

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2025
NAME OF PROVIDER OR SUPPLIER Avantara Pierre		STREET ADDRESS, CITY, STATE, ZIP CODE 950 East Park Street Pierre, SD 57501	

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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45095</p> <p>50015</p> <p>Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, interviews, and policy review the provider failed to ensure the on-call physician was notified of complaints of acute pain by one of one sampled resident (1) for determination of treatment. This citation is considered past non-compliance based on review of the corrective actions the provider implemented immediately following the incident. Findings include:</p> <p>1. Review of provider's 4/2/25 SD DOH FRI revealed:</p> <p>*Resident 1 was admitted on [DATE].</p> <p>*On 4/2/25 resident 1 reported to senior regional nurse consultant (SRNC) A that he was having trouble with two-night nurses and he expressed:</p> <ul style="list-style-type: none"> -They were mean to him. -They would not get him water. -They would not give him pain medication. <p>*Resident 1's pertinent diagnoses are:</p> <ul style="list-style-type: none"> -Cirrhosis of liver (liver damage and scaring). -Diabetes Mellitus type II. -Cardiomyopathy (a disease that makes it harder to pump blood through the heart) -Unspecified convulsions. -Difficulty with walking. -Glaucoma. <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 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Resident 1 reported he was having stomach pain.</p> <p>*Resident 1 was on an ordered 1200 cc fluid restriction.</p> <p>-Resident 1 was given a cup of ice chips by registered nurse (RN) C after reviewing his recent labs values.</p> <p>*Resident 1 did not have orders for a pain medication.</p> <p>*Resident 1's Brief Interview for Mental Status (BIMS) assessment score was 15 which indicated he was cognitively intact.</p> <p>*Resident 1 was unable to name the staff, but was able to give descriptions to SRNC A.</p> <p>*Director of nursing (DON) B was able to identify RN C and certified nursing assistant (CNA) D as the staff members he was reporting based on his descriptions given.</p> <p>-They were immediately suspended on 4/2/25 pending further investigation by DON B.</p> <p>*A new order for Tylenol 500 mg every eight hours PRN was obtained on 4/2/25 for resident 1.</p> <p>*RN C was reinstated on 4/5/25 following education on resident rights regarding fluid restrictions and the abuse and neglect policy by DON B.</p> <p>*RN C was given a disciplinary write-up regarding allegations that were substantiated by the provider for pain management to ensure notification to the provider to obtain an order for pain medication if indicated.</p> <p>*RN C was educated on pain management policy on 4/14/25.</p> <p>*CNA D was reinstated on 4/4/25 after allegations were unsubstantiated by the provider through staff interviews and interview with resident 1.</p> <p>*Resident 1 was seen by a healthcare provider on 4/3/25 and his fluid restriction was discontinued after education and against medical advice of that healthcare provider.</p> <p>*Standing orders have been initiated for residents with the medical director's input.</p> <p>-Those included a PRN pain medication that would be available immediately for pain management needs of the residents.</p> <p>*Audits of all new admissions are to be completed weekly for two months to ensure a scheduled or PRN pain medication is available.</p> <p>*Licensed nurse education has been initiated on notifying the provider of resident pain complaints and the need for additional pain-relieving medication or evaluation.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Education on standing orders was to be completed with all nurses once approved by the medical director.</p> <p>*All care staff were to be educated on their responsibilities for pain management.</p> <p>2. Review of resident 1's electronic medical record (EMR) revealed:</p> <p>*He had pain monitoring completed twice daily on his medication administration record (MAR) that started 3/13/25.</p> <p>*Pain assessment completed on 3/13/25 indicated he rarely had pain.</p> <p>*Pain assessment completed on 3/18/25 indicated he frequently had pain, and it affected his sleep and interfered with his day-to-day activities no pain level was given.</p> <p>*Pain assessment completed on 4/21/25 indicated he rarely had pain.</p> <p>*His care plan had a focus area of being at risk for pain related to impaired mobility and oral pain.</p> <p>-Interventions initiated on 3/25/25 included:</p> <p>--Ask for medication.</p> <p>--I would like to receive pain relief upon request.</p> <p>--My nurse to review my pain level every shift.</p> <p>--Report to nurse any complaints of pain or any requests for pain treatment.</p> <p>*Review of his every shift pain check documentation revealed:</p> <p>-On 3/26/25 he complained of pain, was evaluated in the local emergency room (ER) his X-rays were negative, he was given hydrocodone (a pain medication) and returned to the facility.</p> <p>-On 4/1/25 RN C documented a pain check was completed, and his pain level was 0 out of 10.</p> <p>-On 4/5/25 he rated his pain level at a 10 on a 0 to 10 pain scale, attributed to constipation. He was given milk of magnesium, and it resolved.</p> <p>*Standing orders, that included PRN Tylenol were signed on 4/18/25.</p> <p>*Risks vs Benefits for fluid restriction was signed on 4/24/25.</p> <p>*An order was received for palliative care dated 5/5/25.</p> <p>3. Interview on 5/6/25 at 10:14 a.m. with resident 1 revealed:</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*When he was admitted he was asked about pain.</p> <p>*He was asked daily by the nurses if he was having pain.</p> <p>*He did not have any pain, if he did have pain he would have asked the staff for pain medication.</p> <p>*He felt the staff treat him good. He had no complaints and was happy with his care.</p> <p>Observation and interview on 5/7/25 at 8:36 a.m. with RN/minimum data set (MDS) E revealed:</p> <p>*The number for the hospital is listed on the phone list at the nurse's station.</p> <p>*They call that number to get the on-call physician.</p> <p>Interview on 5/6/25 at 5:44 p.m. with RN C revealed:</p> <p>*She works the night shift.</p> <p>*She does not admit new patients.</p> <p>*She had not had to implement new or admission interventions for residents.</p> <p>*She had worked for the facility for about three months.</p> <p>*She received one month of orientation with a nurse preceptor.</p> <p>*Her initial training consisted of online training and included pain management, resident rights, abuse, neglect, fall risk and fall prevention.</p> <p>*Resident 1 complained of pain on the night of 4/2/25.</p> <p>*He had labs completed on 3/31/25 which indicated he had elevated liver enzymes and low platelets, so she did not want to give him acetaminophen or ibuprofen.</p> <p>*He had no physician ordered pain medication at that time.</p> <p>*She did not call a provider for pain medication orders.</p> <p>-She now knows she can call the on-call physician for orders and has an e-kit (emergency kit) with medications for residents if needed.</p> <p>*She had offered non-pharmacological interventions such as repositioning, but resident 1 refused.</p> <p>-He then fell back to sleep and was observed snoring.</p> <p>*She reported that information to the oncoming nurse in the morning on 4/2/25 and to get orders for a pain medication that he would have been able to take with his abnormal labs.</p> <p>(continued on next page)</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Their was no documentation in resident 1 progress notes that he had complained of pain, any interventions that were offered by RN C, and no documentation of refusals by resident 1.</p> <p>Interview on 5/7/25 at 9:10 a.m. with DON B revealed:</p> <p>*New nurses are oriented with another nurse when they are hired for one to two weeks topics included were pain management, after-hours on-call physician notification.</p> <p>-She checks in with nurses during their orientation period to determine if more orientation time is needed and given, if applicable.</p> <p>*Nurses complete online training based on their nursing position.</p> <p>*If a new nurse had questions, they could ask the other nurse working.</p> <p>*She was always on-call and available as well if there were questions.</p> <p>*The contact phone numbers for the hospital, clinics, physicians and other providers were located at the nurse's station.</p> <p>*The on-call instructions were not posted at the nurse's station or included on the nurse's orientation checklist.</p> <p>*She expected that if a resident complained of pain during the night and did not have orders for a pain medication, the nurse would call the on-call physician.</p> <p>*During her investigation into the above incident RN C did not think she needed to make the physician aware of the situation.</p> <p>*She had offered the resident repositioning and ice and had notified the day nurse to call the physician to request pain medication orders.</p> <p>*She was in the process of adding contact information for on-call physicians and instructions by the phone list at the nurse's station.</p> <p>4. Review of provider's revised 4/28/25 Pain Management policy revealed:</p> <p>*The purpose of this procedure is to help the staff identify pain in a resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.</p> <p>Defining goals and appropriate interventions:</p> <p>4.For those situations where the cause of the resident's pain has not been or cannot be determined, follow current standards of practice for managing pain to help determine appropriate options.</p> <p>Implementing pain management strategies:</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4.The physician and staff will establish a treatment regimen based on consideration of the following:</p> <ul style="list-style-type: none"> -The resident's medical condition. -Current medication regimen. -Nature, severity and cause of the pain. -Course of the illness. -Treatment goals. <p>The provider's implemented actions to ensure the deficient practice does not reoccur was confirmed on 5/7/25 after record review revealed the facility had followed their quality assurance process, education was provided to all nursing care staff regarding pain management policy, and education regarding residents having complaints of pain and needing additional evaluation was provided to applicable staff. Standing pain management orders were developed with their medical director. Postings were at the nurses' station for notification and instructions for contacting the on-call physician. A whole house audit for pain medication orders was completed. Audits were being completed weekly. Observation and staff interviews revealed the staff understood the education provided and the revised process.</p> <p>Based on the above information, non-compliance at F697 occurred on 4/2/25, and based on the provider's implemented corrective actions for the deficient practice confirmed on 5/7/25, the non-compliance is considered past non-compliance.</p>		