| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435064 | A. Building<br>B. Wing | 01/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avantara North | 1620 North 7th Street<br>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 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40788<br><br>Based on a South Dakota Department of Health (SD DOH) facility-reported incident (FRI), observation, interview, record review, and personnel file review, the provider failed to ensure one of one sampled resident (35) was free from physical restraint by two of two certified nursing aides (CNA) (M and Q) and one of one licensed practical nurse (LPN) (R) who physically held down the resident's lower extremities while they provided his personal care. This citation is considered past non-compliance based on a review of the corrective actions the provider implemented immediately following the incident. Findings include:<br><br>1. Review of the provider's [DATE] SD DOH FRI revealed abuse and the physical restraint of resident 35 was identified by registered nurse (RN)/assistant director of nursing S during a review of the resident's progress notes.<br><br>Review of resident 35's electronic medical record (EMR) revealed:<br><br>*His admitted was [DATE] and his diagnoses included vascular dementia, anxiety, depression, and pain.<br><br>*He had been on hospice services since [DATE].<br><br>*His Brief Interview for Mental Status (BIMS) assessment score was 12 which indicated he had moderate cognitive impairment.<br><br>*An [DATE] progress note documented by LPN R indicated:<br><br>-Behavior: resident refused to be changed since he went to bed. at 0400 [4:00 a.m.], this nurse was called to resident's room. when this nurse got there the resident was yelling and swearing at staff. i informed the resident that he needed to be changed. resident still refused. i informed resident that if he wasn't changed that his skin would start to break down. so we started to change the resident and he became combative. we [CNAs M and Q and LPN R] restrained him so that we could get him changed. once changed we left resident's room.<br><br>Observation and interview with resident 35 on [DATE] at 3:40 p.m. in his room revealed he:<br><br>*Sat in his recliner watching television.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | *Stated he was fine and had no concerns.<br><br>-Declined any further conversation at that time or in the future.<br><br>Continued review of resident 35's EMR revealed:<br><br>*A skin assessment was completed on [DATE] and no new skin concerns had been identified following the [DATE] incident.<br><br>*The resident's behavioral care plan was updated on [DATE] and again on [DATE] to reflect staff were to:<br><br>-Approach and reapproach the resident when he refused personal care.<br><br>-Educate the resident regarding the risks of refusing care.<br><br>-Utilize staff who had a rapport with the resident to provide his personal care.<br><br>-Use of an incontinent brief that was more absorbent and provided better skin protection.<br><br>Interview on [DATE] at 6:15 p.m. with CNA M regarding the FRI revealed:<br><br>*He confirmed the content of the FRI above was factual.<br><br>*He complied with LPN R's instruction to physically restrain resident 35 when the resident had refused care knowing what he was asked to do was not right.<br><br>-He failed to report the incident to his supervisor or any other member of management.<br><br>*Resident 35 had a history of non-compliance with personal care that escalated after his spouse passed away in the fall of 2024.<br><br>-They had resided together in the nursing home.<br><br>*Resident 35's care refusals had been managed by leaving him alone for a short period of time and then reapproaching him.<br><br>*Repeated care refusals had been reported to a nurse.<br><br>-The resident sometimes accepted a nurse's explanation of the consequences of care refusal and then allowed staff to perform that care.<br><br>*A new type of incontinent brief had been used since [DATE] that allowed brief changes to occur at a less frequent interval without compromising the resident's skin.<br><br>*CNA M stated no other nursing staff had ever asked him to hold a resident's arms or legs in order to have completed their personal care.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -He had not observed or known of any other instances of any staff who had been asked to or had physically restrained a resident.<br><br>*He was suspended from work pending the outcome of the [DATE] incident investigation.<br><br>-He was required to complete an abuse prevention training before he was allowed to return to work.<br><br>Interview on [DATE] at 8:07 a.m. with RN E regarding resident 35's care refusals revealed:<br><br>*He had a history of care refusal but the frequency had escalated after his spouse died .<br><br>-He was moved to a private room across the hall and that seemed to have helped improve his behavior.<br><br>*The resident verbally refused care by saying No, that type of thing which had indicated to staff he wanted to be left alone.<br><br>-He was not usually physically aggressive.<br><br>*The resident related better to some staff and they provided his care when possible or if he had refused care offered by another staff person.<br><br>*Staff respected the resident's right to refuse care but reapproached him to offer that care again to ensure it had occurred.<br><br>Review of CNAs M and Q and LPN R's personnel files revealed:<br><br>*Their professional certifications or licenses were current and their pre-employment background checks identified no areas of concern.<br><br>*Their mandatory resident rights, abuse/neglect, and restraint training was current.<br><br>*CNA Q was terminated on [DATE] unrelated to the [DATE] incident.<br><br>*LPN R was terminated on [DATE] related to the [DATE] incident.<br><br>Interview on [DATE] at 9:45 a.m. with DON B and administrator A regarding the FRI revealed:<br><br>*The incident was reported to the South Dakota Board of Nursing.<br><br>*Audits of a sample of cognitively intact residents regarding their care and feelings of safety was completed. A review of those audits identified no concerns.<br><br>*Audits of a sample of staff regarding resident care concerns was completed. A review of those audits identified no issues.<br><br>*All staff were re-educated at the [DATE] All Staff meeting regarding resident abuse and neglect.<br><br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Training content was reviewed and included restraint use.<br><br>The provider's implemented systemic actions to ensure the deficient practice does not reoccur was confirmed on [DATE] after:<br><br>*Facility audits of sampled residents and staff identified no resident care or safety concerns.<br><br>*Education was provided to all staff regarding resident abuse/neglect and restraint use.<br><br>-Observations and interviews revealed staff understood that education regarding those topics.<br><br>*Resident 35's care plan was revised to reflect modified behavioral interventions for the management of care refusal.<br><br>-Interviews revealed staff understood the interventions for managing resident 35's care refusal according to his revised care plan.<br><br>Based on the above information, non-compliance at F604 occurred on [DATE], and based on the provider's implemented corrective actions for the deficient practice confirmed on [DATE], the non-compliance is considered past non-compliance. |