STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Saint Cloud	302 St Cloud Street Rapid City, SD 57701

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 42558 Based on observation, interview, record review, policy review, and South Dakota (SD) State Long-Term Care Ombudsman Program handbook review, the provider failed to ensure: *One of one sampled resident (31) had received diabetic fingernail care to maintain a dignified appearance. *One of one sampled resident (8) was dressed in a dignified manner. Findings include: 1. Observation and interview on 11/5/24 at 9:26 a.m. with resident 31 while she rested in her bed revealed: *She was chewing and sucking on her left index and middle finger and stated she was hungry. *Inspection of both hands revealed she had long, uneven, fingernails that extended approximately one-fourth of an inch beyond her finger pads. -There was a dark brown build-up of an unknown substance caked under each fingernail that extended outwards from the edge of each finger pad to the middle of each fingernail. *An odor of feces was detected at her bedside. Observation and interview on 11/6/24 at 9:40 a.m. with the assistant director of nursing (ADON) C and contracted hospice registered nurse (RN) L during resident 31's wound care to her right lateral foot revealed: *ADON C stated she was the provider's wound care nurse. *Hospice RN L stated the resident received a bed bath once weekly from the hospice aides. *Resident 31 was lying in her bed and was sucking on her left index finger during her wound care treatment. (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: 435060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Avantara Saint Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE 302 St Cloud Street Rapid City, SD 57701	

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*ADON C stated: -Every resident was expected to be provided nail care on their bath days. -Resident 31 was provided fingernail care following every meal, or at a minimum of once daily as the resident liked to dig [in her feces]. -Since resident 31 was a diabetic, the resident's charge nurse was expected to provide her fingernail care. A podiatrist provided her with toenail care. *Both ADON C and hospice RN L confirmed resident 31's fingernails were long and caked with a brown substance. Review of resident 31's electronic medical record (EMR) revealed: *She had been on hospice care since April of 2024 for end-of-life care related to multiple co-morbidities that included: advanced dementia with agitation, late-onset Alzheimer's disease, congestive heart failure, chronic obstructive pulmonary disease, peripheral vascular disease, cerebrovascular disease, and type 2 diabetes mellitus with peripheral angiopathy with gangrene. *She had a Brief Interview for Mental Status (BIMS) assessment score of four, which indicated she had severe cognitive impairment. *She was dependent on staff for all her hygiene needs including bathing, personal hygiene, and incontinence care. *A nurse provided a daily dressing treatment to her right foot and completed with weekly assessments of her skin. *Review of her physician's orders, treatment orders, nursing documentation, and CNA care task documentation had not indicated when and by whom nail care was to have been completed. On 11/6/24 at 1:37 p.m., a request was made to the provider for a nail care policy and documentation of resident 31's completed fingernail care. Interview on 11/6/24 at 3:20 p.m. with the director of nursing (DON) B regarding resident 31's fingernail observations and nail care revealed: *She stated the nail care policy was included in the bathing policy. *She stated they had no documentation of when her diabetic nail care was completed, but it was her expectation the bathing policy would have been followed by staff, which indicated nail care would be performed with each bath. -Diabetic nail care was expected to be performed by the nurses and all the nurses were expected to know this was to occur on the resident's bath days. *She confirmed the performance and documentation of diabetic nail care needed to be improved. (continued on next page)

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	435060	A. Building B. Wing	11/07/2024

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the provider's August 2023 bathing policy revealed: *Fingernails and toenails should be inspected on bathing days and nails should be trimmed and filed as necessary. CNAs (certified nurse aides) will not perform nail care on residents with diabetes. *The policy had not addressed who was expected to provide and document diabetic nail care. 40788 2. Observation on 11/5/24 at 9:45 a.m. of resident 8 in her room revealed she: *Was laying on her side asleep in bed. -Wore socks labeled with her roommate's name on them. Observation on 11/6/24 at 9:30 a.m. of resident 8 in her room revealed she: *Was seated in her wheelchair watching television. -Wore socks labeled with an unknown resident's name on them. Review of resident 8's 8/27/24 Minimum Data Set assessment revealed: *Her cognition was severely impaired. -She rarely made her own decisions. Interview on 11/6/24 at 10:00 a.m. with certified nurse aide K regarding resident 8 revealed: *Staff had chosen the clothes she wore each day. *The resident had her own socks. -The socks that were put on her that morning were donated. Review of the August 2019 SD State Long-Term Care Ombudsman Program handbook revealed: *Dignity and Quality of Life: -All residents were entitled to reasonable quality of life including: 2. To be treated with consideration, respect, and dignity. Recognition of your, and every resident's, individuality.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 40788 Based on observation, interview, South Dakota (SD) State Long-Term Care Ombudsman Program handbook review, and policy review, the provider failed to ensure: *Window coverings in 12 of 14 resident rooms (301, 302, 303, 304, 305, 306, 307, 309, 311, 312, 314, and 316) located in the 300 Hall had protected those residents' right to privacy. *Window coverings in 5 of 9 resident rooms (105, 107, 111, 113, and 115) located in the 100 hall had protected those residents' right to privacy. *One of 14 residents' (2) electronic medical records (EMR) were secured and not accessible to other residents, staff, or the public. *One of two medication carts were locked and medications were not accessible to other residents, staff, and the public by one of one registered nurse (RN) J in the Main dining room during the noon medication pass. Findings include: 1. Observation on 11/4/24 at 7:15 p.m. on the sidewalk leading to the main entrance of the facility revealed: *Resident rooms on the north side of the 300 hallway ran parallel to that sidewalk. -The windows in those rooms faced the visitor's parking lot. *The inside of those rooms were visible despite the window shades in those rooms having been pulled down. *Resident rooms on the south side of the 300 hallway had the same type of window shade coverings. -Those windows faced an employee parking lot. Observation on 11/5/24 at 7:30 a.m. on the same sidewalk referred to above revealed the insides of the residents' rooms on the north side of the 300 hallway were not visible through the pulled down window shades during daylight hours. Observation and interview on 11/5/24 at 4:50 p.m. with administrator A on the sidewalk above revealed: *The insides of the resident rooms on the north side of the 300 hall were visible despite the window shades having been pulled down. *Administrator A had not known the pulled window shades failed to protect the privacy of the residents who occupied those rooms. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the August 2019 SD State Long-Term Care Ombudsman Program revealed: *Privacy and Confidentiality -You have the right to privacy and confidentiality regarding personal, financial, and medical affairs. 42558 2. Observation on 11/5/24 at 8:30 a.m. of the 100 hallway resident rooms revealed: *Five of the nine rooms (105, 107, 111, 113, and 115) that faced the north-sided public sidewalk and parking lot contained the same type of shade observed above in the 300 hallway that allowed unobstructed night-time viewing of the resident's rooms when pulled down. -Those shades provided resident with privacy during the daylight hours only. -Those rooms did not contained any other type of window covering to ensure resident privacy at night. 47780 3. Observation and interview on 11/6/24 at 11:20 a.m. with RN J the main dining room during a medication pass revealed: *She had been preparing medications for the residents' who were seated in the main dining room. *She prepared resident 2's medications, placed the medications in a medication cup, and verified the medications were correct as indicated in the resident's medication administration record (MAR). *She returned resident 2's medication card in the medication cart. *She picked up the medication cup with the resident's medications and walked over to the resident. -She left the medication cart unlocked and the computer screen open that displayed resident 2's EMR information. -Multiple staff members walked by the unlocked cart to wash their hands at the sink. -Her back was turned away from the medication cart while she assisted the resident with her medications. *RN J agreed the screen should not have been left open and should have been shut. *RN J agreed the medication cart should have been locked when she walked away from the medication cart. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/6/24 at 2:52 p.m. with director of nursing (DON) B regarding the above observation revealed: *She expected the staff to minimize or lock the computer screen and to make sure the medication cart was locked, and the keys were always with them. Review of provider's September 2019 Resident Dignity & Privacy policy revealed: *Policy. -It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity, as well as, care for each resident in a manner and in an environment, that maintains resident privacy. -18. Protected Health Information should not be in viewing area of public. This includes computer screens, resident room listing, report forms, etc. Review of provider's September 2018 Medication Administration General Guidelines policy revealed: *Policy -Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. -Procedures --Medication Administration --17. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. --18. Resident's health information needs to remain private. The pages of the MAR [Medication Administration Record] notebook containing resident health information must remain closed or covered when not in direct use.

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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** 40788 Based on observation, interview, and policy review, the provider failed to maintain a clean and homelike environment for: *8 of 14 resident rooms (301, 303, 304, 309, 311, 312, 314, and 316) on the 300 hallway. *5 of 22 resident rooms (202, 204, 206, 207 and 209) on the 200 hallway. *6 of 23 resident rooms (103, 104, 108, 110, 115, and 117) on the 100 hallway. Findings include: 1. Random observations on 11/5/24 between 9:30 a.m. and 3:35 p.m. inside the rooms on the 300 hallway revealed: *room [ROOM NUMBER] had areas of exposed sheetrock near the foot and head of the bed, and behind the headboard of that bed which was positioned along the wall beneath the window. -There was an area of exposed sheetrock near the head of another bed that was positioned along the wall near the doorway of that room. *In room [ROOM NUMBER], the recliner's headrest was worn and no longer a cleanable surface. *room [ROOM NUMBER]: There was an area approximately 12 inches by 12 inches on the wall beneath the window near the foot of the bed that appeared to have been a spill of a black substance that had run down that wall. *room [ROOM NUMBER] had an area of the baseboard molding along the wall between the bathroom door and the south wall that was missing. The exterior doorframe of the bathroom had multiple areas where the paint was missing. *room [ROOM NUMBER] had areas of exposed sheetrock near the foot and head of the bed that was positioned on the wall beneath the window. -There was an area of exposed sheetrock behind the headboard of another bed that was positioned along the wall opposite of the window. A crack extended from the top to the bottom of that wall. *room [ROOM NUMBER] had an approximately six inches long by three inches wide oval-shaped outline that appeared to have been made by a black marker on the wall beneath the window. *room [ROOM NUMBER] had areas of exposed sheetrock on the walls near the heads of both beds. -There were multiple scratch-like gouges exposing the sheetrock on the wall behind the recliner. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*room [ROOM NUMBER] had areas of exposed sheetrock on the wall by the window near the head and foot of the bed. -There were areas of exposed sheetrock at the head and midsection of the bed positioned on the wall opposite of the window. 47780 2. Random observations on 11/5/24 between 9:00 a.m. and 5:45 p.m. of the inside of the rooms in the 200 hallway revealed: *room [ROOM NUMBER]: Had areas of missing paint on the wall behind the headrest of the recliner. -There were multiple scratch-like gouges from the bottom of the floor to 12 inches up [NAME] the entrance and the bathroom doorframes. *room [ROOM NUMBER]: There were multiple scratch-like gouges from the bottom of the floor to 12 inches up of the entrance and bathroom doorframes. -There was missing portion of the door panel on the front portion of the entrance door. *room [ROOM NUMBER]: Had an area of exposed sheetrock positioned along the wall next to the sink, and two dime-size holes inside the exposed sheetrock. *room [ROOM NUMBER]: Had multiple scratch-like gouges from the bottom of the floor to 12 inches up from the bathroom doorframe. -There was an approximate ten-inch long by ten-inch wide white square-shape patch on the wall next to the toilet. 51816 3. Observation on 11/4/24 at 3:05 p.m. in room [ROOM NUMBER] revealed: *Gouges and areas where paint was scraped off both sides of the doorframe entering the resident's room. *Multiple areas of missing paint and exposed sheetrock on the wall that extended the length of the resident's bed. *Gouges and areas where paint was scraped off both sides of the bathroom doorframe. *A large area of paint was scraped off the wall opposite the sink in the bathroom. *A privacy curtain in the room was visibly soiled and had an area with an unknown brown substance on it. 42558 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Random observations on 11/4/24 from 1:45 p.m. through 4:55 p.m. of the resident rooms located in the 100-hallway revealed: *room [ROOM NUMBER]: Had several areas of missing paint and exposed sheetrock that included a wall above the left side of the mattress that covered a two-foot long by one-foot-wide area, and a wall near the right side of the bed's headboard that measured approximately six inches long by three inches wide. -In the opposite corner of the room, there were scattered areas of missing paint and exposed sheetrock located on the wall next to each side of a recliner chair. *room [ROOM NUMBER]: Had two linear sections of missing paint and exposed sheetrock located above the bed mattress and at the foot of the bed. *room [ROOM NUMBER]: Had several areas of missing paint and exposed sheetrock located along the wall under the window right above the resident's mattress, and a visible linear crack of peeling paint located at the resident's head of the bed where the room's outside wall and inside wall joined. It extended nearly the entire height of the room. *room [ROOM NUMBER]: Had scattered areas of missing paint and exposed sheetrock throughout the room including on a wall next to a dresser holding a television, and along the doorway entrance into the bathroom. *room [ROOM NUMBER]: Had multiple areas of missing paint and exposed sheetrock throughout the room along three of the four walls. -There was an electrical outlet cover that was broken with half of the cover missing and the interior of the outlet exposed. It was located slightly above the resident's mattress. -There were two-dime sized holes in the wall by the sink and missing paint on the doorway leading into the bathroom. *room [ROOM NUMBER]: Had several areas of missing paint and exposed sheetrock located along the wall under the outside window. Observation and interview on 11/6/24 at 1:38 p.m. with interim maintenance supervisor H during a walking tour of several of the above-mentioned rooms revealed: *He stated the prior maintenance supervisor had resigned approximately one-and-a-half weeks ago. *He worked full-time at a sister facility and had planned on coming to this facility two to three times a week. -He stated there was a maintenance supervisor from another sister facility who could fill in as needed. *They were able to receive the provider's maintenance repair requests through an electronic communication system called TELS (technology for enhanced living solutions). (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*He stated: -The maintenance department was responsible for overseeing the housekeeping department along with a head housekeeper. -He depended on staff and housekeeping supervisor G to submit reports of any building maintenance issues into TELS. -He was aware of some spackling and painting of resident rooms had occurred because he had to educate the prior maintenance supervisor on how to spackle drywall. -He knew there had been contract painters brought in during the last year to repair, paint, and remodel resident rooms. -He thought there were not many rooms remaining that needed to be completely painted. - .of course there is always a need for [paint] touch-ups, door jams, and those type circumstances. *He was not aware of any rooms that needed immediate repair or touch-up painting. *Following a walk-through and random inspection of several of the above-mentioned rooms, he stated he had not been aware there were multiple rooms that needed paint touch-ups and confirmed the rooms appearances were not homelike. -He had not been aware of the broken outlet cover in room [ROOM NUMBER]. *He stated his expectation as a maintenance supervisor, would be to perform a monthly walk-through inspection of resident rooms for needed paint touch-ups and repairs. He was not aware when that had last occurred in this facility. *He stated painting and repairs were difficult to complete because a resident's room had to be empty to repair or paint the room. Interview on 11/06/24 at 4:00 p.m. with administrator A regarding multiple rooms with missing paint, exposed sheetrock, and maintenance repair needs revealed: *It was her expectation for the staff to fill out a TELS maintenance request on any urgent repair needs. -She stated everyone had access to the electronic TELS system. *She had contracted painters and sheetrock repair men working on repairing each room that was identified through an audit as needing paint and repairs. -The contractors had been repairing and painting one room at a time on the weekends when they were available. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She confirmed that according to their 2022 South Dakota Department of Health survey and plan of correction for a homelike environment, there had been a designated empty room to move a resident into while the resident's room was being painted and repaired. However, they had an emergency resident admission in October and were room blocked (no empty room) from continuing with the scheduled painting and repairs. Review of the 2024 contracted drywall and paint invoices revealed seven visits in 2024 (3/20, 5/1, 6/3, 6/7, 9/18, 9/21, and 10/5/2024) had occurred. Resident rooms that had been billed as completed were listed as rooms 104, 205, 303, 308, and 314. There were other repairs listed in those invoices that were not related to resident rooms. Further interview on 11/7/24 at 7:43 a.m. with administrator A regarding paint touch-ups and room repairs performed in between complete room painting revealed: *She was actively trying to hire a full-time maintenance person. *They planned on resuming with complete room painting next week, as an empty room had just become available. She stated room painting was a slow process. *Regarding preventative room maintenance she stated: -Touch-up painting had occurred in the past, but they had backed off as we were looking at permanent fixes. -I should have given more directive to follow through with completion of touch-ups. *She confirmed paint touch-ups should have occurred in between a complete room repainting and agreed the missing paint and exposed drywall had created an uncleanable surface and was not a homelike environment for the residents who resided in those rooms. Interview on 11/7/24 at 8:41 a.m. with housekeeping supervisor G revealed: *He had worked as the housekeeping supervisor for one year. *He agreed numerous rooms had scratched paint and exposed drywall. -He stated he verbally told (name of prior maintenance supervisor) when he received a report of a room in need of repair. *He stated none of the housekeeping or laundry staff had log-in access to the electronic TELS maintenance system. Review of the provider's October 2019 Homelike Environment policy revealed: *Policy: Residents are provided with a safe, clean, comfortable homelike environment and encouraged to use their personal belonging to the extent possible. -2. i. Walls and door scuffs/chips repaired with paint/stain when needed[.] (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788 Based on observation, interview, record review, and job description review, the provider failed to ensure physician's orders were followed for the use of: *TED Hose (thromboembolic deterrent compression stockings used by non-ambulatory residents) by one of one sampled resident (39). *Redi-Wraps (adjustable compression wrap) by one of one sampled resident (8). *Gradual compression stockings (compression stockings that are tightest around the ankle and gradually loosen up the leg) by one of one sampled resident (65). Findings include: 1. Observation and interview on 11/4/24 at 2:26 p.m. with resident 39 in her room revealed: *She was sitting in her recliner with the leg rests elevated. -On the wall behind her recliner was a sign that read [NAME] Hose on in AM and off in PM. *The resident was wearing regular socks on her feet. -She had no TED Hose that fit her and had not worn TED Hose since the summer. Observations on 11/5/24 at 9:11 a.m. and again on 11/6/24 at 9:41 a.m. of resident 39 in her room revealed she was sitting in her recliner with the leg rests elevated wearing regular socks on her feet. Review of resident 39's electronic medical record (EMR) revealed: *Her diagnoses included heart failure. *A 12/23/23 physician's order: TED hose on in the AM and off in the PM related to LE [lower extremity] edema [fluid retention]. *Her November 2024 Treatment Administration Record (TAR) revealed it was documented from 11/1/24 through 11/5/24 that TED Hose had been put on her feet each of those mornings and removed each evening. 2. Observations on 11/4/24 at 2:54 p.m., 11/5/24 at 9:45 a.m., and again on 11/6/24 at 9:45 a.m. of resident 8 in her room revealed: *She was either lying in her bed or sitting in her wheelchair during those times. *A sign near the head of her bed read Put on leg wraps in AM and off in PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/07/2024
NAME OF PROVIDER OR SUPPLIER Avantara Saint Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE 302 St Cloud Street Rapid City, SD 57701	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-At the time of each observation above the resident was wearing regular socks on her feet. Review of resident 8's EMR revealed: *Her diagnoses included edema. *A 2/14/24 physician's order: Redi-Wraps to bilateral LE [lower extremities] and remove per schedule. *Her November 2024 TAR revealed it was documented from 11/1/24 through 11/5/24 that Redi-Wraps had been put on the resident each of those mornings and removed each evening. 3. Observations on 11/4/24 at 3:07 p.m., 11/5/24 at 9:38 a.m., and again on 11/6/24 at 9:57 a.m. of resident 65 in her room revealed: *She was sitting in her recliner wearing regular socks on her feet and a pair of Crocs foam [NAME]. *A foot cradle [a device attached to the foot of the bed that kept sheets and blankets from touching or rubbing the legs and feet]was at the end of her bed. Review of resident 65's EMR revealed: *Her diagnoses included chronic embolism and thrombosis (blood clot formation) of the left femoral vein. *A 9/13/24 physician's order: Knee high 20-30 gradual compression stockings. On in am, off at HS [nighttime]. One time a day for left leg edema and remove per schedule. *A 9/13/24 progress note that indicated the resident's stockings were ordered through a local home health equipment provider. *Her November 2024 TAR revealed it was documented from 11/1/24 through 11/5/24 that her compression stockings had been put on each of those mornings and removed each evening. Interview on 11/6/24 at 9:50 a.m. with certified nurse aide (CNA) K revealed: *Resident 39 was waiting for a new pair of TED hose to replace her pair that were ripped. -Nursing staff were informed the resident had no other TED hose to wear. -She had been without TED hose for a few days. *Resident 8's Redi-Wraps had not returned from the laundry. -She had only one pair of Wraps. *Resident 65's compression stockings were too tight and she needed different-sized stockings. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Her family was expected to provide those. Interview on 11/6/24 at 2:50 p.m. with registered nurse (RN) J regarding the physician-ordered treatments above for residents 8, 39, and 65 revealed: *She had documented in residents 8, 39, and 65's TARs the Redi-Wraps, TED hose, and compression stockings had been put on those residents on the morning of 11/6/24. *CNA staff had dressed residents 8, 39, and 65 that morning. -That would have included their hose and stockings. *She had not known resident 8 had no Redi-Wraps, resident 39 had no TED hose, and resident 65 had no compression stockings. -Resident 8 should have had a back-up pair of wraps to wear and another pair of TED hose should have been obtained from the central supply room for resident 39. Resident 65's hospice nurse should have been contacted about providing her compression socks. Observation on 11/6/24 at 4:40 p.m. of the central supply room revealed there were: *Two packages of size large Redi Wraps and two packages of size extra-large Redi-Wraps. *Multiple packages of size small TED hose. Interview on 11/7/24 at 10:15 a.m. with Qualified Activity Director (QAD)/Central Supply staff F revealed: *She had been responsible for maintaining the facility's central supply room since August 2024. *She had known residents were without their physician-ordered compression socks, TED hose, and Redi-Wraps. -Resident 65's compression stockings were ordered through a specialty supply company a few weeks ago. -In the last week, she had unsuccessfully attempted to order the other supplies from various vendors. *She had notified the facility's corporate office of her difficulty in getting resident supplies. -On 11/6/24 she had talked with administrator A. Administrator A was contacting local sister facilities to determine if they were able to help obtain those needed resident supplies. *QAD/Central Supply staff F did not know how many residents required physician-ordered hose, stockings, and wraps or how many of those items were expected to have been on hand in the event a second pair was needed. Interview on 11/7/24 at 10:45 a.m. with director of nursing B revealed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435060	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Saint Cloud	302 St Cloud Street Rapid City, SD 57701

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*Physician-ordered treatments for residents 8, 39, and 65 were not provided. *Nursing staff were expected to not document completion of physician-ordered treatments delegated to a CNA in a resident's TAR without first visually confirming for themselves the treatment had been completed. *She agreed a process was needed to ensure an adequate number of supplies were kept on hand for residents who required physician-ordered compression stockings, hose, and wraps. Review of the provider's updated 12/1/19 RN Floor Nurse job description revealed 12. Administer or supervise all treatments prescribed by physicians .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788 Based on observation, interview, job description review, and policy review, the provider failed to ensure: *The kitchen and dishroom were maintained in a clean and functional manner. *Food items placed on trays and delivered to residents to eat in their rooms (room trays) were kept covered during transport until they were delivered to their rooms. *Insulated dinner plate covers were handled in a sanitary manner. Findings include: 1. Observation and interviews with food service manager (FSM) E, cook N, and dietary aide O on [DATE] from 5:00 p.m. through 6:40 p.m. during the initial kitchen tour and the evening meal service revealed: *Plastic drinking cups were being filled for the evening meal by cook N. -Twelve of 20 unfilled cups on one of two trays had white-colored build-up on their bottoms and/or their insides. Scratch-like marks on the insides resembled scrub brush marks. *FSM E stated the cup discoloration was lime build-up and commented to cook P Are you the only one who knows how to use a brush? *One side of the dual plate warmer near the serving area held regular plates and the other side held adapted blue plates with raised edges. The side of the warmer that contained the blue plates was not working. -The top surface area of that plate warmer including the areas around the openings where the plates were removed from was littered with food crumbs. -FSM E was aware the warmer was not functioning properly and agreed the top of the unit was unclean. *Near the coffee makers was a four-cup plastic measuring cup that was stained brown throughout its inside. [NAME] N stated coffee from the coffee makers was poured into that cup then transferred to carafes for serving. -FSM E said the cup should no longer have been used since it was unable to be thoroughly cleaned. *The window ledge and window frame above the coffee makers was covered with a brown-colored film of unknown origin. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*On the cook's prep table was a knife holder attached to the side of that table. The surface of the holder and in and around where the knives were inserted was covered with food crumbs that were not removable when swiped with a finger. -Cooking utensils were stored in a lined drawer attached to the cook's prep table. The liner resembled a plastic net. There were dried food particles in the open areas of the liner. -A Saf-T-Wrap (plastic wrap) dispenser holder was opened and was on top of the cook's prep table. The inside of the opened lid had individual compartments for holding things like packaged alcohol pads and pre-printed food labels. The bottoms of those compartments had a build-up of an unknown substance on them. The area surrounding the opening where the plastic wrap was pulled through to be torn off had an unknown build-up around it. *Beneath the Vulcan oven stand was an open area of racked storage for cookie sheets and baking pans. The surface on both sides of those racks was covered with a film of unknown origin and was unable to be removed when swiped with a finger. *A fluorescent light was on the ceiling between refrigerator units one and two and freezer units one through three. The plastic light covering was cracked and broken. *The test strips in the dishroom used to measure the concentration of sanitizer to water for disinfection had expired in [DATE] but were still being used. -FSM E was made aware of the expired strips last week by a service technician. She had not known the test strip holder was labeled with an expiration date. She had not reached out to a sister facility for unexpired test strips to use while she waited for new strips to arrive. *The individual slats of the air conditioner that was running in the dishroom were covered with a film of gray dust. -The air was blowing over clean dishware and a metal rack that held clean cooking pots, pans, soup bowls, cutting boards. *Dietary aide O was responsible for loading and transporting prepared resident food trays in an insulated cart to three of four dining rooms. -She used her bare hand to hold the inside of the insulated covers until she placed them over the top of the individually prepared resident meal plates instead of using the knob on top of the covers to hold them in a sanitary manner. -FSM E and dietary aide O both agreed not having used the knob to hold the covers increased the risk of cross-contamination of resident food items. *Room trays with covered drinking cups and uncovered dishes of mixed fruit sat on the cook's prep table from 6:15 p.m. through 6:40 p.m. At 6:40 p.m. when the room tray was completely plated and covered with an insulated cover. An unidentified aide then transported that room tray out of the dining room to a resident room with the fruit still uncovered. (continued on next page)

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	435060	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-FSM E had not noticed the length of time the uncovered fruit sat waiting to be delivered or that the fruit remained uncovered during transport. Interview on [DATE] at 8:45 a.m. with FSM E revealed: *Individual cleaning checklists were developed for the morning and evening cooks, dietary aides, and dishwashers. -The checklists included daily and weekly cleaning assignments that were initialed by the staff person who had completed those tasks. *FSM E was responsible for regularly reviewing the kitchen cleaning tasks checklists for completion of those tasks by her staff. Review of the provider's updated [DATE] Director of Dietary Services job description revealed: *Essential Functions: -2. Operates the dietary department in a safe and sanitary manner by ensuring compliance with federal, State, and local regulations and following established policies and procedures. -12. Assure that established infection control and prevention practices and standard precautions are maintained at all times. Review of the provider's revised [DATE] Accident Prevention In Food Transport policy revealed: 3. Food should remain covered when in transit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42558 Based on observation, interview, and policy review, the provider failed to maintain the environment and resident use items in a clean and odor-free condition for: *A soiled utility room located directly across from the entrance into the secured unit. *Two of sixteen sampled resident rooms (103 and 108) located in the 100 hallway. *One of one laundry room. *One of one clean utility room located in the secured unit. *A urine-soaked chair from one of one sampled resident's (58) room. Findings include: 1. Observation during the initial tour on 11/4/24 at 12:45 p.m. revealed a strong urine odor upon entrance through the double doors that led into the secured unit of the building where the 100, 200, and 400 hallways were located. Observation on 11/5/24 at 1:48 p.m. and at 1:52 p.m. revealed a strong urine odor was again present upon entrance into the secured unit described above. *A soiled utility room was located directly across the hall from the entrance into the secured unit. -That room had soiled linen and garbage containers in it that were overflowing with soiled clothing, soiled incontinence briefs, and garbage, which caused the container's lids to remain open. -A putrid odor of urine and feces emanated from those containers. -At 1:52 p.m., those items had been removed from the containers and clean liners had been placed in the container however the room continued to emit a strong odor of urine and the floor was sticky. 2. Observation on 11/4/24 at 2:00 p.m. of room [ROOM NUMBER] revealed the room had a strong odor of urine and the bathroom floor was sticky with an odor of urine. Observation on 11/4/24 at 3:02 p.m. of room [ROOM NUMBER]B revealed visible brown fingerprint smudges along the wall right above the resident's mattress. Interview on 11/7/24 at 8:20 a.m. with housekeeper Q regarding cleaning and mopping of resident rooms revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avantara Saint Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE 302 St Cloud Street Rapid City, SD 57701	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He stated all resident rooms were daily wiped down, the trash was removed, toiletes were cleaned, and the floors were mopped. He had no cleaning schedule, but said he could remember which rooms needed to be cleaned. *He stated: -All resident rooms were deep cleaned once a week and that included wiping down the walls from the ceiling to the floor, cleaning windows, and washing the divider curtains. -Lately there had not been a schedule available on what rooms needed to be deep cleaned for that day or the week. -He would deep clean a room if he saw it needed a deep cleaning. 3. Observation on 11/7/24 at 9:15 a.m. of the laundry room revealed: *There was a large amount of gray dust build-up on the pipes and flat surfaces throughout the laundry room. *There were two washing machines and washer number two had a sign that read, needs repaired. -Washer number one was in use, and had a leaking hose that was dripping onto the floor behind the washer causing curled up, corroded, floor tiles that exposed the cement to water build-up. *The handwashing sink had a PVC (plastic) pipe that came out of the ceiling and was dripping a watery liquid into the sink. There was an orange-colored build-up where the water ran down into the sink. 4. Observation on 11/7/24 at 9:20 a.m. of the clean utility room on the secured unit revealed a laundry basket full of various shoes and slippers that had visible unidentified stains on their surfaces. That basket was sitting on the floor next to shelving that contained clean linens and room dividers. Interview on 11/7/24 at 9:00 a.m. with housekeeping supervisor G regarding the cleaning of utility rooms, resident rooms, and the laundry room revealed: *He had been the housekeeping and laundry supervisor for one year. -He had been working every day cleaning rooms, since they did not have enough housekeeping staff. -He stated he had been working on the floor for the past year. -They were trying to hire more housekeeping staff. *He had no housekeeping schedule for the cleaning of the soiled and clean utility closets, but he tried to have them cleaned and mopped once a week. *He was unable to verify when the soiled utility room was last cleaned. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*He stated he had fallen behind on completing the room cleaning schedules for his staff and there was no deep cleaning schedule available. -He stated, I am not sure deep cleanings are being done, but it is supposed to be once a week. *He stated he used to complete a walk-through inspection of the facility every week, then it became once a month, and lately he had fallen behind and had not inspected the facility in about four weeks. *He confirmed the laundry room was not on a cleaning schedule. He was unaware of the washer's leaking hose. -He was not sure why a pipe was draining into the handwashing sink. *After a walk-through of the facility and viewing the above observations, he stated I agree it [cleanliness of the facility] could be better. Review of the 7/2/24 Administrative Policies regarding housekeeping and laundry revealed: *Cleanliness is a must for a safe, comfortable, and orderly environment. The activity of our housekeeping and laundry departments has a direct effect on the comfort, morale, and safety of the residents, the staff and our visitors. Review of the housekeeping and laundry services policies revealed they did not include on how often resident rooms and generalized cleaning should occur. 47780 5. Observation and interview on 11/4/24 at 1:59 p.m. in resident 58's room revealed: *A brown lift chair was turned around and faced the wall. *Resident 58 was seated in a different chair. *She was unsure why the brown lift chair was turned towards the wall. *She would have liked the brown lift chair turned forward to face her television. *She would have preferred to sit in that brown lift chair as the chair she was sitting in was not a lift chair. Interview on 11/4/24 at 3:10 p.m. with certified nursing assistant (CNA) M revealed the brown lift chair in resident 58's room had a soiled spot and it was to be cleaned. Observation on 11/5/24 at 10:10 a.m. revealed that the brown lift chair had been turned forward, and resident 58 was seated in it in a reclining position. Observation on 11/5/24 at 4:06 p.m. in resident 58's room revealed: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Avantara Saint Cloud		STREET ADDRESS, CITY, STATE, ZIP CODE 302 St Cloud Street Rapid City, SD 57701	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*The brown lift chair had a fabric covering laid over the top of it. *When the covering was removed there was a strong odor of urine and a wet stain on the seat of the chair. Interview on 11/5/24 at 4:36 p.m. with director of nursing (DON) B and infection preventionist D revealed: *Their expectation of staff was to remove the chair when they had noticed it had been soiled and not to have covered it and left it in the resident's room for the resident to use. Review of provider's revised February 2024 Cleaning and Disinfection of Equipment policy: *Policy -1. CLEANING refers to removal of visible soil (e.g., organic, and inorganic material from objects and surfaces and is normally accomplished manually or mechanically using water with detergents or enzymatic products. -A. Supplies and equipment will be cleaned immediately after use. Gross blood, secretions and debris will be removed as soon as possible. Cleaning may be done in the resident room or the soiled utility room.