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 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. (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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: *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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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: *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.