a review of the corrective action the provider implemented following the incident.</p> <p>Findings include:</p> <p>1. Review of the provider's submitted SD DOH FRI regarding resident 26 revealed:</p> <p>*On 10/19/24 at 1:30 p.m. resident 26 was being transported from a dialysis appointment to the facility on one of the provider's buses.</p> <p>-During that transport, the driver of the bus had looked in the rear-view mirror and noted the resident to be tilted backward in her wheelchair.</p> <p>-Upon his assessment of the wheelchair, he noted one of the front clamp straps, that was used to secure the wheelchair, was extended.</p> <p>-It was explained that the tie-down system is supposed to automatically tighten when the strap begins to loosen from normal bumps of the bus. The tie-down had not done that.</p> <p>-The facility initiated a tie-down inspection to be completed daily as a part of the daily bus inspections to ensure proper functioning.</p> <p>The provider implemented actions to ensure the deficient practice does not reoccur was confirmed after review revealed the provider had:</p> <p>*Removed the non-functioning tie-down strap.</p> <p>*Purchased a new strap.</p> <p>(continued on next page)</p>		

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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Provided education to the bus drivers regarding the use of the tie-down straps and how to inspect them to ensure they were functioning properly.</p> <p>*Implemented a documented daily inspection process for the buses and functionality of the strap.</p> <p>*Assigned a bus driver to a lead' position to be responsible for communicating any maintenance requirements to the bus driver's supervisor.</p> <p>*Completed audits to ensure the daily inspection forms were being completed.</p> <p>*ensured their audits were presented at the next Quality Assurance meeting.</p> <p>*Followed their quality assurance process.</p> <p>Based on the above information, non-compliance at F689 occurred on 10/19/24, and based on the provider's implemented actions on 10/29/24 for the deficient practice it was confirmed on 12/12/24 the non-compliance is considered past non-compliance.</p>