STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435047	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Pierre	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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52098 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (24) who self-administered medications was able to safely self-administer those medications and had a physician's order for self-administration of medications per the provider's policy. Findings include: 1. Observation and interview on 3/30/25 at 5:10 p.m. in resident 24's room revealed: *The resident was sitting in his recliner chair, administering a nebulizer (a liquid medication that turns into mist and is inhaled through a mask or mouthpiece via a small machine) treatment. *There was a medication cup that contained one medication tablet on the resident's bedside table. -The resident indicated the medication was Tums (an antacid medication). *A bottle of nasal spray (Fluticasone Propionate) was on the resident's bedside table. *He stated that he was able to administer medications and the nebulizer treatment independently in his room, just as he would at home. 2. Review of resident 24's electronic medical record (EMR) revealed: *He was admitted on [DATE]. *He had a Brief Interview for Mental Status (BIMS) assessment score of 15, which indicated he was cognitively intact. *A self-administration evaluation was completed on 1/27/25 and indicated he was not able to self-administer medications. *There was no physician order for him to self-administer his medications. 3. Interview on 4/1/25 at 1:57 p.m. with director of nursing (DON) B 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: 435047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Avantara Pierre		STREET ADDRESS, CITY, STATE, ZIP CODE 950 East Park Street Pierre, SD 57501	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She confirmed the 1/27/25 self-administration evaluation indicated that resident 24 was not able to self-administer his medications. *She confirmed there was no physician order for resident 24 to self-administer his medications. 4. Observation on 4/1/25 at 4:20 p.m. of resident 24 in his room revealed: *The resident was sitting in his chair while he administered a nebulizer treatment. *The bottle of Fluticasone Propionate nasal spray was on his bedside table. *No staff was observing the administration of the nebulizer treatment. 5. Interview on 4/2/25 at 10:30 a.m. with licensed practical nurse (LPN) Q revealed: *She would stand outside resident 24's room while he took the nebulizer treatment. *She could not confirm if resident 24 had an assessment to self-administer medications. *She would not leave medications in resident rooms. *She would verify that all the residents had taken their medications. 6. Interview on 4/2/25 at 1:07 p.m. with resident 24 revealed he stated: *The nurses left the above medications on his bedside table for him to take. *The nurses never stayed in the room during his nebulizer treatments. Review of the provider's 11/19/24 Self-Administration of Medications policy revealed: *Each resident has a right to self-administer medications should they desire, unless this practice is determined unsafe. *If the resident has expressed a desire to self-administer, the interdisciplinary team will complete an evaluation of the resident's cognitive, physical, and visual ability to carry out this responsibility. *The facility may require that drugs be administered by the nurse until the care planning team has the opportunity to obtain information necessary to make a determination on resident's ability to complete the task. *Nurse is to get an order from the clinician for self-administration of medications.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52098 Based on observation, interview, record review, testing, and policy review, the provider failed to ensure adequate temperatures for three of three sampled residents (24, 27, and 304) who expressed their rooms were cold and uncomfortable. Findings include: 1. Observation and interview on 3/30/25 at 4:40 p.m. in resident 27's room revealed: *The temperature of the room felt cold in comparison to other areas within the facility. *The resident was in bed and covered with blankets. *The window shade was down with a blanket along the bottom edge of the window. *The resident stated: -She would get into her bed under the blankets to stay warm. -The room was cold and she had no control over the temperature in her room. -The maintenance man would check the boiler when she reported her room was cold, but her room temperature would remain cold and uncomfortable for her. 2. Review of resident 27's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) assessment score of 14, which indicated she was cognitively intact. 3. Observation and interview on 3/30/25 at 5:10 p.m. in resident 24's room revealed: *The temperature of the room felt cold in comparison to other areas within the facility. *The resident was wearing a lined shirt/jacket and was sitting in his recliner chair. *The window shade was down and two pillows were along the bottom edge of the window. *The resident stated the room was cold, and he walked the hall multiple times daily to warm up. *The resident used extra blankets at night to stay warm. 4. Observation and interview on 3/31/25 at 4:00 p.m. with resident 24 in the west hallway revealed: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The resident was walking up and down the hall with his walker. *He stated he needed to be out of his room and moving to warm up because his room was cold, and he was freezing. 5. Review of resident 24's EMR revealed: *He was admitted on [DATE]. *He had a BIMS assessment score of 15, which indicated he was cognitively intact. 6. Observation and interview on 3/31/25 at 9:00 a.m. in resident 304's room revealed: *The temperature of the room felt cold in comparison to other areas within the facility. *The resident returned from therapy and entered her room and stated, The room is a bit chilly. *The window shade was up and a blanket was along the bottom edge of the window. *The resident stated the room would get cold if the door was shut. 7. Review of resident 304's EMR revealed: *She was admitted on [DATE]. *She had a BIMS assessment score of 12, which indicated she had moderate cognitive impairment. 8. Interview on 4/1/25 at 9:57 a.m. with maintenance director H revealed: *The resident room temperatures should range be between 70 and 80 degrees Fahrenheit (F). *The facility used boiler heat, which could only be adjusted for some areas of the building. -He stated it was difficult to maintain temperatures for residents who were hot or cold. *Resident room temperatures were checked and documented five times weekly. -He would check three to four temperatures in resident rooms and then document the average of those temperatures. *The boilers were checked when the resident room temperatures were out of range. *He stated the resident rooms' windows leaked allowing outside air into the room and the windows should be replaced. *Thermostats were located throughout the building and were locked so staff and resident could not adjust them. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-No thermostats were located within the resident rooms. *Temperature settings were controlled by the maintenance department staff. -The thermostats were set between 70 and 72 degrees F. *He stated a local vendor would complete a check on the facility boilers as requested. 9. Temperature testing on 4/1/25 at 10:07 a.m. with maintenance director H in resident 24's room revealed: *The north wall temperature next to the resident's bed was 65.3 degrees F. *The west wall next to the resident's recliner chair was 68.4 degrees F. *The south wall next to his roommate's bed was 69.1 degrees F. 10. Interview on 4/1/25 at 1:33 p.m. with the assistant director of nursing (ADON) C revealed: *The maintenance director controlled and adjusted the buildings' thermostats for the temperatures of the rooms. *She did not think anyone else touched the thermostats or adjusted the temperatures. 11. Interview on 4/2/25 at 9:06 a.m. with activity aide O revealed: *She had never touched a thermostat at the facility to adjust a room temperature. *She was unsure if the residents' rooms had thermostats. 12. Interview on 4/2/25 at 9:09 a.m. with CNA P revealed: *She confirmed there were no thermostats in residents' rooms to control and maintain comfortable temperatures according to their preferences. *The maintenance director controlled and adjusted the thermostats for temperature control throughout the building. 13. Interview on 4/2/25 at 9:23 a.m. with administrator A revealed: *The facility areas and residents' room temperatures were monitored weekly and documented by the maintenance director. *A grievance was presented at the 2/18/25 resident council meeting regarding cold resident rooms. *There was a plan to replace the facility's windows. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*The expectation was for residents' rooms to be at adequate temperature settings to maintain a comfortable level. *The residents' room temperature should be maintained between 71 and 81 degrees F. *He confirmed that residents' room temperatures below 70 degrees F was not within the required temperature range. Review of the resident council grievance form dated 2/18/25 revealed the residents had complained of being too cold and that the heat needed to be turned up. Review of the investigation and follow-up responses dated 2/19/25 on the above grievance form revealed: *Maintenance was educated on air temperature parameters and steps for notification if the air temperatures were out of range. *The required temperature range should be between 71 and 81 degrees F. *The thermostat was to be adjusted if the temperatures were out of range. *The corporate maintenance consultant and the administrator were to be notified if the appropriate temperatures were not reached. *If necessary, maintenance was to follow up with the vendor as soon as possible. Review of the providers 9/30/24 Homelike Environment policy revealed: *Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. *Staff shall provide person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences. *The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: -Comfortable temperatures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and policy review, the provider failed to ensure resident care plans reflected the residents' current needs and/or to provide interventions as directed on the care plans for four of twenty sampled residents (3, 34, 205, and 206) as follows: *Interventions were not provided as directed on the care plan for resident 3 who required a fall mat and a call light within her reach. *The care plan did not include interventions to prevent the development of a pressure ulcer for resident 205. *Interventions were not provided as directed on the care plan for resident 206 who required the use of a positioning alarm. *The care plan did not include interventions for lymphedema (condition causing swelling in the arms or legs) wraps for resident 34. Findings include: 1. Observations on 3/30/25 at 3:05 p.m., 4:44 p.m., 5:06 p.m. and 5:13 p.m. of resident 3 revealed: *She was in her bed which was in a low position and against the wall. *The privacy curtain was tucked between the bed and the wall near the foot of her bed. *A blue fall mat was folded in half and propped up against her bedside table. *The call light was on a bedside table behind the fall mat and not within her reach. Observation on 3/30/25 at 5:48 p.m. with resident 3 revealed: *She was in her bed which was in a low position and against the wall. *A blue fall mat was folded in half and on the floor near her bed in a position that appeared as if it had fallen over. *The call light was on the bedside table and not within her reach. Review of resident 3's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *Her Brief Interview for Mental Status (BIMS) assessment score was 5, which indicated she was severely cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Her diagnoses included a fracture of the right femur (thigh bone) and dementia. *Her 3/26/25 Fall Risk Evaluation indicated she had a low risk for falling. *Her care plan indicated: -She was At risk for falls related to [the] history of falls, right hip fracture with no right hip joint, dementia, anemia and arthritis. -Please make sure that my call light is within my reach and encourage me to use it to call for assistance. -Bed to be in low position and floor mat is placed next to the bed. Interview and record review on 4/02/25 at 8:45 a.m. with director of nursing (DON) B regarding resident 3 revealed: *She confirmed resident 3's 3/26/25 Fall Risk Evaluation indicated Low Risk. *Resident 3 had fallen on 1/2/25 and was at risk for falls. She thought the fall mat intervention on her care plan was still needed and appropriate. *She expected that resident 3's care-planned interventions of the fall mat and ensuring resident 3's call light was within her reach would have been followed. 2. Observation and interview on 3/31/25 at 8:38 a.m. with resident 205 revealed: *He was seated in his wheelchair and wore padded pressure-reducing boots on both of his feet. *He said he had been at the facility for about two weeks and did not know why he needed to wear those boots. Observation and interview on 4/1/25 at 7:59 a.m. with resident 205 and certified nursing assistant (CNA) R in resident 205's room revealed: *CNA R stated that resident 205 had been at the facility for about two weeks. *Resident 205 wore a Tubi Grip (compression stocking) on his right leg and blue pressure-reducing boots on both feet due to a pressure ulcer on his right heel. *CNA R stated that information on how staff were to care for each resident was located in the residents' care plans in the EMR. Observation on 4/2/25 at 7:43 a.m. with resident 205 revealed: *He was lying in bed on his back with blue boots on both feet. *His bed did not have an air mattress on it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of resident 205's EMR revealed: *He had been admitted on [DATE] from another long-term care facility. *A 3/13/25 physician's order, Transfer to [provider] on current orders. Send current supply of meds [medications]. -Those orders indicated: --Skin prep to bilateral heels for skin protection one time daily. --Pressure Injury Treatment/Prevention on each shift two times a day. 1. Check that [the] air mattress is on [the] bed and operating correctly. 2. Float heels when in bed. 3. Ensure dressings are in place as ordered. 4. Pressure redistributing cushion in w/c [wheelchair]. 5. Reposition q2-3h [every two to three hours]. 6. Pericare as indicated, were noted as received 3/17/25. *His diagnoses included hemiparesis (paralysis) following cerebral infarction (a stroke) affecting the left non-dominant side, Type 2 Diabetes Mellitus, and an unstageable pressure ulcer of the right heel. *A 3/24/25 Skin Alteration Evaluation identified a new pressure injury to resident 205's right heel that measured 4.4 centimeters (cm) in length by 5.0 cm in width and was staged as a suspected deep tissue injury. *His care plan indicated: -I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] impaired mobility. 2 [Two] staff and the hoyer lift [a full-body mechanical lift] for all transfers, was initiated on 3/18/25. -I am dependent on staff with: roll left and right, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, [and] personal hygiene, was initiated on 3/25/25. -Utilizes an [a] bariatric bed, was initiated on 3/18/25. -Ensure that I am wearing appropriate footwear when mobilizing in w/c, was initiated on 3/25/25. -I have an unstageable pressure ulcer to right lateral heel r/t AFO [ankle-foot orthosis] use. My pressure ulcer will show signs of healing and remain free from infection through the review date, was Initiated on 3/25/25. *There was no documentation that indicated an air mattress had been utilized, trialed, or refused. *There was no documentation that indicated that resident 205 wore blue padded pressure-reducing boots. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 4/2/25 at 8:04 a.m. and again at 11:10 a.m. with assistant director of nursing (ADON) C regarding resident 205 revealed: *She was the wound care nurse. *She had been on vacation when resident 205 was admitted to the facility. *Resident 205 did not have any pressure ulcers when he was admitted on [DATE]. *Resident 205 had been assessed as high risk for developing pressure areas when he was admitted . *She stated all residents were to be provided with an air mattress when they were admitted and those were only removed at the resident's request. -Resident 205 did not have an air mattress on his bed. He had a mattress that she felt would not have saved his heels from a pressure ulcer. -She had been told resident 205 refused the air mattress. *Resident 205 was identified as having a pressure ulcer on his right heel on 3/24/25. *She felt that resident 205's right heel pressure ulcer had been caused by his AFO brace (used to control ankle/foot position and movement) that his daughter had brought to the facility for him to wear. -That brace was sent home before she had returned to work, and she had not seen that brace. *She expected interventions including the use of an air mattress, pressure-reducing boots while in bed and while in the wheelchair, and every two-hour repositioning to have been implemented for any resident admitted and assessed as a high-risk for a pressure injury. *She confirmed that there were no interventions, including the pressure-reducing boots, listed in resident 205's care plan before or after the identification of that pressure ulcer. *She stated that those above interventions would not have prevented a pressure ulcer from his AFO. *Resident 205 had been provided with those pressure-reducing boots when the pressure area was identified. -She expected resident 205 to wear those pressure-reducing boots when he was in bed and in his wheelchair. Interview on 4/2/25 at 12:16 p.m. with DON B regarding resident 205 revealed: *She expected resident 205's physician's transfer orders for wound prevention should have been included in resident 205's care plan and implemented before he developed a pressure ulcer. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His care plan should have been updated with additional interventions if needed after his pressure ulcer had been identified. *Resident 205 had been provided with pressure-reducing boots after the right heel pressure ulcer had been identified. Interview on 4/2/25 at 12:30 p.m. with registered nurse (RN) D regarding resident 205's admission orders revealed: *Resident 205 was transferred from another long-term care facility with orders from his physician. *She had reviewed those admitting orders and entered the medication orders and care plan interventions. *The treatment orders and interventions including the pressure injury treatment and prevention orders were to have been reviewed by ADON C before they were entered into the resident's EMR. *When ADON C was unavailable to review those orders and interventions she expected DON B to review and enter them. 3. Observation and interview on 3/30/25 at 2:52 p.m. and again at 6:43 p.m. with resident 206 revealed: *He was lying in his bed. *A tabs alarm (a device that alerts staff with an audible sound when the resident changed position) was draped over the handle of his bedside table and hung down towards the floor. *He stated that he had fallen recently, was getting stronger, and wanted to return home. Observation on 3/30/25 at 6:52 p.m. with resident 206 in the dining room revealed he was seated in his wheelchair with no tabs alarm. Observation on 3/31/25 at 8:06 a.m. with resident 206 in the dining room revealed he was seated in his wheelchair eating breakfast and there was no tabs alarm on his wheelchair. Observation and interview on 4/1/25 at 7:30 a.m. with resident 206 revealed: *He was seated in a recliner chair outside the dining room with his wheelchair parked to the left of a recliner. *He stated that he had transferred himself to that recliner chair and was waiting to go to the dining room for breakfast. *There was no tabs alarm on his wheelchair or the recliner chair. Observation and interview on 4/2/25 at 8:39 a.m. with resident 206 revealed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He was lying in his bed. *The tabs alarm was attached to the bedside table drawer. -He was not wearing the tabs alarm in bed. *He stated he did not know what the tabs alarm was used for and that he did not wear it while in bed or in his wheelchair. Review of resident 206's EMR revealed: *He was admitted on [DATE]. *His diagnoses included Type 2 Diabetes Mellitus, cirrhosis of the liver, convulsions, and difficulty in walking. *Physician orders on 3/13/25 included, Ensure tabs alarm is on at all times when in bed and his wheelchair, and Tabs alarm on in bed and to wheelchair to notify staff of position changes. *His care plan included: -I am at risk for falls related to history of hepatic encephalopathy, cardiomyopathy and glaucoma, was initiated on 3/25/25. -Tab alarm to alert staff with position changes, was initiated on 3/25/25. -I require substantial/max assist [assistance] by staff with: roll left and right, sit to lying, sit to stand, lying to sitting on [the] side of [the] bed, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers. Interview on 4/1/25 at 9:29 a.m. with CNA K revealed: *CNA K worked at the facility for approximately three months. *CNA K had found resident 206 on the floor near his bed a few weeks ago. She could not recall the date that occurred. -Resident 206 had tried to transfer himself to his bed. *Resident 206 required the assistance of one staff person to transfer him from his bed or wheelchair. *Resident 206 did not wear a tabs alarm before or after that fall. *Resident 206 had a call light that he used to request staff assistance. *CNA K reviewed information on how to care for residents from the residents' paper charts and the EMR when she completed her charting. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*CNA K carried an assignment sheet that provided her with information about the residents she cared for. -That sheet was also used to provide a report to the next shift's staff. --It did not indicate that resident 206 required a tabs alarm. Interview on 4/1/25 at 9:53 a.m. with CNA F regarding resident 206 revealed: *Resident 206 did not wear a tabs alarm. *CNA F stated he would ask the nurse or look in the residents' care plan for information on how to care for the residents. -He stated he reviewed those resident care plans every day. Interview on 4/1/25 at 10:03 a.m. with infection preventionist/licensed practical nurse (IP/LPN) G regarding resident 206 revealed: *She was the nurse who was working on the floor that day and was responsible for resident 206's care. *Resident 206 had a tabs monitor. -He would at times refuse to wear that tabs monitor. -IP/LPN G stated that she had ensured resident 206 was wearing that tabs alarm and he had allowed her to clip it to his shirt. *CNAs would find resident care information in the resident's care plan in the EMR. *She completed the CNA daily assignment sheets and would not have included that resident 206 wore a tabs monitor on that sheet. *IP/LPN G confirmed that resident 206's care plan included that he wore a tabs monitor. Interview on 4/1/25 at 10:34 a.m. with DON B revealed: *She expected the CNAs to look at the Kardex (a report of residents' care needs and interventions) or EMR care plans regularly for information on how to care for the residents. *She stated that a resident's need for a tabs alarm would be care planned. *She confirmed that resident 206's care plan indicated his need for a tabs alarm. *She stated a resident's use of a tabs alarm would not be on the CNA's assignment sheet. 45683 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avantara Pierre		STREET ADDRESS, CITY, STATE, ZIP CODE 950 East Park Street Pierre, SD 57501	

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Observation and interview on 3/31/25 at 9:19 a.m. with resident 34 in her room revealed: *She was sitting in her wheelchair. *Her legs were wrapped with Ace bandages. *She stated the physical therapist wraps her legs daily and it had helped reduce the swelling. Interview on 4/1/25 at 10:39 a.m. with physical therapist M revealed: *She wrapped resident 34's legs with Ace elastic bandages daily because it was a physician-ordered treatment for her lymphedema (fluid build-up that causes swelling). *She had worked with the Minimum Data Set (MDS) coordinator to get the physician's orders for resident 34's Ace wrap treatments. Review of resident 34's electronic medical record (EMR) revealed: *She had been admitted on [DATE]. *She had a brief interview for mental status (BIMS) score of 15 which indicated she was cognitively intact. *Her diagnoses included: -Lymphedema, not elsewhere classified. -Edema, unspecified. -Chronic venous hypertension (idiopathic) with ulcer and inflammation of left lower extremity. *Resident 34's current care plan did not include her use of the Ace wraps. -PT/OT/ST as ordered by MD. -Tx and medications as ordered by MD. Interview on 4/1/25 at 1:55 p.m. with assistant director of nursing (ADON) C regarding resident 34's lymphedema revealed: *She knew the physical therapist was providing the Ace wrapping treatment for resident 34's lymphedema. *She expected that treatment to be addressed in the resident's care plan. *Staff needed to be aware of the care being provided. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 4/2/25 at 12:05 p.m. with RN/MDS coordinator D regarding resident 34's lymphedema revealed: *The nursing staff were not trained regarding the elastic bandage wraps resident 34 needed on her legs. *She had obtained orders from resident 34's physician for the wrap treatments that therapy provided. *She did not think resident 34's use of elastic wraps needed to be part of the resident's care plan because the treatments did not involve the nursing staff. Interview on 4/2/25 at 1:30 p.m. with DON B regarding resident 34's lymphedema revealed: *She knew about the treatments for resident 34's lymphedema. *She confirmed the information regarding the lymphedema treatments was not on her care plan. *It was her expectation that information would be a part of the resident's care plan. Review of the provider's revised 9/30/24 Care Plans policy revealed: *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. *Interventions act as the means to meet the individual's needs. The recipe for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met. *Care plans are accessible to all direct-care staff, including the resident's physician/provider. It is the responsibility of all direct care members to familiarize themselves with the care plan and review the routinely for changes.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and policy review, the provider failed to identify and implement pressure ulcer prevention interventions to ensure facility-acquired pressure ulcers had not developed for one of two sampled residents (205) identified at high risk for skin breakdown and dependent on the staff assistance with their activities of daily living (ADL). Findings include: 1. Observation and interview on 3/31/25 at 8:38 a.m. with resident 205 revealed: *He was seated in his wheelchair and wore blue padded pressure-reducing boots on both of his feet. *He said he had been at the facility for about two weeks and did not know why he needed to wear those boots. -He stated his feet did not hurt. 2. Observation and interview on 4/1/25 at 7:59 a.m. with resident 205 and certified nursing assistant (CNA) R in resident 205's room revealed: *CNA R stated that resident 205 had been at the facility for about two weeks. *Resident 205 wore a Tubi Grip (compression stocking) on his right leg and blue boots on both feet due to a pressure ulcer on his right heel. *Resident 205 stated that the ulcer on his right heel did not cause him any pain. 3. Observation on 4/2/25 at 7:43 a.m. with resident 205 revealed: *He was lying in bed on his back with blue boots on both feet. *His bed did not have an air mattress on it. 4. Review of resident 205's electronic medical record (EMR) revealed: *He had been admitted on [DATE] from another long-term care facility. *His Braden assessment score was 18 on 3/13/25 which indicated he was as risk for developing pressure ulcers. *His Braden assessment score was 6 on 3/17/25 which indicated he was at high risk for developing pressure ulcers. -That assessment indicated he did not have a history or an existing pressure ulcer at that time. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

*A 3/13/25 physician's order, Transfer to [provider] on current orders. Send current supply of meds [medications].

-Those orders indicated:

--Skin prep to bilateral heels for skin protection one time daily.

--Pressure Injury Treatment/Prevention on each shift two times a day. 1. Check that [the] air mattress is on [the] bed and operating correctly. 2. Float heels when in bed. 3. Ensure dressings are in place as ordered. 4. Pressure redistributing cushion in w/c [wheelchair]. 5. Reposition q2-3h [every two to three hours]. 6. Pericare as indicated, were noted as received 3/17/25.

---There was no documentation that indicated that those orders had been initiated upon resident 205's admission to the facility.

*His diagnoses included hemiparesis (paralysis) following cerebral infarction (a stroke) affecting the left non-dominant side, Type 2 Diabetes Mellitus, major depressive disorder, pressure ulcer of the right heel, unstageable, and personal history of Staphylococcus Aureus [drug resistant organism] infection.

*A 3/24/25 Skin Alteration Evaluation identified a new pressure injury to resident 205's right heel that measured 4.4 centimeters (cm) in length by 5.0 cm in width and was staged as a suspected deep tissue injury.

*His care plan indicated:

-I have an ADL Self Care Performance Deficit r/t [related to] impaired mobility. 2 [Two] staff and the hoyer lift [a full-body mechanical lift and sling used to move a person's full body] for all transfers, was initiated on 3/18/25.

-I am dependent on staff with: roll left and right, chair/bed-to-chair transfers, toilet transfers, tub/shower transfers, toileting hygiene, shower/bathe self, upper/lower body dressing, putting on/taking off footwear, [and] personal hygiene, was initiated on 3/25/25.

-Utilizes an [a] bariatric bed, was initiated on 3/18/25.

-Ensure that I am wearing appropriate footwear when mobilizing in w/c [wheelchair], was initiated on 3/25/25.

-I have an unstageable pressure ulcer to right lateral heel r/t AFO [ankle-foot orthosis] use. My pressure ulcer will show signs of healing and remain free from infection through the review date, was initiated on 3/25/25.

*There was no documentation that indicated:

-An air mattress had been utilized, trialed, or refused as ordered by the physician at the time of his admission.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	-The resident wore blue padded pressure-reducing boots. -That the above pressure injury treatment and prevention interventions ordered by the physician had been care planned or implemented upon admission. 5. Interview on 4/02/25 at 8:04 a.m. and again at 11:10 a.m. with assistant director of nursing (ADON) C regarding resident 205 revealed: *She was the wound care nurse. *She had been on vacation when resident 205 was admitted to the facility. *Resident 205 did not have any pressure ulcers when he was admitted to the facility on [DATE]. *Resident 205 had been assessed as high risk for developing pressure ulcers when he was admitted . *She stated all residents were provided with an air mattress when they were admitted and those mattresses were only removed at the resident's request. -Resident 205 did not have an air mattress on his bed. He had a mattress that would not have saved his heels from a pressure ulcer. -She had been told resident 205 refused the air mattress. *Resident 205 was identified as having a new pressure ulcer to his right heel on 3/24/25. *She felt that resident 205's right heel pressure ulcer had been caused by his AFO brace that his daughter had brought to the facility for him to wear. -That brace was sent home before she had returned to work, and she had not seen that brace. *She expected pressure relieving interventions including the use of an air mattress, pressure reducing boots in bed and while in the wheelchair, and every two-hour repositioning would have been implemented for any resident admitted and assessed as high risk for pressure injury. *She confirmed that there were no interventions, including the pressure-reducing boots, for pressure relief listed in resident 205's care plan before or after the identification of that pressure area. *She stated that those above interventions would not have prevented a pressure injury from his AFO. *Resident 205 had been provided with those pressure reducing boots when the pressure ulcer was identified. -She expected resident 205 to wear those pressure reducing boots when he was in bed and in his wheelchair. 6. Interview on 4/2/24 at 12:16 p.m. with DON B regarding resident 205 revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	*She expected that all the physician transfer orders and interventions should have been implemented and followed when resident 205 had been admitted including the pressure ulcer prevention orders. -Those interventions for pressure ulcer prevention should have been included in resident 205's care plan before he developed a pressure ulcer and updated with additional interventions if needed after the pressure ulcer had been identified. *Resident 205 had been provided with the pressure reducing boots after the right heel pressure ulcer had been identified. *She confirmed the resident had developed the pressure ulcer after his admission to the facility. 7. Interview on 4/2/25 at 12:30 p.m. with registered nurse (RN) D regarding resident 205's admission orders revealed: *Resident 205 was transferred from another long-term care facility with orders from his physician. *She had reviewed those admitting orders and entered the medication orders and care plan interventions. *The treatment orders and interventions including the pressure ulcer treatment and prevention orders were to have been reviewed by ADON C before they were entered into the EMR. *When ADON C was unavailable to review those orders and interventions she expected DON B to review and enter them. Review of the provider's revised 9/11/24 Skin and Pressure Injury Prevention Program policy revealed: *To ensure a resident who enters the facility without pressure injuries does not develop pressure injuries unless the individual's clinical conditions demonstrates that they are unavoidable. *A plan of care (POC) will be put in place for residents that are identified with actual skin breakdown or at-risk for skin breakdown. *Nursing personnel will utilize the results of the physical exam and the Pressure Injury Assessment tools to determine an individualized pressure injury prevention program for each at-risk resident. This will include interventions to: a. Protect skin against the effects of pressure, friction and shear .d. Educate staff, residents and families, e. Train front-line caregivers, f. Immediate prevention plan instituted when potential areas are identified. *Pressure can come from splints, casts, bandages, and wrinkles in the bed linen.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50015 Based on record review, interview, and policy review, the provider failed to ensure the implementation of their smoking policy for one of one sampled resident (11) who smoked and was not assessed for smoking risks and safety. Findings include: 1. Review of resident 11's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a history of being burned while smoking, preferring to smoke down to the filter of the cigarette. *Her current care plan had a focus area that indicated she preferred to smoke and had the potential for injury. That focus area was initiated on 9/28/21 and revised on 5/10/22. *Interventions for the focus area included: -Ascertain her wishes about smoking and respect her decision. -Assess her ability to smoke independently/safely. Staff were to supervise her while she was smoking. -If the weather was below zero, she was not allowed to smoke. -She was to use a cigarette extender and a protective smoking apron to prevent her from further burns when she smoked. -She could smoke per facility's smoking schedule after meals in the courtyard. -Staff were to encourage her to put out her cigarette before it got to the filter. -Staff were to stay with resident 11 while she was smoking and remind her to not make any sudden turns when smoking. -Her smoking materials were to be stored in a locked area per facility policy. *She had the following smoking program evaluation assessments completed: -An as needed assessment on 11/23/23. -An annual assessment on 9/5/24. -A quarterly assessment on 12/30/24 and 3/31/25. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-No quarterly smoking program evaluation assessments were completed for her between December 2023 and August 2024. *She was hospitalized on [DATE] and returned to the facility on [DATE]. -No smoking program evaluations assessment was completed upon her return to the facility on [DATE]. 2. Interview on 4/01/25 10:17 a.m. with certified nursing assistant (CNA) F revealed: *Resident 11 had needed to have staff present when she smoked. *There were no set smoking times. *Resident 11's cigarettes were locked up in a cabinet. *CNA's had access to that cabinet. 3. Interview on 4/01/25 at 10:53 a.m. with licensed practical nurse (LPN) E revealed: *Resident 11 had not been smoking for approximately the last three weeks. -She had paranoid schizophrenia and had stated that someone told her she should not be smoking. -Her smoking supplies were kept in a locked cupboard in the activities room. -She was to have staff stay with her while she smoked. *Assessments including the smoking program evaluation assessments, could be completed by floor nurses. *The assessments would automatically appear red in the EMR system when they were due, and that was how she would know she needed to complete an assessment. 4. Interview on 4/2/25 at 7:44 a.m. with registered nurse (RN) D revealed: *She or director of nursing (DON) B would complete the user-defined assessments (UDA's) for a resident's smoking risk. *She said the floor nurses had never completed the resident's smoking risk evaluations. *Those smoking assessments were required to be completed quarterly at the same time the resident's minimum data set (MDS) assessments was completed. *She had worked on 10/24/24 when resident 11 was hospitalized . *She had worked between December 2023 and August 2024. *She felt she could have missed resident 11's assessment's during those above dates. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*She stated their EMR system did not automatically populate the resident's smoking program evaluation assessments for completion. 5. Interview on 4/2/25 at 8:15 a.m. with assistant director of nursing (ADON) C revealed: *She did not complete the residents' smoking program evaluation assessments and was unsure of how often they were to be completed. *She thought that DON B had completed those assessments before. 6. Interview on 4/2/25 at 10:20 a.m. with DON B revealed: *She or RN D would complete the residents' smoking program evaluation assessments. *Those assessments did not auto-populate in their EMR system for them to complete. *Floor nurses did not complete those assessments. *She stated she assumed resident 11's smoking risk assessments between December 2023 and August 2024 and upon her readmission after her hospitalization on [DATE] were missed. *She expected staff to follow their policy for when the smoking program evaluation assessments should be completed. Review of provider's 2/10/24 revised Smoking Policy revealed: *If the facility allows smoking, all residents who smoke will be assessed for their ability to safely smoke with or without assistance or supervision and such will be included on the [resident's] care plan. The Smoking Assessment will be completed at admission, readmission, quarterly, annually and with a change in condition.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45683 Based on observation, interview, record review, Voluntary Agreement for Arbitration review, and policy review, the provider failed to ensure 50 of 55 residents (1, 2, 3, 4, 5, 7, 10, 12, 13, 15, 16, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 50, 104, 105, 106, 115, 154, 156, 204, 205, 206, 304, 305) who had entered into an Arbitration Agreement upon admission to the facility were explicitly granted the right to rescind the agreement within 30 calendar days of signing it. Findings include: 1. Observation and interview on 3/31/25 at 1:25 p.m. with resident 34 in her room regarding the Voluntary Agreement for Arbitration addendum she had signed upon admission revealed she: *Knew she signed several papers when she was admitted . *Was not sure what a Voluntary Agreement for Arbitration was for. *Did not recall signing a Voluntary Agreement for Arbitration specifically. Review of resident 34's electronic medical record (EMR) revealed: *She was admitted on [DATE]. *She had a Brief Interview for Mental Status (BIMS) score of 15 which meant she was cognitively intact. *Her 12/30/24 admission agreement was signed by resident 34. *The admission packet included information regarding arbitration. 2. Review of the provider's undated Voluntary Agreement for Arbitration agreement revealed: *The execution of this Arbitration Agreement is voluntary and is not a precondition to receiving medical treatment at or for admission to the Facility. *The Resident and/or Legal Representative understands that this Arbitration Agreement may be rescinded by giving written notice to the Facility within 10 days of its execution. If not rescinded within 10 days of its execution, this Arbitration Agreement shall remain in effect for all claims arising out of the Resident's stay at the Facility. 3. Interview on 4/2/25 10:19 a.m. with administrator A regarding the amount of time a resident had to rescind the arbitration agreement revealed: *All residents were offered arbitration upon admission. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The social services director went over the arbitration agreement during the admission process with the resident and/or their representative. *Arbitration was not a condition for admission to the facility. *No residents had used the arbitration process to settle a dispute. *He was not sure why the corporate agreement allowed 10 days for a resident/responsible party to rescind the agreement. *He agreed it should be 30 days in the arbitration agreement according to the requirements. *All residents would have signed the same agreement. *50 of the 55 current residents (1, 2, 3, 4, 5, 7, 10, 12, 13, 15, 16, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 46, 47, 48, 50, 104, 105, 106, 115, 154, 156, 204, 205, 206, 304, 305) admitted after the 2019 arbitration agreement implementation and had signed arbitration agreements. *The five residents who did not have those signed agreements were admitted prior to the 2019 arbitration agreements being implemented. *The social services director was not available for an interview during the survey. 4. Review of the provider's undated Arbitration Agreement policy revealed: *It is the policy of Avantara [NAME] (Facility) to present the Arbitration Agreement to Resident/Resident's Legally Authorized Representative (Representative) after the admission paperwork is completed. *Not require any resident or his/her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at a facility. *Provide the resident or his/her representative a 30-day rescission period.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on observation, interview, record review, and manufacturer's manual review, the provider failed to ensure appropriate infection control practices were followed for: *Enhanced barrier precautions (EBP) (gloves and gown use when providing direct contact care) by two of two certified nursing assistants (CNAs) (J and S) for one of one sampled resident (205) with a catheter, multidrug-resistant organism (MDRO), and a pressure injury. *Appropriate whirlpool (WP) tub cleaning by two of two CNAs (F and I) in one of two WP tub rooms used for bathing residents. *Maintaining the cleanliness of the laundry room. Findings include: 1. Observation on 3/30/25 at 5:26 p.m. with resident 205 revealed: *There was a sign on his door that indicated Stop Enhanced Barrier Precautions Everyone must: Clean their hands, including before entering and leaving the room. Providers and staff must also: Wear gloves and a gown for the following high-contact resident care activities dressing bathing/showering, transferring, changing linen changing briefs, or assisting with toileting . *Resident 205 was in bed and had been rolled on his side facing the window. *CNA J and CNA S were providing resident 205 assistance with personal hygiene and changing his undergarments. *CNA J and CNA S had gloves on but did not have gowns on while they assisted resident 205. Interview on 3/30/25 at 5:37 p.m. with CNA S regarding the above observation revealed: *She stated that the EBP sign on resident 205's door meant that she needed to wear gloves and a gown when she emptied his catheter. *She confirmed that she and CNA J had been wearing gloves but no gowns when they changed resident 205's undergarments. *She did not think they needed to wear a gown when they provided the above care, because they did not empty his catheter. Review of resident 205's electronic medical record (EMR) revealed: *He had been admitted on [DATE]. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avantara Pierre		STREET ADDRESS, CITY, STATE, ZIP CODE 950 East Park Street Pierre, SD 57501	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*His diagnoses included, a pressure ulcer of the right heel, unstageable, and personal history of Staphylococcus Aureus (a bacterial) infection. *His care plan indicated: -I am on Enhanced Barrier Precaution r/t [related to] catheter and wound care. -Ensure that gown and gloves are used during high-contact resident care activities of catheter cares, draining of Foley catheter and wound care that provide opportunities for transfer of MDROs to staff hands and clothing. Interview on 4/1/25 at 10:08 a.m. with infection preventionist/licensed practical nurse (IP/LPN) G regarding EBP revealed she expected staff to wear both a gown and gloves while providing direct care, such as personal hygiene and changing undergarments to residents with catheters and wounds. 2. Observation and interview on 4/1/25 at 10:49 a.m. with CNA I and CNA F in the west WP tub room of the cleaning and sanitizing process of the resident WP tub revealed: *Both CNA I and CNA F used the WP to bathe residents that day. *CNA I took a spray bottle of Micro-Kill Q10 disinfectant cleaner from the cabinet and sprayed the surfaces of the WP tub. *CNA F indicated that the Micro-Kill Q10 was not the correct cleaner for the WP tub and took a spray bottle of BruTab 6S cleaner/disinfectant from that same cabinet. -That spray bottle of BruTab 6S was not dated, the bottle's label was worn, and there was no indication of the time the surface needed to remain wet with that product to achieve sanitization. *There were instructions for cleaning the WP tub posted and taped to the front of that cabinet. *CNA F sprayed the surfaces of the tub and tub seat with the BruTab 6S spray, stated he would wait 10 minutes, and then used the shower sprayer to rinse down the surfaces. *CNA F stated that was the process used to clean and sanitize the WP tub between each resident's bath. *CNA I and CNA F confirmed there was no brush used to clean the tub. Observation and interview on 4/1/25 at 2:08 p.m. with director of nursing DON B in the west WP tub room revealed: *She expected the CNAs to clean the WP tub with the BruTab 6S cleaner and that the surface needed to remain wet for 10 minutes. -That spray bottle's contents had been made with an effervescent tablet of that cleaner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*Page 23 of the manual indicated, Perform these procedures in the following order: 1. Use the drain plug to close the drain. 2. Remove and disassemble all jet assemblies. Lay all pieces in the bottom of the tub . 4. Clean the pieces and spray all surfaces of the tub with Dispatch Cleaner and Disinfectant. Take a long handled brush and thoroughly clean surfaces of the tub and the jet casings. 5. Allow the Dispatch Cleaner and Disinfectant to sit on the surfaces for one minute. 6. Rinse all surfaces and pieces in the footwell of the tub with water. 7. Use a clean towel to dry all tub surfaces . 3. Observation and interview on 4/2/25 at 9:18 a.m. with laundry aide L in the facility laundry room revealed: *Laundry aide L had worked at the facility for approximately 3 years. *She stated that the laundry staff were responsible for cleaning the laundry room. *There was an oscillating fan mounted to the wall adjacent to the entrance door. -That fan blew air from the side of the laundry room where the soiled linens were brought in and loaded into the washing machines towards the area where the laundry aide folded the clean linens. *There was an area under the wall-mounted chemical system approximately two feet by two feet where the paint was peeled and had exposed concrete. *The area of the floor near that chemical system had more than three areas two inches by five inches where the tiles were cracked or peeling and were uncleanable surfaces. *Laundry aide L stated those areas were from when the chemicals leaked. The leak had been fixed but the floor and wall had not been repaired. -She could not recall when that leak had occurred and stated it had been a while, and that maintenance was aware of those areas. *In the clean linen room there were hooks on the wall that held the mechanical lift slings. -More than six of those lift slings touched the floor and had thick gray dust on them. *The area below the slings had an area of approximately three inches by two feet of cracked or missing tiles and peeling paint on the wall. -Laundry aide L was not sure if maintenance was aware of those areas. Observation and interview on 4/2/25 at 9:41 a.m. with maintenance director H in the laundry room revealed he: *Was aware of the areas near the wall-mounted chemicals that needed repair. -Had not ordered tiles to replace the cracked ones. *Was not aware of the areas on the wall or the cracked flooring in the clean linen room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the provider's revised 2/28/25 Infection Prevention Program Policy revealed: *The facility-wide comprehensive infection prevention and control program addresses detection, prevention, and control of infections among residents and personnel. It is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.