DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 26632<br>An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/6/21 through 4/9/21. Avantara Ipswich was found not in compliance with the following requirements: F578, F580, F656, F658, F679, F684, F686, F690, F725, F835, F867, F880, and F881. | F 000 | | |
| F 578 SS=D | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the | F 578 | 1. Resident 125's code status has been confirmed and updated. All residents could potentially be at risk. All residents' medical records will be reviewed to ensure their code status is in their medical record by the LSW or designee by May 7, 2021.<br><br>2. Policy was reviewed with no revisions needed. The Director of Nursing (DON) will provide education to Social Services and licensed nursing staff on policy and process to ensure the resident's code status is obtained and recorded in the medical record within 24 hours of admission. Education will occur no later than May 7, 2021. Those not in attendance will be educated prior to their first shift worked.<br><br>3. The DON or designee will audit all new admissions weekly as part of the admission process to ensure the resident's code status was obtained and recorded in the medical record. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 5/5/21

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.

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| F 578 | Continued From page 1<br>requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.<br>Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br><br>Based on record review, interview, and policy review, the provider failed to follow their policy to ensure 1 of 1 newly admitted resident's (125) code status was confirmed and documentation was available within 24 hours of admission.<br>Findings include:<br><br>1. Review of resident 125's electronic health record (EHR) revealed:<br>*He was admitted to the facility on 4/1/21.<br>*His admitting diagnoses included:<br>-Hemiplegia.<br>-Polyneuropathy.<br>-Brain stem stroke.<br>-Post traumatic stress syndrome (PTSD).<br>-Anxiety.<br>-Prostatic hyperplasia.<br>-Type two diabetes mellitus.<br>-Hypertension.<br>*Resident 125 did not have a code status or advance directive listed in his EHR. | F 578 | | |

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| F 578 | Continued From page 2<br><br>Further review of resident 125's paper medical record revealed a code status sheet with his name on it and no other information.<br><br>On 4/9/21 at 9:00 a.m. resident 125's advance directive was requested from the director of nursing services (DNS).<br><br>On 4/9/21 at 1:07 p.m. requested the advance directive or code status from social services designee (SSD) E. She stated she had not seen a code status for him.<br><br>At 3:30 p.m. the same day SSD E brought this surveyor a paper the resident had signed that stated he wished to be a "no code." This was on a piece of paper that looked like the blank one in the paper chart. It did not have a physician signature. There was a date that stated 4/1/21. This document was not in his plan of care nor in his medical record.<br><br>Review of provider's September 2019 advanced directive policy revealed:<br>*"It is the policy of the facility for each resident to choose their Advanced Directives upon admission and such may be changed by the resident at any time during their stay."<br>*"1. Staff will provide the resident and/or representative with information regarding advance care planning which will address types of Advance Directives, treatment options and refusal of treatment."<br>*"2. An Advance Directive form (as provided by the healthcare facility) or POLST form shall be completed with resident and/or legal representative to verify treatment options as well as code status." | F 578 | | |

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| F 578 | Continued From page 3<br>*"3. Appropriate information will be added to the Physician Order Sheet (POS)."<br>*"4. The resident's Advance Directive choices/options shall be reviewed with resident/resident representative during quarterly and significant change assessment and care planning."<br>*"5. Discussion of Advance Directives and treatment options/refusals will be addressed in an appropriate chart documentation as well as care planned during the admission process, as indicated."<br>*"6. Staff will initiate a resident choice discussion concerning the DNR (do not resuscitate) option or Full Code."<br>*"7. Staff will request documentation to determine if the resident has a Power of Attorney for Health Care in place. If the resident has a Power of Attorney for Health Care (POA) a copy of the document will be placed in the medical record (this included being scanned into a virtual medical record). If the resident does not have Power of Attorney for Health Care, Staff will educate the resident on the completion process and the right to choose to assign or not assign a Power of Attorney for Health Care. The POA form itself should be readily retrievable by any facility staff member, according to the CMS [Centers for Medicare Services] rule."<br>*"8. If the resident is unable or chooses not to initiate any type of Advance Directive, it is the policy of this facility for the resident to be a Full Code and to receive appropriate life sustaining treatment interventions such as CPR."<br><br>Review of provider's current admission/readmission checklist revealed:<br>*Nursing was to confirm with the physician within 24 hours of admission the residents code status. | F 578 | | |

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| F 578 | Continued From page 4<br>*Also within 24 hours:<br>-Certified nursing assistants were to ensure they were completed.<br>-Social services were to make an admission/advance directive note. | F 578 | | |
| F 580 SS=E | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or | F 580 | 1. No immediate correction could be made for lack of notification of change for Resident 74's previous change of condition. Resident 74's representative is aware of resident's current health status. All residents are potentially at risk. The DON, or designee, will complete a retrospective review of all residents going back to March 1, 2021 to identify any omissions of documentation of notification of resident falls and hospitalizations to their medical provider and their representative when appropriate. The medical provider and the resident representatives will be notified of any identified omissions by May 7, 2021.<br><br>2. Policy was reviewed with no revisions needed. The DON or designee will provide education to all nursing staff on the Notification of Change Policy and the regulatory requirements, which includes notifying the medical provider and the resident's representative of resident changes of condition such as: change in health, physical functioning, vital signs, falls/accidents, medication variances or mood and behavior and to ensure documentation of the notification. Education will occur no later than May 7, 2021. Those not in attendance will be educated prior to their first shift worked.<br><br>3. The DON or designee will audit 3 random residents' medical records weekly to ensure the physican and resident representative, when appropriate, has been notified of any resident change of condition and the notifications are documented. In addition, the specific residents cited will be included in the audit for 4 weeks. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| F 580 | Continued From page 5<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br><br>Surveyor: 26632<br>Based on record review, interview, and policy review, the provider failed to ensure one of one sampled residents (74) representative had been notified of a fall and hospitalization, Findings include:<br><br>1. Review of resident 74's medical record revealed he had a fall on 3/29/21 at 12:00 midnight.<br>*The Injuries noted from his fall were abrasions to his left great toe, right elbow, and the last three fingers on his right hand.<br>*Progress notes for this resident revealed:<br>-On 3/29/21 at 5:07 a.m. an incident summary was faxed to the PCP [primary care provider] and a call would be placed to his daughter later in the morning. | F 580 | | |

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| F 580 | Continued From page 6<br>-On 3/30/21 at 2:35 p.m. a call was placed to the residents PCP reporting,he was having an increased amount of pain, was not able to ambulate, dress, or do therapy.<br>--Orders were received to send him to the emergency department.<br>-On 3/30/21 at 4:02 p.m. revealed the emergency department called and stated the resident would be admitted to the hospital due to a fractured right hip.<br>-No documentation that his daughter had been notified of his fall, hospitalization, or his fractured hip.<br><br>Telephone interview on 4/8/21 at 3:00 p.m. with resident 74's daughter revealed she found out about his fall, hospitalization, and surgery to repair his fractured hip when he called her on 3/29/21 after he got out of surgery. She was confused because she was not aware of any of the circumstances the resident told her about in that call.<br><br>Interview on 4/8/21 at 4:30 p.m. with social services director (SSD) E revealed:<br>*She had received an email from resident 74's daughter after she found out he was in the hospital and had just had surgery for a fractured hip.<br>*She was upset because she had not been contacted about the fall, hospitalization, and surgery.<br>*SSD E was unaware the daughter had not been notified.<br>*She confirmed the daughter had not been contacted regarding this event from the nurse that had given this information.<br><br>Review of the provider's December 2019 | F 580 | | |

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| F 580 | Continued From page 7<br>Notification of Change of Condition policy revealed:<br>*"The facility will provide care to residents and provide notification of resident change in status."<br>*"The facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:"<br>a. "An accident involving the resident which results in injury and has the potential for requiring physician intervention;"<br>b. "A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;"<br>c. "A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or"<br>d. "A decision to transfer or discharge the resident from the facility as specified in..."<br>*"2. The facility must also promptly notify the resident and resident representative, if any when there is:"<br>-"B. A change in resident rights under Federal or State law or regulations." | F 580 | | |
| F 656 SS=E | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial | F 656 | 1. Residents 5, 7, 11, 13, 19 and 126 care plans will be reviewed and updated to reflect their current needs and preferences by the interdisciplinary team (IDT) by May 7, 2021. All residents are potentially at risk. The IDT will review and update all residents' care plans to reflect their current needs and preferences by May 7, 2021. | |

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| F 656 | Continued From page 8<br>needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 26632<br>Based on observation, interview, record review, and policy review, the provider failed to have care plans with measurable goals, current status, and complete interventions for six of fourteen (5, 7, | F 656 | 2. Policy was reviewed with no revisions needed. The DON or designee will educate all care staff, no later than May 7, 2021, on the need to ensure care plans are up to date and reflect residents' current care needs. Education will include reporting any changes in care needs or preferences to the charge nurse so the care plans can be updated as changes occur. Those not in attendance will be educated prior to their next shift worked. The IDT will review the prior day's progress notes and clinical alerts each business day morning to identify potential care plan update needs.<br><br>3. The DON or designee will audit 3 resident's care plans each week to ensure they reflect their care needs and preferences. In addition, the specific residents cited will be included in the audit for 4 weeks. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| F 656 | Continued From page 9<br>11,13, 19, and 126) sampled residents which would ensure staff could provide the appropriate care and services the residents required. Findings include:<br><br>1. Review of resident's 5, 7, 11,13, 19, and 126 current care plans revealed they did not accurately reflect each of these residents current status.<br>*Resident 5 refer to F679 finding 4.<br>*Resident 7 refer to F658 finding 2 and F686 finding 4.<br>*Resident 11 refer to F679 finding 2 and F686 finding 2.<br>*Resident 13 refer to F686 finding 5 and F690 finding 2.<br>*Resident 19 refer to F690 finding 1.<br>*Resident 126 refer to F679 finding 1, F684 finding 1, F686 finding 1, and F690 finding 3.<br><br>Review of the provider's September 2019 Care Planning policy revealed:<br>*"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."<br>*"Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis-based care considerations." | F 656 | | |
| F 658 SS=E | Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, | F 658 | 1. Residents 7 and 126 are being weighed per physician order. Resident 126's admission assessment has been completed and resident is being repositioned per physician orders. Resident 7's physician has been notified of resident's high blood sugar levels. No immediate correction could be made for the medication error for Resident 7. Resident 7's orders have been reviewed and the resident is receiving medications and edema wraps are being | |

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| F 658 | Continued From page 10<br>must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 26632<br>Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure professional standards had been followed for:<br>*Two of two sampled resident's (7 and 126) had daily weights taken per physicians orders.<br>*One of one sampled resident (126) admission assessment had been completed.<br>*One of one sampled resident (126) was repositioned per physicians order.<br>*One of one sampled resident (7) physician had been notified according to blood glucose parameters for her high blood glucose levels.<br>*One of one observed unlicensed assistive personnel (UAP) (P) had administered a medication as ordered for one of three (7) residents.<br>*One of one sampled resident (7) had her edema wear applied per physicians order.<br>*Physician's orders were followed for one of three closed record sampled residents (25).<br>*Controlled substances were documented when given for one of three closed record sampled residents (25).<br>Findings include:<br><br>1. Review of resident 126's medical record revealed:<br>*She had been admitted on 3/22/21 after a fall at home and subsequent surgery to her left ankle and foot.<br>*Her other diagnoses included: urinary tract infection, diabetes mellitus with underlying chronic kidney disease, cirrhosis of liver, ascites, | F 658 | applied and removed as ordered. Resident 26 has been discharged, therefore, no immediate corrections could be made. All residents are potentially at risk.<br><br>2. Policies were reviewed with no revisions needed. The IDT will review the prior day's progress notes and clinical alerts each business day morning to identify to identify any lapses in resident care. Additionally, the DON or designee will educate all care staff, no later than May 7, 2021 on the need to ensure care is provided per professional standards of care, including following physician orders, notifying physician of anything outside of ordered parameters, completion of ordered assessments, and documentation in the MAR. Those not in attendance will be educated prior to their next shift worked.<br><br>3. The DON or designee will audit 3 residents weekly to ensure professional standards are being followed, including: correct medication administration, notification of the physician of anything outside ordered parameters, ensuring treatments are completed per order, completion of assessments, and documentation of such in the MAR. In addition, the specific residents cited will be included in the audit for 4 weeks.Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 658 | Continued From page 11<br>heart failure, gastro-esophageal reflux disease, muscle wasting and atrophy, and difficulty in walking.<br>*She had a 3/22/21 physician's order for daily weights.<br>-Her weight had only been obtained on 3/25/21, 3/27/21, 3/28/21, 3/29/21, 3/30/31, 3/31/21, and 4/4/21.<br>*She had a 3/23/21 physician's order to "Rotate and reposition every 2 hrs. [hours] Multiple sores to buttocks/coccyx."<br>-Documentation of every two hour repositioning had only been documented on 3/23/21.<br>*Had an unspecified type of ulcer to her right lateral foot. No measurements had been completed.<br>*There were no assessments to determine her risk for skin issues.<br>*Her initial admission comprehensive assessment had not been completed.<br>*Was continent of bowel and bladder prior to her admission.<br>*No bladder or bowel program had been initiated.<br>*She had been mostly incontinent since her admission.<br><br>2. Review of resident 7's medical record revealed she had:<br>*A 3/9/21 physician's order "Skin/Wound Care: ONCE Comments: As per facility protocol: edema wear for chronic leg swelling."<br>*An additional 3/9/21 physician's order "EDEMA WEAR. Comments: Nursing to apply. Follow manufacturer's recommendations for sizing. Apply foam pads over pressure point as needed for fragile skin. Wearing schedule: Remove and reapply every 12 hours.<br>"*A 3/11/21 physician's order for daily weights. Those weights had only been obtained on | F 658 | | |

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| F 658 | Continued From page 12<br>3/13/21, 3/14/21, 3/19/21, 3/24/21, 4/5/21, and 4/6/21.<br>*On 4/7/21 a skin evaluation revealed she had open sores to both of her lower legs.<br>*A 4/2/21 at 4:07 p.m. progress note "Nurse was pulled into resident's room by son [name] who wanted to show nurse his mom's legs. [son's name] was upset that is mom's TEDs [compression stockings] were not on so he applied and noticed her legs had sores. Nurse in to check and resident has small open area to RLE [right lower extremity] that is weeping, and several small open areas to LLE [left lower extremity], some are weeping some are not."<br>*A 4/7/21 at 5:52 p.m. progress note "Resident seen by wound care today. Foam to wounds and change every 3 days. Edema wear to BLE [bilateral lower extremities] on during day. Off at night. Elevate legs BID [twice a day] above level of heart for 30 minutes. Keflex 500 mg TID [three times a day] x 7 days. Return in 1 week on 4/16/21 at 1400 [2:00 p.m.]."<br><br>Review of resident 7's 3/9/21 care plan revealed:<br>*Focus: "{Resident] has altered cardiovascular functioning related to HTN [hypertension], CHF [congestive heart failure], morbid obesity."<br>*Goals included: "Will be free from cardiac overload through review date."<br>*Interventions included: "Daily weight."<br><br>*Review of resident 7's March 2021 medication administration record (MAR) revealed:<br>*Daily weights had been initialed as having been completed on 3/11/21, 3/12/21, 3/15/21, 3/16/21, 3/17/21, 3/21/21, 3/22/21, and 3/26/21.<br>*A 3/11/21 physician's order for daily weights. Those weights had only been obtained on 3/13/21, 3/14/21, 3/19/21, 3/24/21, 4/5/21, and | F 658 | | |

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| F 658 | Continued From page 13<br>4/6/21. The MAR also had been initialed with the code DR for 3/18/21, 3/20/21, 3/23/21, 3/22/21, 3/25/21, and 3/27/21 through 3/31/21. The DR code was "drug refused."<br>*A 3/10/21 blood glucose schedule before meals and at bedtime. The physician was to have been called if the blood sugar was great than 250 or less than 80. There were seventy-one times her blood sugar had been recorded as above 250 in March 2021 and twenty times from 4/1/21 through 4/7/21.<br>*A 3/10/21 Novolog insulin sliding scale schedule that corresponded to the blood sugar schedule. The physician was to have been notified if the blood sugar was above 400. There were twenty-one times her blood sugar had been recorded as above 400 in March and one time from 4/1/21 through 4/7/21.<br>*Her physician had been notified one time of a blood sugar above the 400 parameter on 3/10/21.<br><br>3. Observation and interview on 4/8/21 at 8:06 a.m. with UAP P during a medication pass revealed:<br>*UAP P gave resident 7 her medications that included:<br>*Vitamin D 10 microgram (mcg) in which she gave 1 tablet.<br>*The order was for 2 tablets daily.<br>*Review of the dosage on the vitamin D bottle revealed one 10 mcg tablet equaled 400 units.<br>*She stated that was the over-the-counter medication she had been told to use.<br>*There was no other bottle of vitamin D found in the 100 hallway medication cart.<br>*She confirmed she had only given one tablet.<br>*Review of the April 2021 MAR revealed "Cholecalciferol tablet 1000 UNIT Give 2 tablet by mouth one time a daily for Vit. [vitamin] D | F 658 | | |

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| F 658 | Continued From page 14<br>deficiency."<br><br>Interview on 4/8/21 at 10:30 a.m. with the clinical nurse consultant V revealed:<br>*UAP P had used the wrong bottle of vitamin D.<br>*She agreed the order was for 2000 units of vitamin D.<br>*She agreed resident 7 had not received the correct dosage of vitamin D.<br>*There was no way of finding out how long resident 7 may have received the wrong dose.<br><br>Review of the 3/9/21 physician's order for resident 7's cholecalciferol revealed it read "Vitamin D3 (cholecalciferol) 50 mcg (2000 unit) tablet. Take 1 tablet (50 mcg) by mouth 1 time per day.<br><br>Interview on 4/9/21 at 3:15 p.m. with the director of nursing services (DNS) U revealed:<br>*She had just started on 3/5/21.<br>*She agreed the above findings had not followed professional standards of practice.<br>Surveyor: 42477<br>4. Review of resident 25's closed record review revealed:<br>*He was admitted to the facility on 2/2/21.<br>*He was in the hospital from 2/6/21 to 2/12/21.<br>*He died at the facility on 2/15/21.<br>*He had the following diagnoses:<br>-Rhabdomyolysis.<br>-Diabetes.<br>-Atrial Fibrillation<br>-Cardiomyopathy.<br>*He was supposed to have daily weights starting on 2/3/21,<br>-He had one weight which was his admitting weight on 2/2/21.<br>*He was supposed to be assessed three times | F 658 | | |

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| F 658 | Continued From page 15<br>per day for signs and symptoms (s/s) related to COVID-19 monitoring.<br>-He was not assessed for s/s of COVID-19 three times per day.<br>*He was supposed to have lactulose solution 20 gm (gram)/ 30 mL (Milliliter) -give 45 mL by mouth every 6 hours for encephalopathy. Goal is to have 2-3 bms (bowel movements) per day. If not, contact PCP (primary care physician).<br><br>Review of resident 25's medication administration record (MAR) revealed he had not had 2 -3 bms from when he was admitted on 2/2/21 till he was sent to the hospital on 2/6/21:<br>*Lactulose was marked as refused on 2/5/21 at 12:00 a.m.<br>*Physician was not called until 4:25 p.m. on 2/6/21.<br><br>Review of resident 25's hospital records revealed;<br>*He was admitted to the hospital due to elevated ammonia levels and a gastrointestinal (GI) bleed.<br>*He was found with the following wounds:<br>-2 skin tears.<br>-1 bruise.<br>-1 ulcer on his perineum.<br>-Had an indwelling catheter.<br><br>Review of resident 25's controlled substance destruction record and MAR revealed:<br>*There were some doses marked on the controlled substance destruction record that were not signed off in the MAR they were:<br>-A dose of Lorazepam 2/13/21 at 2:30 p.m.<br>-Two 0.5 ml doses of morphine given at 11:16 a.m. and 2:30 p.m. on 2/13/21.<br><br>Review of resident 25's initial care plan did not mention monitoring of his bm's or daily weighing. | F 658 | | |

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| F 658 | Continued From page 16<br><br>Resident 25 had not had any skin assessments or any documentation regarding the skin alterations found when he was admitted to the emergency department. | F 658 | | |
| F 679 SS=F | Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br><br>Surveyor: 26632<br>Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure an individualized activity program based on residents interests and needs had been provided for nine of twelve sampled resident (5, 6, 10, 11, 13, 14, 19, 125, and 126).<br>Findings include:<br><br>1. Interview on 4/7/21 at 6:35 p.m. and on 4/9/21 at 11:09 a.m. with resident 126 revealed:<br>*No one asked her what she liked to do.<br>*She did not have any involvement with the activity coordinator.<br>*She had played bingo a couple of times. | F 679 | 1. All resident, including residents 5, 6, 10, 11, 13, 14, 19, 125, and 126 have been encouraged to participate in individual and group programming since survey exit. Activities have been documented in the Resident participation record. All residents are potentially at risk. The activities director or designee will review records and interview residents, as appropriate, to obtain current activity preferences by May 7, 2021.<br><br>2. Policy was reviewed with no revisions needed. The administrator or designee will educate all staff no later than May 7, 2021 that all staff are responsible and accountable for interaction with residents and assisting in ensuring they have a meaningful and purposeful existence. Education will also include care staff are to provide appropriate interactions and offer meaningful and purposeful activities. Those not in attendance will be educated prior to their first shift worked.<br><br>3. The Administrator or designee will perform 3 weekly audits at random times of activities programming to ensure residents are observed being engaged in a structured activity, one on one activity, or individual activity, and observe staff for appropriate interactions with residents. Additionally, the administrator or designee will ask 3 random residents weekly about their satisfaction with the activities offered at the facility. In addition, the specific residents cited will be included in the audit for 4 weeks.<br>Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| F 679 | Continued From page 17<br>*She watched television most of the time.<br>*She gets bored lying in bed.<br><br>Review of resident 126's activity participation records from 3/24/21 through 4/8/21 revealed:<br>*One-on-one activities were documented four times.<br>*They were all documented at 1:59 p.m.<br>*Independent activities happened seven times and were marked as watching television and using the phone<br>-Had active participation on 3/24/21, 3/25/21, 4/1/21, 4/5/21, 4/7/21, 4/8/21, and 4/9/21. Each of those activities was marked a television and phone communication.<br>*It was documented she played bingo two times.<br><br>2. Review of resident 11's medical record revealed she was dependent on staff for all of her activities of daily living (ADL). The 1/6/21 quarterly Minimum Data Set (MDS) indicated she was unable to answer the questions so staff were interviewed and indicated she had both short and long term memory issues. Review of her activity participation records from 1/8/21 through 4/7/21 revealed:<br>*January 2021 she had four one-on-one activities documented. They had all been documented at the same time of 1:59 p.m.<br>*February 2021 she had ten one-on one activities documented. They had all been documented at the same time of 1:59 p.m.<br>*March 2021 she had nine one-to-one activities documented. They had all been documented at the same time of 1:59 p.m.<br>*4/1/21 through 4/7/21 she had three one-to-one activities documented. Two of those had all been documented at the same time of 1:59 p.m. | F 679 | | |

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| F 679 | Continued From page 18<br>Review of resident 11's 1/31/21 care plan revealed:<br>*Focus: "[Resident] is dependent on staff for activities, cognitive stimulation, social interaction r/t [related to] Cognitive deficits."<br>*Goal: "Will maintain involvement in cognitive stimulation, social activities as desired through review date."<br>*Interventions:<br>-"Invite to church services."<br>-"[Resident] enjoys watching TV, visiting with family, attending church services."<br>-"Continue assisting [resident] to activities she wishes to attend and help keep [resident] from feeling lonely."<br>-"[Resident] responds positively and has a decrease in agitation when physical touch of hand holding, arm/shoulder rub, or a gentle hug is offered and she initiates this contact."<br><br>3. Review of resident 6's medical record revealed:<br>*She required guidance or limited assist from staff for her activities of daily living.<br>*Her 1/4/21 annual MDS BIMs score was 3. That score indicated she had severe cognitive impairment.<br><br>Review of resident 6's activity participation records from 1/8/21 through 4/7/21 revealed:<br>*January 2021 she had no one-on-one activities documented.<br>*February 2021 she had eight one-on one activities documented. They had all been documented at the same time of 1:59 p.m.<br>*March 2021 she had seven one-to-one activities documented. They had all been documented at the same time of 1:59 p.m.<br>*4/1/21 through 4/7/21 she had no one-to-one | F 679 | | |

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| F 679 | Continued From page 19<br>activities documented. She had not participated in other activities for January 2021.<br>*She had participated in three group activities, two special events, and one spiritual activity for February 2021.<br>*She had participated in sixteen group activities, one special event, and two spiritual activities for March 2021.<br>*She had participated in two group activities, one special event, and one spiritual activity from 4/1/21 through 4/7/21.<br><br>Resident 6's care plan had been requested and not received as of the exit on 4/9/21.<br><br>4. Review of resident 5's medical record revealed she required extensive assistance from staff for all her ADLs. The 3/8/21 quarterly MDS indicated she was unable to answer the questions so staff were interviewed and indicated she had both short and long term memory issues. Review of her activity participation records from 1/8/21 through 4/7/21 revealed:<br>*She had twenty-one one-on-one activities documented.<br>*They had all been documented at the same time of 1:59 p.m.<br>*She had participated in twenty-three group activities, two special events, and three spiritual activities.<br><br>Review of resident 5's 6/11/20 care plan revealed:<br>*Focus: "INDEPENDENT ACTIVITY, SELF DIRECTED: [Resident] is functioning at an independent level in her leisure pursuits. She is alert and oriented and able to express her needs, desires and opinions. [Resident] frequently engages in the following leisure pursuits: television, movies, outside recreation, arts and | F 679 | | |

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| F 679 | Continued From page 20<br>crafts, shopping."<br>*Goals:<br>-"[Resident] will make one positive statement about her leisure pursuits to staff weekly."<br>-"[Resident] will establish a significant relationship with one peer with similar interests through next review date."<br>-"[Resident] will suggest one program that she would like to see placed on the activity calendar monthly."<br>*Interventions included:<br>-"[Resident] likes to shop and will have a list for shopping day. She needs help to estimate the cost and remember the facility shopping procedure."<br>-"Invite and encourage her to engage in activities."<br>-"Offer independent materials as desired; coloring pages and markers/crayons, newsletter."<br><br>Review of the provider's daily activities listed on the February 2021 activity calendar included:<br>-Exercise on Tuesday and Thursday at 10:30 a.m.<br>-News on Monday and Wednesday at 11:00 a.m.<br>-Piano music at 11:30 a.m.<br>-Other activities on 2/23/21 through 2/28/21 included: Bingo, resident council, church service, snack social, correspondence and salon day, weekend newsletter, and church on television on Sunday.<br>*Daily activity listed on the March 2021 activity calendar had piano music at lunch.<br>-Other activities for the month included: Crafts, bingo, correspondence and salon day every Thursday, big screen movie and popcorn, morning exercise three times, church service every Wednesday, weekend newsletter every Saturday, and church services on television every | F 679 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 679 | Continued From page 21<br>Sunday.<br>*Daily activities listed on the April 2021 activity calendar included:<br>-Exercise and news at 10:30 a.m.<br>-Live piano before lunch.<br>-Snack social at 2:30 p.m.<br>-Other activities for the month included: Crafts, bingo, correspondence and salon day every Thursday, big screen movie and popcorn, church service every Wednesday, weekend newsletter every Saturday, and church services on television every Sunday.<br>-Special activities from 4/1/21 through 4/9/21 included:<br>--Easter egg hunt, relaxation exercise, shopping day, and walking recreation.<br><br>Review of the provider's 9/27/20 Communal Activities and Dining During COVID-19 Pandemic policy revealed:<br>*"Communal dining and activities may occur no matter what the county positivity rate zone is where the facility resides."<br>*"Communal activities and dining may occur as long as the Core Principles of COVID-19 Infection Prevention is adhered to."<br><br>Review of the provider's 12/1/19 Director of Activities job description revealed:<br>*The director of activities was responsible for the planning, development, and overall operation of the activities department.<br>*The activity department implemented and directed activity programs that met the physical, emotional, and psychosocial needs of the residents.<br>*Regularly develops new programs to meet the new trends and industry standards.<br>*Observe and report residents attendance, | F 679 | | |

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| F 679 | Continued From page 22<br>participation, behavior changes by documenting and charting<br>*Participated in the care planning process by attending care plan meeting, providing specific information and observations of the residents needs and preferences.<br><br>Surveyor: 42477<br>5. Review of resident 10, 13, 14, 19, and 125's activity records revealed that majority of their one-on-one activities took place at 1:59 p.m.<br>*Resident 125 and resident 14 were documented to have participated in group activities on 4/7/21 at 12:15 p.m.<br>-Resident 125 was quarantined due to being a newly admitted resident to the facility and unable to participate in group activities.<br>*Observations on 4/7/21 from 12:15 p.m. through 4:30 p.m. there were no activities observed being conducted or residents engaged.<br><br>Interview on 4/9/21 at 11:15 a.m. with activities director F revealed:<br>*She is the only activities person in the facility.<br>*She said lack of activities was due to their facility outbreak of COVID-19 and she had to work the floor as a CNA.<br>*She said sometimes it would be stated on the staff schedule if she was pulled to work the floor.<br>*Agreed the last time the provider had a COVID-19 outbreak was in February.<br>*The facility has a channel set-up through the residents televisions. She did devotions, newsletters, and reading the newspaper on this channel.<br>*She said she does not work on the weekends so staff will put on movies for the residents.<br>*Activities or the frequency that resident's require | F 679 | | |

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| F 679 | Continued From page 23<br>activities is not on their care plans.<br>*She does not know if staff are able to complete the weekend activities or who is able to attend.<br>*The one-to-one activities program was based on the residents needs.<br>*She did not have a current list of which residents required one-to-one activities.<br>*She did not have a specific activities planned for those residents.<br>*When a new resident was admitted she was to complete an assessment within the first week of their likes and dislikes.<br>*She did not realize the frequency of the activities and what activity preferences each resident had should have been on the care plan.<br>*She had been trying to think of a way to document if activities were actually being completed during the weekend and if resident's were attending. | F 679 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 26632<br>Based on observation, interview, record review and policy review, the provider failed to ensure residents received treatment and care in accordance with professional standards of | F 684 | 1. All residents, including resident 14, 19, 124 and 126 are being weighed as ordered. Resident 10's tube feeding orders have been reviewed and are being followed. All residents, including residents 6, 7, 11, 13, 19 and 126 have had skin assessments completed and are receiving care as ordered. All residents are potentially at risk. By May 7, 2021, the DON or designee will conduct a retrospective chart review going back to March 1, 2021 to ensure ordered treatments are in place and followed as ordered; and residents are weighed as ordered.<br><br>2. The IDT will review the day prior progress notes and clinical alerts each weekday morning in the daily stand up meeting to identify lapses in resident care. The DON or designee will educate all care staff, no later than May 7, 2021, on the need to ensure physician orders, including orders for daily weights, tube feedings, skin assessments and treatments, are followed. Those not in attendance will be educated prior to their next shift worked. | |

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| F 684 | Continued From page 24<br>practice, including:<br>*Daily weights for four of four sampled residents (14, 19, 124, and 126).<br>*Following provider's policy regarding holding feedings for one of one sampled residents (10) who received feedings via feeding tube.<br>*Ensured residents with skin alterations received assessments and treatments to prevent further breakdown for six of six sampled residents. (6, 7, 11, 13, 19, and 126).<br>Findings include:<br><br>1. Interview on 4/7/21 at 10:30 a.m. with resident 126 revealed she:<br>*Was continent of bowel and bladder prior to her admission.<br>*Had tried the bedpan once but was left on it so long it hurt.<br>*Was concerned if she tried the bedpan again she would be left on it for too long.<br>*Used the full body lift for transfers.<br>*Had not been offered any way to use the toilet.<br><br>Review of resident 126's medical record revealed:<br>*No comprehensive admission assessment had been completed.<br>*She required the use of a mechanical lift for transfers.<br>*Her toilet use performance had been marked as activity did not occur.<br>*Her toilet transfer (the ability to get on and off a toilet or commode) had been marked as:<br>-Not applicable.<br>-Not attempted due to medical condition or safety concerns.<br>-Not assessed/no information.<br><br>Review of resident 126's point of care bowel and | F 684 | 3. The DON or designee will audit 3 residents each week to ensure: residents are weighed as ordered, tube feedings are administered as ordered, assessments are completed and skin treatments are in place as ordered. In addition, the specific residents cited will be included in the audit for 4 weeks. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| F 684 | Continued From page 25 | F 684 | | |

bladder documentation from 3/23/21 through 4/8/21 revealed she had been marked as:
*Incontinent of urine thirty-seven times.
*Continent of urine eight times.
*Incontinent of bowel nineteen times.
*Continent of bowel one time.
*Independent with toilet use three times.
*Requiring limited assistance two times.
*Requiring extensive assistance fourteen times.
*Requiring total assistance four times.
*Activity did not occur twenty times.

Review of resident 126's 4/8/21 care plan revealed:
*Focus: "[resident name] has a physical functioning deficit related to self care and mobility impairment. Fx [fracture] and surgical repair of LLE [lower left extremity], Non weight bearing to LLE."
-Goal: "Will improve current level of physical functioning through review date." Review date of 6/30/21.
-Interventions included:
--"Bed mobility assistance of extensive assist of two."
--"May be transferred with hoyer lift."
--"Toileting assistance of extensive assist of two."
*Focus: "[resident name] has a potential for pressure ulcer development related to impaired mobility, Non weight bearing status, diabetes, incontinence."
-Goal: Will have intact skin, free of redness, blisters or discoloration caused by pressure through review date."
-Intervention: "Small open area to lower lt [left] buttock and sheering to sacrum."

Interview on 4/8/21 at 4:00 p.m. with clinical care coordinator N revealed:

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| F 684 | Continued From page 26<br>*None of the residents were on a toileting program or plan.<br>*It would have caused more problems due to the documentation required.<br>*Agreed the comprehensive admission assessment should have been completed.<br>*The care plan did not include any information on her continence.<br><br>Observation during resident 126's sacral dressing change and perineal care on 4/7/21 at 10:15 a.m. with licensed practical nurse (LPN) Q and certified nursing assistant (CNA) R revealed:<br>*The lower part of her spine above her tailbone had a heart shaped area that extended from just above her anus approximately two inches and on each side approximately three inches. The skin in that area had peeled away and was white in color. The inner part was red. There was a scant amount of yellowish drainage on the soiled dressing.<br>*A nickel size closed red area was noted to the left buttock area. The area blanched slowly.<br>*LPN Q said she would keep an eye on that area.<br>*LPN Q and CNA R assisted resident 126 to move up higher on the mattress using the underpad to lift her.<br>*Her buttocks was drug against the mattress when she was repositioned.<br><br>Interview on 4/7/21 at 10:30 a.m. with resident 126 revealed she:<br>*Did not have a sore on her bottom when she was admitted.<br>*Was continent of bowel and bladder prior to her admission.<br>*Had tried the bedpan once but was left on it so long it hurt.<br>*Was concerned if she tried the bedpan again | F 684 | | |

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| F 684 | Continued From page 27<br>she would be left on it for too long.<br>*Now used incontinent briefs and had to be changed when they were soiled.<br>*Used the full body lift for transfers.<br>*Had not been offered any way to use the toilet.<br>*Stated staff rarely assisted her to reposition in her bed.<br>*Was unable to reposition herself other than slightly.<br><br>Review of resident 126's medical record revealed:<br>*She had been admitted on 3/22/21 after a fall at home and subsequent surgery to her left ankle and foot.<br>*Her other diagnoses included: urinary tract infection, diabetes mellitus with underlying chronic kidney disease, cirrhosis of liver, ascites, heart failure, gastro-esophageal reflux disease, muscle wasting and atrophy, and difficulty in walking.<br>*There were no assessments to determine her risk for skin issues.<br>*She had a revision of her left ankle and foot surgery on 3/27/21.<br>*Documentation of her every two-hour repositioning was only documented on 3/23/21.<br><br>Review of resident 126's daily nursing evaluations revealed:<br>*Her initial admission comprehensive assessment had not been completed.<br>*3/23/21 at 5:35 p.m. was the first assessment completed revealed she:<br>-Did not have a wound which required a dressing change.<br>-Required extensive assistance of two staff for bed mobility.<br>-Had not been transferred out of bed and toileting | F 684 | | |

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| F 684 | Continued From page 28 | F 684 | | |

had been marked that the activity did not occur.
-Had no complaints of pain.
-Remained in bed all shift.
-Was repositioned by staff every two hours and as needed.
*Other nursing evaluations had been completed on:
-3/27/21 at 4:48 p.m. indicated:
--"Resident has ulcer to lateral side of right foot and skin shearing to sacral and left lower buttocks. Foam dressings applied to bottom the Am [morning] and Right foot dressed already from surgery yesterday. To be kept in place and not to remove both foam leg booties."
--"Denies pain or discomfort when asked. Repos. [repositioned] by staff every 2 hours and PRN [as needed]. Full hoyer lift as post surg [surgery] is NWB [non weight bearing] LLE [lower left extremity] and RLE [right lower extremity]. Keep on heel bootie foam-NOT TO REMOVE. to f/u [follow-up] in 7 days for incision check. Noted resident still has distended abd. [abdomen] Did weight today with hoyer lift with everything on (ref. [reference] chart). Noted that incision site LLE dressing still intact/non soiled. Noted white part of eyes were slightly jaundiced today. Will inform PCP [primary care provider]. Cont. [continue] with therapies as ordered."
-3/29/21 at 1:24 p.m. indicated:
---"Dressing intact until next appt. [appointment]. Wound vac intact."
--"No c/o [complaints of] pain or discomfort. Alert, oriented x [times] 4."
-3/31/21 at 12:59 p.m. indicated:
--"Dressing intact until next appt. Wound vac intact."
--"No c/o pain or discomfort. Alert, oriented x 4. Wound vac intact and working as instructed."
-4/3/21 at 1:08 p.m. indicated:

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| F 684 | Continued From page 29<br>--"Right outer foot ulcer, is dry and intact."<br>-4/4/21 at 2:32 p.m. indicated:<br>--"Right outer foot ulcer, is dry and intact, foam dressing applied."<br>--"Resident complains of a little pain, I have such arthritis in my hands that it is hard for me to reposition myself."<br>-4/5/21 at 9:05 a.m., 4/5/21 at 7:43 p.m., 4/7/21 at 9:05 a.m., and 4/8/21 at 11:50 a.m. indicated no skin or wound changes from the previous evaluations.<br><br>Review of resident 126's skin alteration evaluations revealed:<br>*On 3/25/21 at 1:38 p.m. she:<br>-Had shearing of her skin to her sacrum. The area measured 2 centimeters (CM) by 1.2 cm. The edges were rolled. She had pain.<br>-Had another area which the type was marked as other. The area was on her left lower buttock and measured 0.5 cm X 0.5 cm.<br>-Other relevant information provided by the nurse was "Shearing of skin to sacral area, foam dressing applied. Small open area to the left lower buttocks. Foam dressing applied."<br>*On 3/25/21 at 2:57 p.m. she:<br>-Had an unspecified type of ulcer to her right lateral foot. No measurements had been completed.<br>-Had difficulty repositioning herself and required staff to assist.<br>-Was not continent of bowel and bladder.<br>-Expressed pain that limited her movement.<br>*No further skin alteration evaluations had been completed.<br><br>Review of a 3/26/21 physician's order indicated to "Rotate and reposition every 2 hrs. [hours] Multiple sores to buttocks/coccyx." | F 684 | | |

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| F 684 | Continued From page 30 | F 684 | | |

Review of resident 126's 4/8/21 care plan revealed:
*Focus areas, goals, and interventions:
-Focus: "Diabetic Ulcer related to outer right foot.
-Goal: "Ulcer will improve by review date." Review date listed as 6/30/21.
-Goal: "Will have no complications related to ulcer through review date." Review date listed as 6/30/21.
-Interventions:
-- "Admitted with TTWB [toe touch weight bearing] to Rt [right] leg. Betadine soaked gauze, covered with kerlix, and ace wrap to RLE. Change daily and PRN. 3/26 Weight bearing has been changed to NON weight bearing on right as ulcer is not healing."
--"Ensure appropriate protective devices are applied to affected areas."
--"Monitor/document/report to MD as needed changes in wound color, temp,[temperature], sensation, pain, or presence of drainage and odor."
-Focus: "[resident name] has a potential for pressure ulcer development related to impaired mobility, Non weight bearing status, diabetes, incontinence."
-Goal: "Will have intact skin, free of redness, blisters or discoloration caused by pressure through review date." Review date listed as 6/30/2.
-Intervention: "Small open area to lower lt [left] buttock and sheering to sacrum. See TAR [treatment administration record] for current tx [treatment] order."

2. Review of resident's 6, 7, 11, and 13's medical records revealed alterations in their skin integrity. The provider did not provide quality care to

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| F 684 | Continued From page 31<br>ensure those residents had been free from impaired skin integrity.<br><br>Refer to F686, findings 2, 3, 4, and 5.<br><br>Surveyor: 42477<br>3. Review of sampled resident 14's medical record revealed.<br>*On 1/10/21 she was to have daily weights completed.<br>*She was not receiving daily weights.<br>*On 3/15/21 she had a weight of 152.2 lbs.<br>-Her next recorded weight was 133 lbs., on 4/6/21 which was a significant weight loss.<br>*There was no documentation regarding that weight loss or that the physician was notified.<br><br>4. Review of resident 19's EHR revealed:<br>*Starting on 2/13/21 he was to have daily weights due to edema from chronic kidney disease.<br>*He had multiple days were he did not receive daily weights.<br><br>5. Review of resident 10's EHR revealed:<br>*He had a peg tube to receive enteral feedings every 4 hours.<br>*Staff would often hold his feedings due to residual.<br>*There was no physicians order to hold the feedings.<br>*There were days multiple feedings would be held.<br><br>Review of provider's current enteral feeding policy revealed:<br>*If there was residual then the ph should be checked.<br>*The policy did not state feedings should be held | F 684 | | |

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| F 684 | Continued From page 32<br>if there was residual.<br><br>6. Review of resident 124's EHR revealed:<br>*He was admitted to the facility on 1/25/2021.<br>*He was on a 1800 cc per day fluid restriction that could not be lower than 1500 cc per day.<br>*He had a recorded weight on 2/3/21 of 182.0. lbs.<br>*On 3/10/21 he had a recorded weight of 166.5 lbs.<br>-This was equal to a significant weight loss.<br>*As of 4/9/21 he had not had another weight since 3/10/21.<br>*On 3/13/21 he was discharged from a hospital stay and had an order for the nursing home to:<br>-Obtain daily weights.<br><br>Interview on 4/9/21 at 11:42 a.m. with clinical care coordinator N about resident 124 revealed:<br>*Resident 124 was to be weighed daily starting 3/13/21.<br>*The order for daily weights was not for one time, it was ongoing.<br><br>Review of the provider's March 2021 Weighing the Resident policy revealed:<br>*Review the care plan to assess for any special needs of the resident.<br>*Weight was measured upon admission, weekly for four weeks, monthly, or per physician order.<br>*Report any significant weight loss/gain to the nurse supervisor who would then report to the registered dietician and physician.<br>*If the weight does not appear correct, re-weigh resident to ensure the weight was accurate.<br>*Notify the nurse supervisor if the resident refused to be weighed. | F 684 | | |
| F 686 SS=H | Treatment/Svcs to Prevent/Heal Pressure Ulcer | F 686 | | |

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| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

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| F 686 | Continued From page 33<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br><br>Surveyor: 26632<br>Based on observation, interview, record review, policy review, and job description review, the provider failed to follow their skin integrity policy for:<br>*The prevention of five of five (6, 7, 11, 13, and 126) sampled residents who had acquired pressure ulcers.<br>*Accuracy of weekly skin assessments and/or wound documentation for five of five [6, 7, 11, 13, and 126] sampled residents.<br>*A turning and repositioning program for five of five [6, 7, 11, 13, and 126] sampled residents to off load pressure areas.<br>*Monitoring all residents for impaired skin integrity.<br>Findings include:<br><br>1. Observation during a sacral dressing change | F 686 | 1. Residents 6, 7, 11, 13 and 126 have been assessed, appropriate skin measures have been put into place, and their care plans have been updated to reflect those interventions. All residents are at potential risk for skin breakdown and residents with actual pressure injuries are at risk for worsening of those pressure injuries.<br><br>2. The skin program policy was reviewed with no revisions needed. The DON, a licensed nurse, and/or a wound care certified nurse will complete Braden scales on all residents to identify risk and put appropriate interventions into place by May 7, 2021. All residents will receive skin assessments by the DON, a licensed nurse, and/or a wound care certified nurse by May 7, 2021. All residents with actual skin breakdown will be evaluated by a Wound Care Certified nurse to ensure assessments were accurate, and treatments and interventions were appropriate by May 7, 2021.<br><br>3. The DON or designee, in collaboration with the Wound Care Certified nurse, will educate all nursing staff on the facility's Skin Program Policy and their roles and responsibilities of the active pressure injury prevention program, including: identifying, initiating, following, and updating interventions on resident's care plans for those at risk and completing skin related assessments and documentation timely and accurately. Education will occur no later than May 7, 2021. Those not in attendance will be educated prior to their first shift worked. The DON or designee will audit all residents with pressure injuries weekly to ensure: Care plans have skin management interventions, those interventions are being followed, refusals are documented, and skin assessments are completed timely and accurately. Additionally, the DON or designee, will audit 3 random residents' medical records each week to ensure: Braden scales are current and those at risk have interventions in place to prevent skin breakdown. In addition, the specific residents cited will be included in the audit for 4 weeks. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of effectivness and recommendations.<br><br>4. | 5/7/21 |

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| F 686 | Continued From page 34<br>and perineal care on 4/7/21 at 10:15 a.m. with licensed practical nurse (LPN) Q and certified nursing assistant (CNA) R of resident 126's right lateral foot and sacral area revealed:<br>*Her right lateral foot had betadine painted on it. There were no signs of infection.<br>*Her sacral area had a heart shaped area that extended from just above her anus approximately two inches and on each side approximately three inches. The skin in that area had peeled away and was white in color. The inner part was red. There was a scant amount of yellowish drainage on the soiled dressing.<br>*A nickel size closed red area was noted to the left ischial area. The area blanched slowly.<br>*LPN Q said she would keep an eye on that area.<br>*The skin to her legs was very dry and flaky.<br>*LPN Q and CNA R assisted to reposition resident 126 up higher on the mattress.<br>*They lifted her by using the underpad.<br>*Her buttocks still dragged against the mattress when she was repositioned.<br><br>Interview on 4/7/21 at 10:30 a.m. with resident 126 revealed she:<br>*Did not have a sore on her bottom when she was admitted.<br>*Was continent of bowel and bladder prior to her admission.<br>*Had tried the bedpan once but was left on it so long it hurt.<br>*Was concerned if she tried the bedpan again she would be left on it for too long.<br>*Used the full body lift for transfers.<br>*Had not been offered any way to use the toilet.<br>*Stated staff rarely assisted her to reposition in her bed.<br>*Was unable to reposition herself other than slightly. | F 686 | | |

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| F 686 | Continued From page 35<br><br>Review of resident 126's medical record revealed:<br>*She had been admitted on 3/22/21 after a fall at home and subsequent surgery to her left ankle and foot.<br>*Her other diagnoses included: urinary tract infection, diabetes mellitus with underlying chronic kidney disease, cirrhosis of liver, ascites, heart failure, gastro-esophageal reflux disease, muscle wasting and atrophy, and difficulty in walking.<br>*No Braden assessments had been completed.<br>*She had a revision of her left ankle and foot surgery on 3/27/21.<br>*Documentation of her every two hour repositioning had only been documented on 3/23/21.<br><br>Review of resident 126's daily nursing evaluations revealed:<br>*Her initial admission comprehensive assessment had not been completed.<br>*3/23/21 at 5:35 p.m. was the first assessment completed revealed she:<br>-Did not have a wound which required a dressing change.<br>-Required extensive assistance of two staff for bed mobility.<br>-Had not been transferred out of bed and toileting had been marked that the activity did not occur.<br>-Had no complaints of pain.<br>-Remained in bed all shift.<br>-Was repositioned by staff every two hours and as needed.<br>*Other nursing evaluations had been completed on:<br>-3/27/21 at 4:48 p.m. indicated:<br>--"Resident has ulcer to lateral side of right foot | F 686 | | |

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| F 686 | Continued From page 36 | F 686 | | |

and skin shearing to sacral and left lower buttocks. Foam dressings applied to bottom the Am [morning] and Right foot dressed already from surgery yesterday. To be kept in place and not to remove both foam leg booties."
--"Denies pain or discomfort when asked. Repos. [repositioned] by staff every 2 hours and PRN [as needed]. Full hoyer lift as post surg [surgery] is NWB [non weight bearing] LLE [lower left extremity] and RLE [right lower extremity]. Keep on heel bootie foam-NOT TO REMOVE. to f/u [follow-up] in 7 days for incision check. Noted resident still has distended abd. [abdomen] Did weight today with hoyer lift with everything on (ref. [reference] chart). Noted that incision site LLE dressing still intact/non soiled. Noted white part of eyes were slightly jaundiced today. Will inform PCP [primary care provider]. Cont. [continues with therapies as ordered."
-3/29/21 at 1:24 p.m. indicated:
----"Dressing intact until next appt. [appointment]. Wound vac intact."
--"No c/o [complaints of] pain or discomfort. Alert, oriented x [times] 4."
-3/31/21 at 12:59 p.m. indicated:
--"Dressing intact until next appt. Wound vac intact."
--"No c/o pain or discomfort. Alert, oriented x 4. Wound vac intact and working as instructed."
-4/3/21 at 1:08 p.m. indicated:
--"Right outer foot ulcer, is dry and intact."
-4/4/21 at 2:32 p.m. indicated:
--"Right outer foot ulcer, is dry and intact, foam dressing applied."
--"Resident complains of a little pain, I have such arthritis in my hands that it is hard for me to reposition myself."
-4/5/21 at 9:05 a.m., 4/5/21 at 7:43 p.m., 4/7/21 at 9:05 a.m., and 4/8/21 at 11:50 a.m. indicated no

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| F 686 | Continued From page 37 | F 686 | | |

skin or wound changes from the previous evaluations.
*There was no other documentation of a wound vac or a physician's order for that type of wound treatment.

Review of resident 126's skin alteration evaluations revealed:
*On 3/25/21 at 1:38 p.m. she:
-Had shearing of her skin to her sacrum. The area measured 2 centimeters (CM) by 1.2 cm. The edges were rolled. She had pain.
-Had another area which the type was marked as other. The area was on her left lower buttock and measured 0.5 cm X 0.5 cm.
-Other relevant information provided by the nurse was "Shearing of skin to sacral area, foam dressing applied. Small open area to the left lower buttocks. Foam dressing applied."
*On 3/25/21 at 2:57 p.m. she:
-Had an unspecified type of ulcer to her right lateral foot. No measurements had been completed.
-Had difficulty repositioning herself and required staff to assist.
-Was not continent of bowel and bladder.
-Expressed pain that limited her movement.
*No further skin alteration evaluations had been completed.

Review of a 3/26/21 physician's order indicated to "Rotate and reposition every 2 hrs. [hours] Multiple sores to buttocks/coccyx."

Review of resident 126's 4/8/21 care plan revealed:
*Focus areas, goals, and interventions:
-Focus: "Diabetic Ulcer related to outer right foot.
-Goal: "Ulcer will improve by review date." Review

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| F 686 | Continued From page 38<br>date listed as 6/30/21.<br>-Goal: "Will have no complications related to ulcer through review date." Review date listed as 6/30/21.<br>-Interventions:<br>-- "Admitted with TTWB [toe touch weight bearing] to Rt [right] leg. Betadine soaked gauze, covered with kerlix, and ace wrap to RLE. Change daily and PRN. 3/26 Weight bearing has been changed to NON weight bearing on right as ulcer is not healing."<br>--"Ensure appropriate protective devices are applied to affected areas."<br>--"Monitor/document/report to MD as needed changes in wound color, temp,[temperature], sensation, pain, or presence of drainage and odor."<br>-Focus: "[resident name] has a potential for pressure ulcer development related to impaired mobility, Non weight bearing status, diabetes, incontinence."<br>-Goal: "Will have intact skin, free of redness, blisters or discoloration caused by pressure through review date." Review date listed as 6/30/2.<br>-Intervention: "Small open area to lower lt [left] buttock and sheering to sacrum. See TAR [treatment administration record] for current tx [treatment] order."<br><br>Review of resident 126's March 2021 medication administration record (MAR) and TAR revealed:<br>*A 3/28/21 physician's order for Optifoam dressing to the right lateral foot ulcer, change three times per week. This order was discontinued on 4/4/21.<br>*A 3/24/21 physician's order for Optifoam dressing to sacrum change every three days and PRN for wound. | F 686 | | |

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| F 686 | Continued From page 39<br>*There was no documentation this had been changed on 3/30/21.<br><br>Review of resident 126's April 2021 MAR and TAR revealed:<br>*The Optifoam dressing to the right lateral foot had not been documented as changed on 4/3/21 and was discontinued on 4/4/21.<br>*A new physician's order on 4/4/21 for her right lateral foot ulcer was to apply betadine twice a day.<br>*The Optifoam dressing to her sacrum remained the same. There was no documentation it had been changed on 4/2/21 and on 4/8/21.<br><br>2. Review of resident 11's medical record revealed she had recurring pressure ulcers as noted:<br>*Acquired a stage two pressure ulcer on that same right heel on 12/28/20.<br>-That pressure ulcer had been considered healed on 2/25/21.<br><br>Review of resident 11's skin alteration evaluations revealed:<br>*On 12/28/20 a intact blood filled blister was noted to her right heel.<br>-It measured 5.2 cm long, 5.1 cm wide, and 1 cm deep.<br>-It was a stage two pressure ulcer.<br>-The treatment was to swab with betadine, keep heel dressed, and keep heel protectors in place.<br>*1/4/21 still had the intact blood filled blister to her right heel.<br>-It measured 7.5 cm long, 5 cm wide, and 1 cm deep.<br>-No change in the treatment.<br>*1/14/21 the right heel blister had opened. The skin was dry and flat against the heel. Ulcer was | F 686 | | |

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| F 686 | Continued From page 40 | F 686 | | |

blackened from the betadine treatment.
-It measured 6 cm long, 4 cm wide, and no depth was indicated.
-No change in the treatment.
*1/21/21 the stage two pressure ulcer continued to the right heel,
-It measured 6 cm long, 4 cm wide, and no depth was indicated.
-There was 100 % granulation tissue in the pressure ulcer.
-No change in the treatment.
*1/27/21 the stage two pressure ulcer continued to the right heel.
-It measured 5.6 cm long, 4 cm deep, and no depth was indicated.
-No change was made for the treatment.
-There was 100 % granulation in the pressure ulcer.
*2/11/21 the stage two pressure ulcer continued to the right heel.
-It measured 5 cm long, 3.5 cm wide, and no depth was indicated.
-There was 100 % granulation in the pressure ulcer.
-"Dry, dark scab is gone. New pink skin noted. Scabbed area approx [approximately] 0.5 x 0.5 cm noted in center."
*2/18/21 the stage two pressure ulcer continued to the right heel.
-It measured 1 cm long and 1 cm wide.
-"Scab is dry. Heel protectors in use. Will leave open to air and continue to monitor."
*2/25/21 "Rt [right] heel is completely healed."

Review of resident 11's skin evaluation revealed:
*On the following dates it was documented there was no alteration to her skin:
-12/30/21, 1/13/21, and 1/23/21.
*On 1/26/21, three days later it was documented

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| F 686 | Continued From page 41<br>there was a sore that measured 2.4 cm long, 1.5 cm wide, and no depth was documented.<br>-It was described as "right heel- dried- skin intact, Heel boots in bed."<br>*1/26/21 "Resident has alteration in skin integrity" was answered as a "yes".<br>-"Right heel healing/scabbed over dried blister region. Cares of betadine to affected area and leave open to air."<br>*2/3/21 "Resident has alteration in skin integrity" was answered as a "yes".<br>-"Right heel 1 cm blister, popped. Betadine applied."<br>*It had been documented again on 2/17/21 and 2/24/21 there was no alteration to her skin.<br><br>Review of resident 11's Braden Scale scores revealed:<br>*On 10/6/20 her score was thirteen which indicated she was at an elevated risk for developing a pressure ulcer.<br>*On 1/6/21 her score was thirteen which indicated she was at an elevated risk for developing a pressure ulcer.<br>-The clinical evaluation said she did not have a history of or an existing pressure ulcer. She had a stage two pressure ulcer to her right heel currently.<br><br>Review of resident 11's revised 1/31/21 care plan revealed:<br>*Focus area revised on 1/31/21.<br>-"[resident name] has a stage II [two] pressure ulcer to inner right heel. She has hx [history] of pressure ulcers, is immobile."<br>*Goals:<br>-"Will be free of further skin breakdown caused by pressure." Revised on 1/31/21.<br>-"Ulcer will heal without complications." Initiated | F 686 | | |

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| F 686 | Continued From page 42<br>on 1/31/21.<br>*Interventions included:<br>-"Pressure reducing mattress in use." Initiated on 1/31/19.<br>-"Skin assessments weekly." Revised on 7/6/19.<br>*Focus area revised on 7/19/19.<br>-"[Resident name] has a physical functioning deficit related to self care and mobility impairments, alzheimers."<br>*Goal revised on 1/31/21.<br>-"Will accept staff assistance regarding performance of ADLs [activities of daily living] with maximum self participation as able through the review date."<br>*Interventions included:<br>-"Bed mobility assistance of extensive assist of two." Initiated on 1/31/19.<br>-"Transfers assistance of extensive assist of two and hoyer lift." Initiated on 1/31/19.<br>*The stage two pressure ulcer to her right heel had healed on 2/25/21.<br>*There were no interventions related to the prevention of her right heel pressure ulcer.<br>*There was no documentation of the use of any pressure relieving or reducing boots.<br>*There was no documentation of the treatment for the right heel pressure ulcer.<br><br>3. Review of resident 6's skin alteration evaluation revealed:<br>*The only evaluation had been completed on 2/25/21.<br>*Resident 6 has an unstageable pressure ulcer to the back of her left thigh that measured 1 cm long by 0.5 cm wide. There was no depth recorded.<br>*Resident 6 had an unstageable pressure ulcer to the back of her right thigh that measured 0.9 cm long by 0.5 cm wide. There was no depth recorded. | F 686 | | |

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| F 686 | Continued From page 43<br>*Resident 6 had an unstageable pressure ulcer to her left outer labia that measured 1 cm long by 0.4 cm wide. There was no depth recorded.<br>*Other relevant information included: Resident has a superficial, reddened area to sacral area. Dressing applied for extra protection and will update doctor. There were no further measurements or documentation of that area.<br><br>Review of resident 6's skin evaluations revealed:<br>*On 1/9/21 documentation of "Buttocks, red area, foam dressing put on." No measurements had been documented.<br>*On 1/14/21 documentation that the area was listed as a pressure ulcer to her coccyx. No measurements or staging of that area. "Resident buttocks/coccyx noted redness."<br>*On 1/18/21 listed the right and left buttocks as being red.<br>*On the following dates it was documented there was no alteration to her skin:<br>-1/21/21, 2/8/21, 3/3/21, 3/4/21, and 3/11/21.<br>*On 1/28/21 0.3 cm long by 1 cm wide scratch to right buttock and 0.1 cm by 6 cm scratch to left buttock had been documented.<br>*On 2/18/21 "Reddened areas under abdominal folds- nystop."<br>*On 3/8/21 "Resident has open area to left buttock, orders for foam dressing to be applied." There were no measurements or staging of this area.<br>*On 3/18/21 A pressure ulcer was noted to her sacrum it measured 0.2 cm long by 0.2 cm wide. No depth or stage was documented.<br>*On 3/22/21"Resident has a few scattered scratches to arms from resident scratching/picking. Bottom has some redness but no open areas at this time. Left labial fold area is healed." | F 686 | | |

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| F 686 | Continued From page 44<br>*On 3/29/21 "Resident has open area to buttocks." There was no measurements or staging of this area.<br><br>Review of resident 6's Braden scale scores revealed she had a risk for developing a pressure ulcer.<br><br>Review of resident 6's:<br>*February 2021 TAR revealed a 2/16/21 order to apply a foam dressing to gluteal fold until it was healed. *Documentation revealed:<br>-February there was six days it had not been documented as having been completed.<br>-March there were nine days it had not been documented as having been completed.<br>-April there was one day it had not been documented as having been completed.<br><br>Interview on 4/6/21 at 4:30 p.m. with LPN K regarding the 100 hallway residents skin conditions revealed resident 6 had MASD and a pressure ulcer to her gluteal area.<br><br>On 4/9/21 at 9:00 a.m. a copy of resident 6's care plan had been requested from the provider. The care plan was not received.<br><br>4. Review of resident 7's medical record revealed:<br>*She had been admitted on 3/9/21.<br>*Diagnoses that included: Diabetes mellitus, hypertension, congestive heart failure, chronic obstructive pulmonary disease, Chronic kidney disease; stage 3, difficulty in walking, severe obesity, and weakness.<br>*A 3/16/21 at 11:32 p.m. progress note "Reported with Skin alteration - Right Buttock. Noted"<br>*No further documentation for the right buttock | F 686 | | |

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| F 686 | Continued From page 45<br>skin alteration in progress notes.<br>*A 3/28/21 skin evaluation revealed she had no alteration in her skin integrity.<br>*A 4/7/21 skin evaluation revealed she did have an alteration in her skin integrity. The areas were open sores to both of her lower legs.<br>*A 4/2/21 at 4:07 p.m. progress note "Nurse was pulled into resident's room by son [name] who wanted to show nurse his mom's legs. [son's name] was upset that is mo's TEDs [compression stockings] were not on so he applied and noticed her legs had sores. Nurse in to check and resident has small open area to RLE [right lower extremity] that is weeping, and several small open areas to LLE [left lower extremity], some are weeping some are not."<br>*There was no further documentation of her right buttock alteration in skin integrity.<br>*A 4/7/21 at 5:52 p.m. progress note "Resident seen by wound care today. Foam to wounds and change every 3 days. Edema wear to BLE [bilateral lower extremities] on during day. Off at night. Elevate legs BID [twice a day] above level of heart for 30 minutes. Keflex 500 mg TID [three times a day] x 7 days. Return in 1 week on 4/16/21 at 1400 [2:00 p.m.]."<br>*A Braden scale had been completed on 4/9/21 that showed she was at high risk for developing a pressure ulcer.<br>*The clinical evaluation on the same date said she had a history or an existing pressure ulcer but there was no summary completed<br><br>Review of resident 7's March TAR revealed two days the dressing was not documented it had been completed.<br><br>Review of resident 7's 3/9/21 care plan revealed:<br>*Focus: [Resident] has an impairment to skin | F 686 | | |

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| F 686 | Continued From page 46 | F 686 | | |

integrity, sheering to coccyx, BLE open areas related to incontinence, diabetes, excess fluid." Revised on 4/7/21.
*Goal: "Will no develop signs and symptoms of infection on the wound site." Initiated on 4/6/21.
*Interventions included:
-"Encourage frequent repositioning as [resident] is always sitting, either in w/c [wheelchair] or recliner. She also chooses to sleep in recliner."
-"Medihoney to bottom, cover with foam dressing, Change daily and PRN."
-"Thorough peri care with each episode of incontinence."
*Focus: [Resident] is at risk for alteration of bowel and bladder functioning related to need for assistance with toileting, incontinence, and UTI [urinary tract infection] on admit."
*Goals included: "Will remain free from skin breakdown due to incontinence and brief use."
*Interventions included: "If incontinent, apply moisture barrier to the peri-area after incontinent episode."
*Focus: "[Resident] has a potential for pressure ulcer development related to Immobility, incontinence, diabetes."
*Goal: "Will have intact skin, free of redness, blisters or discoloration caused by pressure through review date." Target date 4/10/21.
*Interventions: "Pressure reducing wheelchair pad in use."
-"Sleeps in recliner."
-"Weekly skin assessments."

Surveyor: 42477
5. Review of resident 13's progress notes revealed:
*He was noted to have shearing to his coccyx and a Mepilex was applied.
*Wife called the facility to state resident 15 told

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| F 686 | Continued From page 47<br>her that his bottom is hurting:<br>-"...Also to get him up into bed out of wheelchair and shift weight. Spouse aware of open areas on gluteal aspect relating to discomfort dressing is applied and intact at this time. Advised noted requests and will comply. Will continue to monitor."<br>*The physician had put in an order for the provider to consult wound care.<br>-On 1/15/21 Clinical care coordinator N faxed the doctor requesting to cancel the wound care referral because it was "not a pressure ulcer- has some moisture related excoriation."<br>*There was multiple documented incidents of incontinence and behaviors with cares.<br>*On 1/21/21 he was noted to have an "open area to buttocks."<br>*On 1/21/21 wife had asked if they could use a cream she found on the open areas.<br>*On 1/22/21 Pharmacist was contacted regarding resident 15's behaviors.<br>-Pharmacist recommended checking for a UTI and PRN pain meds to rule out pain.<br>*Wife requested his physician be changed on 2/18/20.<br>*On 2/25/21 Open area to his bottom was 1 cm X .5 cm.<br>-Requested orders for collagen/hydrogel, cover with foam dressing and change QD [three times per day] and PRN [as needed].<br>*Wife came to the facility on 2/28/21 and asked why they were not using the cream she purchased on resident 15.<br>*Staff informed the wife of the new wound orders as her cream was not working.<br><br>Review of resident 13's current care plan revealed;<br>*Focus: | F 686 | | |

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| F 686 | Continued From page 48<br>-"[resident's name] is at risk for pressure ulcer development due to: Assistance required in bed mobility. 1/29/20 is no longer ambulatory. He uses his wheelchair for all locomotion and staff utilize hoyer lift for transfers, occasional incontinence, hx of ulcers."<br>*Goal:<br>-"Skin will remain free of breakdown caused by pressure ulcer through review date."<br>*Interventions:<br>-"Conduct weekly skin inspection, daily weights required, Give med pass 2.0 4 oz TID for wound healing. Provide pressure reducing wheelchair cushion, Provide pressure reduction/relieving mattress, Provide thorough skin care after incontinent episodes and apply barrier cream."<br>*For toileting he was an extensive assist of two people.<br>*"Check and change every 2 hrs. Thorough pericare with each episode of incontinence. Need to be kept clean and dry as much as possible to aid in healing of excoriated areas to buttocks and scrotum. 1/22/21 Per family request, Emuaid cream to be used on [resident's name] bottom until healed then PRN. Wife bought some and would like [resident's name] to use it."<br>*Careplan was not updated to include resident's new wound orders.<br><br>Review of clinical care coordinator N's wound assessments revealed:<br>*She was the wound nurse for the facility.<br>*States that his wounds were facility acquired on 2/8/21 to his sacrum and inner buttock.<br>-Other documentation of her weekly skin report stated the wounds were facility acquired on 2/18/21.<br><br>Review of resident 13's skin assessments in the | F 686 | | |

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| F 686 | Continued From page 49 | F 686 | | |

EHR revealed:
*No diagnosis.
*Inconsistency in documentation.

Surveyor: 26632
6. Review of the provider's weekly skin report revealed:
*Resident 124 had been listed for the weeks of 3/19/21, 3/25/21, and 4/1/21 as having an acquired stage 2 pressure ulcer
*Resident 13 had:
-An open area to his sacrum on 3/19/21.
-Moisture associated skin damage (MASD) to to his sacrum on 3/25/21.
-MASD to his sacrum on 4/1/21.
*On 3/25/21 and 4/1/21 resident 26 had a diabetic foot ulcer, sacrum sheering, and a open area to her left lower buttock.

Interview on 4/9/21 at 11:42 a.m. with clinical care coordinator N revealed she:
*Was responsible for the skin program.
*Had no formal training in wound care.
*Was to have measured all pressure ulcers and other wounds on a weekly basis.
*Reported skin problems on a weekly report.
*Did not have any formal turn and reposition program.
*Based her MDS data off documentation the nurses completed.

Review of the provider's September 2019 Skin Program policy revealed:
*"A baseline assessment of the resident's skin status will be completed upon admission/readmission by completing the Nursing Admission/Readmission UDA [user defined assessment]. This will include a physical exam of the resident's skin, a risk assessment

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| F 686 | Continued From page 50<br>Assessment Tool, and a comprehensive assessment of the resident's history and physical condition. A plan of care (POC) will be put into place for residents that are identified with actual skin breakdown or at-risk for skin breakdown."<br>*"Comprehensive skin assessments will be completed with admission/readmission, annually, and with change of condition."<br>*"Risk Assessments (Braden or PUSH [pressure ulcer scale for healing] will be completed with admission/readmission weekly for four weeks, quarterly, annually, and with change in condition."<br>*"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, b) Protect skin from moisture, c) Encourage optimal nutrition and fluid intake, d) Educate staff, residents and families, e) Train front-line caregivers, and f) Immediate prevention plan instituted when potential areas are identified."<br>*"A comprehensive wound assessment will include:<br>A) When a pressure injury is identified: This assessment will include,<br>a) Site, stage, size, appearance of wound bed, (use %) undermining, depth, drainage, (amount, color, type, consistency and odor) and status of peri-wound tissue;<br>b) Treatment of the pressure injury (cleansing, debridement, dressings);<br>c) A review of the resident's current POC and medical status any other possible risk factors, impaired healing due to diagnoses;<br>d) Type of skin injury (MD [medical doctor]/Provider is asked to identify type of injury, | F 686 | | |

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| F 686 | Continued From page 51<br>if needed - e.g. [example given] pressure, stasis (venous), ischemic (arterial, or neuropathic (Diabetic), and provide skin treatment orders. Reassess the would at least weekly (If the wound has not improved within 2-3 weeks, contact MD/Provider for a change in treatment)."<br>*"When a bruise of skin tear is noted, a Skin Alteration Evaluation UDA [user defined assessment]."<br>*"Nursing personnel who will be providing care for the resident will receive pressure injury training to include checking potential pressure areas and recognize pressure injuries in "at-risk" residents, (skin-reddening that does not disappear after pressure removed) and instructed to notify the nurse when this is observed. They will also be instructed in individual interventions for each resident. Nursing personnel will periodically monitor response to the POC, to ensure implementation of the POC." | F 686 | | |
| F 690 SS=G | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that | F 690 | 1. Residents 13 and126 have been placed on a toileting schedule. Resident 19's catheter has been removed. Residents 13, 19 and 126's care plans will be reviewed and updated by the interdisciplinary team by May 7, 2021. All resident have the potential to be at risk. The DON or designee will complete Bladder and Bowel Evaluations for all residents and place on individualized toileting schedules as appropriate by May 7, 2021. The DON or designee will review medical records for residents with catheters and ensure appropriate diagnosis has been obtained and is documented in the medical record. Their Intake and output is being recorded as ordered. Residents bowel movements is being recorded in the medical record.<br><br>2. Policy was reviewed with no revisions needed. The DON or designee will educate all nursing staff on the facility's Catheter and Toileting and Incontinence Policies; the staff roles and responsibilities for proper catheter protocol; ensuring toileting plans are implemented; bowel movements are documented and ordered bowel protocols are initiated as indicated. Education will occur no later than May 7, 2021.Those not in attendance will be educated prior to first shift worked. | |

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| F 690 | Continued From page 52<br>catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, record review, and policy review, the provider failed to ensure residents received services to maintain continence including:<br>*One of one sampled resident (126) who had been continent prior to admission and was now incontinent.<br>*One of one sampled resident (19) who had a foley catheter placed had a diagnosis for the catheterization.<br>*One of one sampled resident (13) who was incontinent and was not on a toileting program.<br>*Resident's were assessed on a regular schedule to determine if they were candidates for a toileting program. Findings include:<br><br>1. Review of resident 19's medical record | F 690 | 3. The DON or designee will audit 3 random residents each week to ensure: toileting plans/interventions are on the care plan and are being followed; any refusals of such are documented; bowel movements are documented; and bowel protocol is being followed for lack of bowel movements. he DON or designee will also audit all residents with catheters each week to ensure catheter placement has an appropriate diagnosis and input and output are being recorded as ordered. In addition, the specific residents cited will be included in the audit for 4 weeks.<br>Results of audits will be presented by the DON or designee at the monthly QAPI meeting for discussion of the effectiveness of the correction and recommendation.<br><br>4. | 5/7/21 |

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| F 690 | Continued From page 53<br>revealed:<br>*He was admitted to the facility May of 2020.<br>*His diagnosis included:<br>-Bipolar disorder.<br>-Post traumatic stress disorder (PTSD).<br>-Abnormalities of gait and mobility.<br>-Depressive episodes.<br>-Obstructive and reflux uropathy.<br>-Type II diabetes.<br>*His brief interview for mental status was 99, meaning resident did not participate in assessment.<br><br>Observation on 4/6/21 at 4:43 p.m. revealed certified nursing assistant (CNA) H and nursing assistant (NA) L revealed:<br>*They went into resident 19's room and closed the door.<br>*Surveyor could hear resident 19 yelling at CNA H and NA L.<br>*CNA H and NA L came out of his room and stated that he was very unhappy right now.<br><br>Further observation on 4/6/21 at 5:22 p.m. of resident 19's room revealed:<br>*His bed had been stripped of all sheets and bedding.<br>*He was sitting in his recliner eating dinner.<br><br>Interview on 4/7/21 at 10:30 a.m. with resident 19's wife revealed:<br>*She had been coming to the facility as resident 19's compassionate caregiver.<br>*She had been doing this for the past 2 or 3 months.<br>*Resident 19 has been soaked in urine every day she has came into the facility.<br>*She stated she felt like they were short staffed.<br>*Surveyor asked why she felt that way, she | F 690 | | |

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| F 690 | Continued From page 54<br>stated:<br>-Resident 19 had been wet with urine every day she came into the facility.<br>-CNA M told her they were short staffed and that is why the residents were soaked.<br>*Had voiced concerns about the cleanliness of his room.<br>*There was dry urine underneath his bed, dried food on his fall mat and a soiled trash can.<br>-This had been this way since Saturday 4/3/21.<br>*When she had told staff about her concerns she is told it is an "old building."<br>*She understands that he has behaviors but she has been asking staff to give her a call if he refuses cares.<br>*She reiterated they can call her any time of day or night, usually she is able to talk him into having cares done.<br>*She had not been told the resident had any issues with his legs she had noticed them during a window visit.<br>*Stated his legs looked terrible, red, swollen, and oozing.<br>*Resident 19 had falls and she was not notified when they occurred.<br>*She was not aware the catheter had cause a wound on his penis until the hospital told her.<br>*She was not aware the facility put a catheter in the resident until after it was done.<br>*She had bought a plastic shower curtain liner to put on the bed and recliner to try to prevent it from being soaked in urine.<br>*He has an opened sore on his buttock which she was not informed about.<br>*Recalled one time after he had a shower she performed cares and he still had ointment caked on his bottom.<br>-It looked as if they had not thoroughly cleaned his bottom. | F 690 | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 690 | Continued From page 55 | F 690 | | |

*She was concerned if she voiced her concerns to us she would no longer be allowed to come into the facility.
*She had talked to administrator G about these concerns and nothing changed.

Observation on 4/7/21 at 2:51 p.m. of resident 19 revealed:
*He was lying in his bed; the door was open.
*There was a strong odor of urine in the room.

Observation on 4/8/21 at 7:50 a.m. with resident 19's wife regarding the cleanliness of his room revealed:
*Dried urine on the floor underneath his bed.
*Dried food on the fall mat.
*Soiled trash can in his room.

Interview on 4/8/21 at 8:02 a.m. with CNA T revealed:
*She had just given resident 19 a shower.
*She had not noticed any sores on him.
*She said she has been able to thoroughly clean his perineal (peri) area while he is in the shower chair.
*He is very red in his peri area.

Review of resident 19's 5/28/20 admission Minimum Data Set (MDS) assessments revealed:
*No toileting program had been tried for bowel or bladder.
*He was an extensive assist of one for toilet use.
*He was not steady moving on and off the toilet.
-He was only able to stabilize with human assistance.

Review of resident 19's 8/28/20 quarterly MDS assessment revealed:
*No change in the bowel and bladder information

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| F 690 | Continued From page 56<br>on 5/8/20 but the following had been added or changed:<br>-He was frequently incontinent of bladder.<br>-He was always continent of bowel.<br><br>Review of resident 19's 11/25/20 quarterly MDS assessment revealed:<br>*No change in the bowel and bladder information on 5/8/20 but the following had been added or changed:.<br>-He was occasionally incontinent of bladder.<br>-He was always incontinent of bowel.<br><br>Review of resident 19's last 30 days of paper and electronic bowel and bladder records revealed:<br>*Resident was incontinent of bladder every day for 30 days.<br>*Resident was to be checked and/or changed every two hours.<br>*There had been multiple hours missed without documented behaviors or refusals.<br>*Specifically on 4/6/21 when surveyor heard resident yelling at CNA's:<br>-They documented that he refused to be changed at 3:57 a.m. despite being visibly wet.<br>-At 4:54 p.m. resident exhibited behaviors but staff were able to change him.<br>-It was documented in his EHR that he was incontinent at 7:08 a.m. and 9:15 p.m.<br>-Resident 19's wife was not called to try to offer any assistance over the phone.<br>-As needed (PRN) Lorazepam and Tylenol that had been ordered for the resident had not been given.<br>*On 4/7/21 while survey team was on site:<br>-Resident 19 was documented in his EHR to be incontinent of bladder at 9:42 a.m. and 8:58 p.m.<br>-There was no documentation of behaviors on 4/7/21 or refusals. | F 690 | | |

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| F 690 | Continued From page 57<br>-Resident 19's wife said she had not been called.<br><br>Review of resident 19's progress notes revealed:<br>*Since admission he was often found visibly wet.<br>*On 8/13/20 he started to have redness to his groin area.<br>*On 9/9/20 he had been documented to have:<br>-"nurse in resident room to apply Betadine to BLE (bilateral lower extremity)on scattered scratches and scabs. Nurse noticed red, slightly raise, warm to touch blotchy areas to BLE as well. No discharge noted to red, blotchy areas but some of the scabs are weeping a clear/yellowish discharge. Resident had 4+ pitting edema to BLE but resident doesn't always keep lets elevated when in recliner and he doesn't always sleep in bed at night..."<br>-"...Redness still noted to groin area, nystatin powder applied..."<br><br>Review of resident 19 faxed provider communication revealed:<br>*Staff faxed the physician on 11/5/20:<br>-"[Resident's name] has frequent incontinence. (urinary) - dx [diagnosis] of obstructive uropathy. He has skin issues on BLE. He sees wound care for special drsgs [dressings] weekly. We are having trouble keeping them dry. May we have an order for a foley catheter."<br>-Physician Assistant (PA-C) responded: "No foley- may complicate things."<br>*Staff faxed physician on 11/19/20:<br>-"Please see attached sheets [with] labs [and] appointment. From nephrology. [Dr's name] increased lasix to 80 mg on 10/28/20. Normally resident has 3-4 + pitting and weeping to BLE. Resident is incontinent multiple times [and] doesn't always let staff change him so he sits in urine for hours sometimes. Resident sees wound | F 690 | | |

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| F 690 | Continued From page 58<br>at [hospital name] [and] has compression wraps to stay on for a week but they become saturated with incontinence [and] interferes [with] healing. Resident already has adult briefs."<br>*Physician faxed back:<br>-"Insert Foley and record I/O [intake and output] for 3 days. Decrease Lasix to 80 mg[milligrams] a.m. and 40 mg p.m. Keep daily weights. Recheck BMP [basic metabolic panel] in 3 days."<br>*There was one communication regarding a fall on 12/22/20, with "no injuries noted."<br>*On 12/26/20 the provider faxed the doctor asking to have the catheter dc'd<br>*Faxed not stated:<br>-"Resident pulled out foley this afternoon. May we have an order to DC the foley? Resident's penis is eroding away."<br>*PA-C sent a note back that stated:<br>-"I have no [illegible] records. Why does he have the foley?"<br>--Three days later 12/29/20 she added another note, "May DC foley or leave out."<br>*There was no other communication or notes regarding resident 19's penis eroding away.<br>*There was no communication regarding the open sore on his buttocks.<br><br>Review of resident 19's progress notes revealed:<br>*On 11/20/20 at 1:00 p.m. documentation stated wife was updated on foley catheter.<br>*Foley catheter was placed on 11/20/20 at 1:45 a.m.<br>*On 11/23/20:<br>-"New foley bag applied this AM as part of old bag missing. Also, new foley securement placed on right leg."<br>*On 11/24/20 they attempted to draw the BMP.<br>*On 11/24/20:<br>-"Alerted to residents room- is sitting in | F 690 | | |

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| F 690 | Continued From page 59 | F 690 | | |

wheelchair. States that his seat is wet. "im peeing!" Got resident up into bathroom. Noticed that statlock holding foley cath was twisted and cutting off tubing. Appears urine had nowhere to go but to bypass catheter leading to wet pants and chair. had to take off statlock as it was twisted and tape was peeling off and holding it twisted. Got out 1000 cc of clear yellow urine in cath bag and additional 300 cc post twisted cath line incident. Resident cleaned up. Wheelchair cushion placed in laundry as it was full of urine. New brief and pants on resident. He refuses new statlock placement. Will continue to monitor."
*On 11/25/20 MDS note stated:
-"...He report[s] frequent pain in look back period he rates #7 and relates to his foley..."
*On 12/4/20 Social Services note regarding phone call from wife:
-"...Also mentioned he has changed since getting the catheter and not having a chair in his room. Feels all he does now is lay in bed..."
*On 12/8/20 note stated:
-"Contacted [wife's name], advised her that we would not be able to get [resident's name] catheter dc'd [discontinued] at this time as without it his leg wraps would be ruined and they are helping to heal his legs..."
*On 12/8/20 there is a change of condition note that stated:
-"Unable to weight resident/week/fatigue/HA [headache]/loose stools. so weak had to use a sit to stand to get him into bed. Was leaned over in wheelchair...."
*On 12/8/20 it is noted that he has not been eating or drinking.
*On 12/11/20 a note that stated:
-"Received a phone call from residents wife [wife's name]. States talking to resident on the phone and he is telling her that he feel[s] tied

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| F 690 | Continued From page 60 | F 690 | | |

down and does not want to eat or drink because of being tied down with the catheter. Wife feels like he is declining and is concerned about his health and if he continues to not eat or drink."
*On 12/11/20 at 3:08 p.m.:
-"Nurse in to check on resident and he was lying on his bed with his catheter bag setting on w/c[wheelchair]. Resident made the comment to nurse, "We have a problem here." Nurse asked what was wrong and resident stated, "I have this thing here and a poopy brief." Nurse stated that resident would help him clean up but that he would need to come into the bathroom to get cleaned up. Resident stated, "I can't get up." Nurse explained to resident that he can as he walked to the bathroom carrying this catheter [bag] with him in his old room, and that he can do the same in this room. Resident stated, "You don't understand, I can't." Nurse stated to resident that he needs to get up and come to the bathroom. Resident stated, "No, I can't get up..."
--After documented coaxing the resident was able to get up and go to the bathroom with assistance.
*On 12/14/20 at 12:46 p.m. a note stated:
-"Resident's breathing could be heard nurses station. Check O2 [oxygen] and it was 82% on RA [room air]. N [?] no temp, but resident has chills. Placed on 2L of O2 via [by] NC [nasal cannula]..."
*12/14/21 AT 1:48 p.m.:
-"CNA emptied foley bag this afternoon. Only took out 50 mL[milliliters]. Urine is really dark yellow and the consistency of syrup.
*On 12/15/20 at 2:45 p.m. they received orders to obtain urine analysis [UA] and labs.
*On 12/17/20 they started resident 19 on an antibiotic due to urinary tract infection (UTI).
*On 12/20/20 faxed the doctor stating:
-"Resident not eating much-less than 10- 15%. Drinking ok. Eats snacks in room on own accord.

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| F 690 | Continued From page 61<br>he really likes Boost calorie supplement drink. ok to order- Boost drink with meals TID as scheduled."<br>*On 12/22/20 he had a fall out of bed.<br>-There was no documentation of informing the doctor or the resident's wife.<br>*On 12/24/20 at 4:02 p.m.:<br>-"Resident had wet brief. Foley is still patent, but it may be leaking."<br>*On 12/25/20 at 12:53 a.m. resident had another fall after loud crash found beside bed on fall mat.<br>-There was not documentation about notifying the physician or wife.<br>*On 12/25/20 he refused his supper.<br>*On 12/26/20 he was found beside his bed on his fall mat again.<br>-There was no documentation about notifying the physician or his wife.<br>*On 12/26/20 documentation stated:<br>-"Resident pulled foley catheter out. Sent order to provider asking to DC the catheter.<br>*Faxed not stated:<br>-"Resident pulled out foley this afternoon. May we have an order to DC the foley? Resident's penis is eroding away."<br>*PA-C sent a note back that stated:<br>-"I have no [illegible] records. Why does he have the foley?"<br>--Three days later 12/29/20 she adds another note, "May DC foley or leave out."<br><br>Further review of resident 19's progress notes revealed:<br>*On 12/27/20:<br>-"Wife [wife's name] called facility for an update on residents condition, informed of percentages of meals, fluids and medications taken/refused today, voices understanding and concerns for his health, can hear wife crying on the phone, | F 690 | | |

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| F 690 | Continued From page 62<br>repeats if only I could come in there and talk to him and help him, but I cant, I cant come in there and do it. Also states wanting to change residents PCP (primary care physician) to either VA [veterans administration] or Avera, requesting VA but would accept [hospital name], states I just want to stick to where he was. I prefer [hospital name] or [hospital name]. Wife requesting resident to be sent to [hospital name] ER in the morning."<br>*On 12/28/20 at 7:20 a.m."<br>-"...Wife [wife's name] would like to utilize a different PCP et[typo] also to be evaluated at the ER."<br>*Resident 19 was taken by ambulance to [hospital name] ER.<br>*On 12/11/20 resident's wife called the facility and wanted the catheter removed because she stated her husband was not eating or drinking because he felt "tied down."<br>*There were only two notes made in the progress notes regarding residents lack of eating or drinking.<br>-One on 12/20/20 where a boost was ordered.<br>-One on 12/25/20 stating he refused his supper.<br>*There is a note that the wife called on 12/27/20 asking for an update and she requested that he be evaluated at the emergency department.<br><br>Review of resident 19's weight records revealed:<br>*He was supposed to have daily weights taken.<br>-This was ordered with a start date of 11/6/20.<br>*On 12/1/20 he had a recorded weight of 262 and 264 lbs. (pounds)<br>*His next weight was on 12/21/20 and was a weight of 264lbs.<br>*On 12/28/20 his weight was 226.2 lbs.<br>-He did not have another weight until he returned from the hospital which was 233 lbs on 1/8/20. | F 690 | | |

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| F 690 | Continued From page 63<br>*There had been 52 opportunities to obtain daily weights from 11/6/20 to 12/28/20.<br>-Resident 19 had been weighed 17 out of 52 times before his hospitalization.<br><br>Review of resident 19's MAR and TAR for November and December revealed:<br>*There was no record of monitoring intake and outputs from catheter.<br>*There was "May insert foley catheter. Change per facility protocol (every 30 days) one time a day starting on the 19th and ending on the 19th every month..."<br>-It was check marked for 12/19/20.<br>*November did not have anything that mentioned the catheter on the MAR or TAR<br><br>Review of resident 19's hospital summary from 12/28/20 revealed:<br>*He had Hypernatremia:<br>-"sodium 156, careful correction with D5W [5% dextrose solution] at 100 cc/hr starting at 1100. serial BMP [basic metabolic panel] with correction to 145."<br>*He had Acute on chronic AKI (acute kidney injury):<br>-"creatinine nearly 4, presumed to be pre-renal due to lack of oral intake."<br>*Odynophagia/dysphagia:<br>-"Patient reports pain with swallowing..."<br>--"...Nursing home reports very little oral intake for the last two weeks and while in the ER attempts were made to allow him to drink which cause excessive drooling and choking..."<br>*Malnutrition:<br>-"Weight loss suspected."<br>*"...brought from the [nursing home name] for evaluation of decreased oral intake of both food and fluids over the last 2 weeks. Nursing home | F 690 | | |

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| F 690 | Continued From page 64<br>staff reported that the patient has not been eating or drinking hardly at all the last couple of weeks..."<br>*"...Patient does not answer my questions and is mostly nonverbal. Reportedly he typically can speak normally..."<br>*"...He is noted to have bruising to the left side of his forehead, the left shoulder and to the anterior lower chest bilaterally. The bruising across the lower chest appears in a pattern typical for gait belt bruising. Patient has numerous superficial abrasions and skin tears down both shins bilaterally. Reportedly this is typical for him. Wife also expresses concern that she was just told that his Ativan was reduced recently from 3 times daily to twice daily due to a concern about drug interaction from pharmacy. She reports he has severe anxiety and typically the Ativan is required to keep him functional from the standpoint of his anxiety."<br>*The reports continued referring to the physician's report saying:<br>-"...veteran with PMH [primary medical history] of PTSD, bipolar disorder, essential tremor, DM2 [diabetes mellitus type II], Chronic memory impairment and gait difficulty, living at nursing home who was admitted 12/28/2020 with poor po [by mouth] intake. He has no eating or drinking for 2 weeks with significant weight loss. In ED, pt was noted to have hypernatremia (156) and acute renal failure..."<br><br>Review of resident 19's current care plan revealed:<br>*"Focus: [resident's name] has impairment to skin. Hx [history] of cellulitis to BLE. Often scratches legs. 1/20/21 BLE much improved. Does have multiple scattered dry scabs to BLE. Often has reddened groin, moisture related | F 690 | | |

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| F 690 | Continued From page 65<br>excoriation to bottom related to refusal of cares. Hx of fine rash breakouts x2 to upper body."<br>*"Goal: Will not develop signs and symptoms of infection on the wound site to BLE."<br>*"Interventions: Monitor /document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD. Staff to ensure thorough peri care with each episode of incontinence. Utilize nystantin powder as ordered to groin. When [resident's name] refuses to be changed even when incontinent, leave room and reproach, may need different staff to approach. Wife is willing to talk on the phone anytime he is refusing cares."<br>*"Focus: [resident's name] has a physical functioning deficit related to self care and mobility impairments, requires assistance with most ADL, tremors."<br>*"Goal: Will maintain currently level of physical function through review date"<br>*"Toileting requires assistance of extensive assist of two."<br>*"Focus: [resident's name] has a diagnosis of benign prostatic hypertrophy (BPH) and obstructive uropathy: Has difficulty with urination., Increased risk for UTI, frequent urinary incontinence, Needs assistance with toileting. [resident's name] does have hx of UTI."<br>*"Goal: Will be free of s/s [signs and symptoms] of UTI."<br>-"Will have a soft formed bowel movement at least every three days."<br>-"Will urinate without difficulty through review date."<br>*"Interventions: Attempt to assist [resident's name] with toileting every couple of hours to minimize incontinence."<br>-"Diagnosis BPH. Please look for signs and | F 690 | | |

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| F 690 | Continued From page 66<br>symptoms of BPH including: distended, tender bladder, bladder spasms, dribbling at the end of urination, dysuria, frequent urination, incontinence, nocturia, pain, residual urine, urgency, urinary tract infection."<br>-"Takes medication, tamsulosin for BPH. Encourage [resident's name] to report any difficulty with urination to the nurse so he/she can notify MD."<br><br>Review of paper toileting record implemented for resident 19 showed most of the document was incomplete and missing data. From 3/3/21 through 4/6/21 there was not a day that was complete.<br><br>2. Review of resident 13's EHR Revealed:<br>*He had a BIMS of 9.<br>-Which meant he had moderately impaired cognition.<br>*His diagnoses included:<br>-Parkinson's Disease.<br>-Constipation.<br>-Acute Kidney failure.<br>-Major depressive disorder.<br>-Chronic dehydration.<br>-Acute cystitis with hematuria.<br>-Muscle wasting and atrophy.<br><br>Interview 4/9/21 at 9:14 a.m. with resident 13's wife revealed:<br>*They have been married for 53 years.<br>*Her husband has Parkinson's diease.<br>-They have been told this is due to exposure to toxins during his service in Vietnam.<br>*Surveyor asked how things are going she replied,<br>-"I could write a book, I don't know where to start." | F 690 | | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| F 690 | Continued From page 67<br>*He had been admitted to the hospital with severe dehydration in October 2020.<br>*He was admitted to the hospital with COVID-19 in December.<br>*His water is always empty when she comes in to visit him.<br>*She feels that staff are not attentive enough.<br>*He has had UTIs.<br>*CNA M told her that he had a UTI because they are not changing or toileting him enough.<br>*She was not informed that he had a bed sore until after the fact.<br>*Every time she called they would tell her he had a new one.<br>*She felt the provider was not doing anything about the bed sores so she found some cream on her own.<br>-She was not sure what else to do.<br>*She asked that he change physician.<br>-Then they finally said they would call wound care.<br>*She felt the sores were a result of resident 13 not being changed routinely.<br>*She saw him visibly wet and soiled when she came to visit him.<br>*She said he is being told that he is "naughty, naughty, naughty" when staff try to change him.<br>*He told her that was because his bottom hurts so much.<br>*She asked the CNAs if there was any way to watch how much he was drinking to ensure he received enough fluid.<br>-CNA M informed her "no, that is entirely too much work."<br>*She noticed how dry his skin and lips look when she comes in to visit him.<br><br>Review of resident 13's progress notes revealed:<br>*On 9/13/21 he was documented to have | F 690 | | |

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| F 690 | Continued From page 68<br>bleeding from his urethra.<br>*On 10/1/20 he had urine that was "brown/green & slimey."<br>-Had a UA via straight catheter.<br>*Started an antibiotic for a UTI on 10/1/20.<br>*He was having increased confusion, behavior and decreased appetite.<br>*He had lost more than 10 pounds since 10/1/20.<br>*Had no skin concerns noted on 10/15/20.<br>*He had another UA on 10/26/20 due to increased confusions, behaviors, and decreased appetite.<br>*UA obtained via straight catheter, received 60 cc of dark orange urine.<br>*He was sent to the ER on 10/28/20.<br>-He returned from the ER on the same day.<br>*He was supposed to have daily weights starting 12/18/20 due to his COVID-19 hospitalization that resulted in an acute kidney injury due to dehydration.<br><br>Review of resident 13's record weight record revealed:<br>*He weighed 214 lbs. on 12/4/20.<br>-His next weight was on 12/30/20 and was 196 lbs.<br>*Out of 90 opportunities to be weighed, he was weight 46 times.<br><br>Review of resident 13's hospital admission paperwork revealed:<br>*"75 yo [year old] with acute on chronic renal failure. Had gotten covid and has sopped [sp] eating and drinkin[g]. Now is very dry with acute renal failure I and the ED Doc tried to get a central line in but were unable so looked and an IO [intraosseous infusion] Pt [patient] is confused and has Parkinson's diseases [sp]."<br>*Starting on 12/19/20 he was to have daily skin | F 690 | | |

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| F 690 | Continued From page 69<br>assessments as part of his discharge orders.<br><br>Further review of resident 13's progress notes revealed:<br>*On 1/5/21 was noted to have shearing to his coccyx and a Mepilex was applied.<br>*Wife called the facility to state resident 13 told her that his bottom is hurting:<br>-"...Also to get him up into bed out of wheelchair and shift weight. Spouse aware of open areas on gluteal aspect relating to discomfort dressing is applied and intact at this time. Advised noted requests and will comply. Will continue to monitor."<br>*The physician had put in an order for the provider to consult wound care.<br>-On 1/15/21 clinical care coordinator N faxed the doctor requesting to cancel the wound care referral because it was "not a pressure ulcer- has some moisture related excoriation."<br>*There was multiple documented incidents of incontinence and behaviors with cares.<br>*On 1/21/21 he was noted to have an "open area to buttocks."<br>*On 1/21/21 wife had asked if they could use a cream she found on the open areas.<br>*On 1/22/21 pharmacist was contacted regarding resident 13's behaviors.<br>-Pharmacist recommended checking for a UTI and a PRN pain meds to rule out pain.<br>*Wife requested his physician be changed on 2/18/21.<br>*On 2/25/21 Open area to his bottom was 1cm X .5 cm.<br>-Requested orders for collagen/hydrogel, cover with foam dressing and change QD [three times per day] and PRN [as needed].<br>*Wife came to the facility on 2/28/21 and asked why they were not using the cream she | F 690 | | |

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| F 690 | Continued From page 70 | F 690 | | |

purchased on resident 13.
*Staff informed the wife of the new wound orders as her cream was not working.

Review of resident 13's bowel and bladder notes revealed:
*Provider faxed the doctor on 2/5/21 to hold colace due to frequent loose stools.
-Physician stated it was ok to hold the colace.
--The colace was dc'd on 2/5/21.
*He was recorded to have no bowel movement for 3 days recorded on:
-2/25/21.
-2/26/21.
-2/27/21.
-3/4/21.
-3/6/21.
-3/10/21.
-3/11/21.
*From 3/22/21 to 3/27/21 he was recorded has not having any bowel movements.
*He did not have a bowel movement from 3/31/21 to 4/4/21.
*He did not have a bowel movement from 4/5/21 to 4/9/21.
*In his March MAR he had an order for "Biscodyl suppository..." every 24 hours.
-He did not receive it at all in March.
*In April and February he had prn orders for Milk of Magnesia and MiraLax.
-He did not receive any dose of either medication.

Further review of resident 13's MAR's revealed:
*Starting 12/19/20 he was to have daily skin assessments completed.
-Out of 13 opportunities, he received 7 daily skin assessments.
*He did not have off-loading on his heels done, he was not turned and repositioned, or his ted hose

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| F 690 | Continued From page 71<br>placed on, as ordered.<br>*He did not receive any prn Tylenol past 12/7/20.<br>*In February there were 31 opportunities for daily skin assessments.<br>-He had 12 completed.<br>--There was a 9 day gap in between a set of assessments.<br>*He did not have his heels off-loaded, turned and repositioned, or his ted hose placed on, as ordered.<br>*There was no documentation in his MAR of refusals.<br><br>Review of resident 13's current care plan revealed;<br>*Focus:<br>-"[resident's name] is at risk for pressure ulcer development due to: Assistance required in bed mobility. 1/29/20 is no longer ambulatory. He uses his wheelchair for all locomotion and staff utilize hoyer lift for transfers, occasional incontinence, hx of ulcers."<br>*Goal:<br>-"Skin will remain free of breakdown caused by pressure ulcer through review date."<br>*Interventions:<br>-"Conduct weekly skin inspection, daily weights required, Give med pass 2.0 4 oz TID for wound healing. Provide pressure reducing wheelchair cushion, Provide pressure reduction/relieving mattress, Provide thorough skin care after incontinent episodes and apply barrier cream."<br>*For toileting he was an extensive assist of two people.<br>*"Check and change every 2 hrs. Thorough pericare with each episode of incontinence. Need to be kept clean and dry as much as possible to aid in healing of excoriated areas to buttocks and scrotum. 1/22/21 Per family request, Emuaid | F 690 | | |

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| F 690 | Continued From page 72<br>cream to be used on [resident's name] bottom until healed then PRN. Wife bought some and would like [resident's name] to use it."<br>*Careplan was not updated to include resident's new wound orders.<br><br>Review of clinical care coordinator N's wound assessments revealed:<br>*Stated that his wounds were facility acquired on 2/8/21 to his sacrum and inner buttock.<br>-Other documentation of her weekly skin report stated the wounds were facility acquired on 2/18/21.<br><br>Review of resident 13's skin assessments in the EHR revealed inconsistent documentation and missing diagnoses.<br><br>Review of resident 13's 12/21/20 significant change MDS and March quarterly MDS revealed:<br>*He was always incontinent of bladder and bowel.<br>*In the past year he had not been assessed for a toileting program.<br>*He had not currently been on a toileting program.<br><br>Review of provider's September 2019 Catheter Care policy revealed:<br>*"The purpose of this procedure is to prevent catheter-associated urinary tract infections."<br>*"Following aseptic technique, disconnection, or leakage occur, replace the catheter and collecting system using aseptic technique and sterile equipment, as ordered.<br>*"Observe the resident's urine level for noticeable increases or decreases. If the level stays the same, or increases rapidly, report it to the physician or supervisor."<br>*"Maintain accurate record of the resident's daily output, per facility policy or physician order." | F 690 | | |

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| F 690 | Continued From page 73<br>*"Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks."<br>*"Unless specifically ordered, do not apply a clamp to the catheter."<br>*"The urinary drainage bag must be held or positioned lower than the bladder to prevent the urine in the tubing and drainage back from flowing back up into the urinary bladder. A leg strap may be used to help secure tubing to the leg."<br>*"Notify the physician or supervisor in the event of bleeding, or if the catheter is accidentally removed."<br>*"Report any complaints the resident may have of burning, tenderness, or pain in the urethral area."<br>*"Observe for other signs and symptoms of urinary tract infection or retention. Report findings to the physician or supervisor immediately."<br><br>Review of provider's January 2020 Incontinence/Toileting policy revealed:<br>*"It is the policy of this facility to ensure that residents are assisted to the restroom to reduce the number of incontinent episodes."<br>*"1. If the individual remains incontinent despite treating transient causes of incontinence the staff will initiate a toileting plan."<br>*"2. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, bowel routines, or other interventions to try to manage incontinence. Incontinence care should be individualized at night in order to maintain comfort and skin integrity and minimize sleep disruption. Prompted voiding is not helpful at night (e.g., between the hours of 10 p.m. and 5 a.m.) and has been shown to disrupt sleep."<br>*"Toileting plans will be included on the plan of | F 690 | | |

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| F 690 | Continued From page 74<br>care."<br><br>Surveyor: 26632<br>3. Interview on 4/7/21 at 10:30 a.m. with resident 126 revealed prior to to admission she was continent of bowel and bladder. She had tried a bed pan once but had been left on for too long and it hurt. She was concerned to use it again because she would be left on for too long. She also required a full body lift for her transfers she had not been offered any way to use the toilet.<br><br>Review of resident 126's medical record revealed:<br>*No comprehensive admission assessment had been completed.<br>*She required the use of a mechanical lift for transfers.<br>*Her toilet use performance had been marked as activity did not occur.<br>*Her toilet transfer (the ability to get on and off a toilet or commode) had been marked as:<br>-Not applicable.<br>-Not attempted due to medical condition or safety concerns.<br>-Not assessed/no information.<br><br>Review of resident 126's point of care bowel and bladder documentation from 3/23/21 through 4/8/21 revealed she had been marked as:<br>*Incontinent of urine thirty-seven times.<br>*Continent of urine eight times.<br>*Incontinent of bowel nineteen times.<br>*Continent of bowel one time.<br>*Independent with toilet use three times.<br>*Requiring limited assistance two times.<br>*Requiring extensive assistance fourteen times.<br>*Requiring total assistance four times.<br>*Activity did not occur twenty times. | F 690 | | |

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| F 690 | Continued From page 75<br><br>Review of resident 126's 4/8/21 care plan revealed:<br>*Focus: "[resident name] has a physical functioning deficit related to self care and mobility impairment. Fx [fracture] and surgical repair of LLE [lower left extremity], Non weight bearing to LLE."<br>-Goal: "Will improve current level of physical functioning through review date." Review date of 6/30/21.<br>-Interventions included:<br>--"Bed mobility assistance of extensive assist of two."<br>--"May be transferred with Hoyer lift."<br>--"Toileting assistance of extensive assist of two."<br>*Focus: "[resident name] has a potential for pressure ulcer development related to impaired mobility, Non weight bearing status, diabetes, incontinence."<br>-Goal: Will have intact skin, free of redness, blisters or discoloration caused by pressure through review date."<br>-Intervention: "Small open area to lower lt [left] buttock and sheering to sacrum."<br><br>4. Interview on 4/8/21 at 4:00 p.m. with clinical care coordinator N revealed:<br>*None of the residents were on a toileting program or plan.<br>*It would have caused more problems due to the documentation required.<br>*Agreed the comprehensive admission assessment should have been completed.<br>*The care plan did not include any information on her continence. | F 690 | | |
| F 725 SS=F | Sufficient Nursing Staff<br>CFR(s): 483.35(a)(1)(2) | F 725 | | |

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| F 725 | Continued From page 76<br><br>§483.35(a) Sufficient Staff.<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br>(i) Except when waived under paragraph (e) of this section, licensed nurses; and<br>(ii) Other nursing personnel, including but not limited to nurse aides.<br><br>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 26632<br>Based on observation, interview, record review, and policy review, the provider failed to ensure sufficient nursing staff were available at all times to provide nursing services to meet residents' needs safely and in a manner that promoted each resident's rights and physical, mental, and psychosocial well-being.<br>Findings include: | F 725 | 1. Resident 19's care plan has been reviewed and updated. All Residents are potentially at risk. Interdisciplinary team reviewed direct care staffing pattern and facility assessment has been updated.<br><br>2. Staffing will be reviewed by IDT during morning meeting to ensure appropriate coverage. The DON or designee will check staffing daily determine if appropriate for census and acuity. If staffing is found to be inadequate due to acuity, census or staff call off, an emergency staffing meeting will be held. Staffing meetings will be held weekly to determine ongoing staffing needs, review openings in position and shift, and ensure appropriate workforce pool to meet resident care needs.<br><br>3. The DON or designee will conduct 3 resident interviews and documentation reviews weekly to ensure cares are being satisfactorily provided. In addition, the specific residents cited will be included in the audit for 4 weeks. Staffing trends and audit results will be reported by DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations.<br><br>4. | 5/7/21 |

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| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 725 | Continued From page 77<br><br>1. Interview on 4/9/21 at 10:00 a.m. with the clinical nurse consultant V revealed the provider was staffed correctly for the resident census of twenty-eight. The budget was based on the acuity of the residents. She was not sure of current acuity.<br><br>*Interview on 4/9/20 at 2:30 p.m. with administrator G revealed:<br>*He agreed with the clinical nurse consultants statement of staffing levels.<br>*He had been aware staff had been concerned of the staffing levels and not meeting the needs of the residents.<br>*There had been an informal discussion in February to come up with some ideas to free up the nurses on the floor.<br>*The social services director, the activities director, and the business office manager were all able to assist on the floor if required.<br>*He was not aware during the survey observations those staff members did not assist any of the nursing staff.<br><br>Review of the provider's updated 3/5/21 Facility Assessment revealed:<br>*Average daily census was 30-34.<br>*Types of care the resident population required included:<br>-Bowel/bladder toileting programs, incontinence prevention and care, responding to requests for assistance to the bathroom/toilet to maintain continence and promote resident dignity.<br>-Pressure injury prevention and care, skin care, and wound care.<br>-Awareness of any limitations of administration of medication.<br>-Assessment of pain. | F 725 | | |

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| F 725 | Continued From page 78<br>-Identification and containment of infections and the prevention of infections.<br>-Assessment and early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions.<br>-Individualized dietary requirements, liberal diets, specialized diets, tube feeding, and fluid monitoring or restrictions.<br>-Provide person-centered/directed care.<br>*Facility resources needed to provide competent support and care the residents every day and during emergencies. Those resources included:<br>-Identifying the type of staff members needed to provide support and care for residents.<br>-Nurse aides of 60 to 82.5 hours each day.<br>-Other nursing personnel (for example those with administrative duties) 16 to 20 hours each day.<br>*General staff plan to ensure a sufficient amount of staff to meet the needs of the residents.<br>-One registered nurse (RN)/director of nursing.<br>-RN or licensed practical nurse (LPN) charge nurse: 2 for day shift.<br>-RN or LPN charge nurse: 1 for night shift.<br>-Minimum Data Set (MDS) RN responsible for the MDS, care planning, and a member of the interdisciplinary team. May fill in as charge nurse occasionally.<br>-Certified nursing assistants:<br>--Day shift 3 to 5 staff.<br>-Evening shift 3 to 5 staff.<br>-Night shift 1-2 staff.<br>*"Describe how you evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. Those provisions included:<br>-Corporate structure develops policies and disseminates them to facilities. If a policy for a specific question arises; we seek guidance | F 725 | | |

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| F 725 | Continued From page 79<br>through CDC [centers for disease control and prevention], APIC [association for professionals in infection control], or other respectable agencies/associations. The guidance would then be disseminated to all staff, discussed QAPI [quality assurance performance improvement] with IDT [interdisciplinary team], staff and Medical Director."<br><br>Review of the provider's 4/8/21 Resident Census and Conditions of Residents report completed by the Minimum Data Set (MDS) coordinator revealed of the twenty-eight residents that lived in the facility:<br>*Twenty-three residents required assistance of one or two staff for bathing.<br>*Twenty-three residents required assistance of one or two staff for dressing.<br>*Eighteen residents required assistance of one or two staff for transferring from one surface to another.<br>*Twenty-three residents required assistance of one or two staff for use of the toilet.<br>*Eleven residents required assistance of one or two staff for eating.<br><br>*Three residents had a urinary catheter.<br>*Seventeen residents were occasionally or frequently incontinent of bladder.<br>*Nine residents were occasionally or frequently incontinent of bowel.<br>*No residents had been on a urinary or bowel toileting program.<br>*One resident received nutrition through a gastrostomy tube.<br><br>Surveyor: 42477<br>Interview on 4/6/21 at 5:52 p.m. with [position title | F 725 | | |

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| F 725 | Continued From page 80<br>withheld due to anonymity] revealed:<br>*She has recently put in her two week notice.<br>*She asked to speak to the surveyors regarding her concerns regarding residents in the facility.<br>*She voiced that they do not have enough staff and as a result resident cares were not being done.<br>*Residents were not being changed, repositioned, and toileted as needed.<br>*Stated they have a lot of residents who were two person assist and use Hoyers.<br>*Resident 19 does have a lot of behaviors towards staff, he is not being changed as much as he should be.<br>*Stated at night it is usually one aide and one nurse for the residents.<br>*She stated that she has filed grievances on these situations with the provider.<br>*She has also offered solutions to management for staffing but they have not been followed up on.<br>*She stated that she had just had a med error regarding a newly admitted resident.<br>*She stated that when residents are admitted the orders should be double signed.<br>*The orders that she put in were not double signed, therefore the error was not caught until 8 days later.<br><br>Interview on 4/6/21 at 6:32 p.m. with [position title withheld due to anonymity] revealed they:<br>*Asked to speak with surveyors regarding her concerns.<br>*Rarely gets to take a break or a lunch.<br>*Are unable to get cares and charting completed for residents.<br>*Had filed grievances with the provider.<br>*Stated residents should receive water two times per day but sometimes they are lucky to be able to pass water one time a day. | F 725 | | |

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| F 725 | Continued From page 81<br>*Stated dietary is not passing water at 2:00 p.m.<br>*Residents are not being toileted or repositioned as they should be.<br><br>Interview on 4/7/21 at 10:30 a.m. with resident 19's wife revealed:<br>*She stated she felt like they were short staffed.<br>*Surveyor asked why she felt that way, she stated:<br>-Resident 19 had been wet with urine every day that she has came into the facility.<br>-CNA M told her they were short staffed and that is why the residents were soaked.<br>*Had voiced concerns about the cleanliness of his room.<br>*There was dry urine underneath his bed, dried food on his fall mat and a soiled trash can.<br>-This had been this way since Saturday 4/3/21.<br>*When she had informed staff about her concerns she had been told it is an "old building."<br>*She was concerned if she voiced her concerns to us she would no longer be allowed to come into the facility.<br>*She had talked to administrator G about these concerns and felt nothing changed.<br><br>The provider did not ensure the facility maintained staffing levels to meet the needs of the residents.<br>Refer F690, F868, and F881. | F 725 | | |
| F 835 SS=F | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial | F 835 | 1. Immediate corrections have been made for al l residents affected with a deficient practice. Refer to F578, F580, F656, F658, F679, F684, F686, F690, F725, F880, and F881. All resident are potentially at risk.<br><br>2. Experienced Director of Nursing was hired on 4/5/21. Administrator performance improvement plan has been initiated. Governing body will maintain weekly oversight either onsite or virtually. | |

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| F 835 | Continued From page 82<br>well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 26632<br>Based on observation, interview, record review, job description review, and policy review, the provider failed to ensure the facility was operated and administered in a manner that ensured the safety and overall well-being for all 28 residents in the facility. Those areas included:<br>*An advance directive was in place for one of one newly admitted resident (125).<br>*Three of three sampled residents (15, 19, and 74) had timely notification of changes to the residents' representatives and physician.<br>*Implement and follow the comprehensive care plan for seven of fourteen (5, 6, 7, 10, 11, 13, 14, 124, 126, and 129) sampled residents to ensure they had received the appropriate care and services they required.<br>*Ensure professional standards had been followed for:<br>-Two of two sampled resident's (7 and 126) physician's orders had been followed for obtaining daily weights.<br>-One of one sampled residents (126) admission assessment had been completed.<br>-One of one observed unlicensed assistive personnel (UAP) (C) had followed professional standards for medication administration.<br>-One of one sampled resident (7) physician had been notified according to blood glucose parameters set for her high blood glucose levels.<br>*An individualized activity program had been implemented for the interests and needs of the residents.<br>*Follow their skin integrity policy for:<br>-The prevention of six of six (6, 7, 11, 13, 19, and 126) sampled residents who had acquired | F 835 | 3. Governing body will review audits related t o forementioned deficiencies weekly for 4 weeks and then monthly thereafter until they, in conjunction with the QAPI team, determine substantial compliance. The Regional Director of Operations (RDO) and/or Regional Nurse Consultant (RNC) will attend monthly QAPI for three months, either in person or virtually, and offer support and guidance. The need for continuation will be re-evaluated at the end of the three months.<br><br>4. | 5/7/21 |

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| F 835 | Continued From page 83<br>pressure ulcers.<br>-Accuracy of weekly skin assessments and/or wound documentation for six of six (6, 7, 11, 13, 19, and 126) sampled residents.<br>-A turning and repositioning program for six of six (6, 7, 11, 13, 19, and 126) sampled residents to off load pressure areas.<br>-Monitoring all residents for impaired skin integrity.<br>*Residents received services to maintain continence including:<br>-One of one sampled resident (126) who had been continent prior to admission and was now incontinent.<br>-One of one sampled resident (19) who had a urinary catheter placed had a diagnosis for catheterization.<br>-One of one sampled resident (13) who was incontinent and was not on a toileting program.<br>-Residents were assessed to determine if they were candidates for a toileting program.<br>*Identify and provide feedback on concerns with grievances<br>*Implement an effective performance improvement plan (PIP) and quality assurance program.<br>*Follow appropriate infection control procedures including:<br>-Hand hygiene after caring for residents.<br>-Cleaning and disinfection of residents rooms.<br>*Ensuring one of two facility tub rooms (100 hall) remained clean and free of clutter.<br>*Maintaining an effective infection control program including an ongoing antibiotic stewardship program.<br>Findings included:<br><br>1. Interview on 4/9/20 at 2:30 p.m. with administrator G revealed: | F 835 | | |

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| F 835 | Continued From page 84<br>*He had been aware staff had been concerned of the staffing levels and not meeting the needs of the residents.<br>*There had been an informal discussion in February to come up with some ideas to free up the nurses on the floor.<br>*The social services director, the activities director, and the business office manager were all able to assist on the floor if required.<br>*He was not aware during the surveyors observations those staff members did not assist any of the nursing staff.<br><br>Review of the provider's 4/8/21 Resident Census and Conditions of Residents report completed by the Minimum Data Set (MDS) coordinator revealed of the twenty-eight residents that lived in the facility:<br>*Twenty-three residents required assistance of one or two staff for bathing.<br>*Twenty-three residents required assistance of one or two staff for dressing.<br>*Eighteen residents required assistance of one or two staff for transferring from one surface to another.<br>*Twenty-three residents required assistance of one or two staff for use of the toilet.<br>*Eleven residents required assistance of one or two staff for eating.<br>*Three residents had a urinary catheter.<br>*Seventeen residents were occasionally or frequently incontinent of bladder.<br>*Nine residents were occasionally or frequently incontinent of bowel.<br>*No residents had been on a urinary or bowel toileting program.<br>*One resident received nutrition through a gastrostomy tube. | F 835 | | |

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| F 835 | Continued From page 85<br>Review of the provider's 12/1/19 Executive Director job description revealed:<br>*The executive director provides overall direction for all activities related to administration, personnel, physical structure, information systems, office management, and marketing of the entire facility.<br>*The executive director works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged.<br>*The executive director was responsible for the day to day operations of the facility and ensuring all facility operations are in compliance with federal, state, and local regulations.<br>*Essential functions of the executive director included:<br>-Develops and implements facility policies and procedures that comply with federal, state, and local regulations.<br>-Hires, monitors, and directs the activities of several departments within the facility.<br>-Take necessary action to make sure the facility meets set budgetary goals while being compliant with government regulations and providing quality of care to residents.<br>-Assist with the recruitment and retention of staff for all departments within the facility.<br>-Ensures that all residents complaints/concerns are addressed timely and works with appropriate department heads for a resolution.<br>-Identify opportunities for improvement through analysis of data, observation of operations, and consultation with leadership and staff.<br>-Collaborate with the quality committee and senior leaders to prioritize and develop quality assurance process improvement efforts.<br>-Lead performance improvement projects and provider education and coaching in order to build | F 835 | | |

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| F 835 | Continued From page 86<br>needed skills in others to lead process improvement projects.<br><br>Review of the provider's 12/1/19 Director of Nursing (DON) job description revealed the DON was responsible for providing consistent and sufficient staffing for resident needs as well as regulatory requirements.<br><br>Refer to F578, F580, F656, F658, F679, F684, F686, F690, F725, F867, F880, and F881. | F 835 | | |
| F 867 SS=E | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(g)(2)(ii)<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee must:<br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on interview, record review, job description review, and policy review, the provider failed to identify concerns with grievances and to implement an effective performance improvement plan (PIP) and quality assurance program.<br>Findings include:<br><br>1. Interview on 4/6/21 at 5:52 p.m. and 4/6/21 at 6:32 p.m. with staff members revealed:<br>*They had filed grievances with administrator G.<br>*They had not felt that their grievances were taken care of or appropriately responded to.<br>Refer to F690.<br><br>Review of the March 2021 resident council | F 867 | 1. Immediate corrections have been made for all residents affected with a deficient practice. Education will be provided conducted on deficient practice and auditing will take place to monitor compliance. All residents are potentially at risk. Audits will be performed to ascertain compliance with facility policies, regulations, and will be discussed at monthly QAPI as needed.<br><br>2. Policy was reviewed with no revisions needed. The interdisciplinary team will be educated by the Regional Director of Operations (RDO) no later May 7, 2021 on the elements of an effective process improvement program, as well as, the facility grievance process/policy. The RDO and/or Regional Nurse Consultant (RNC) will attend monthly QAPI for 3 months, either in person or virtually, and offer support and guidance. The need for continuation will be re-evaluated at the end of the 3 months.<br><br>3. The RDO or RNC will review all grievances each week for 4 weeks and then monthly for 2 months to ensure grievances are completed timely and have an acceptable resolution. Results of audits will be discussed by the RDO or RNC at the monthly QAPI meeting for discussion of the effectiveness of the correction and recommendation.<br><br>4. | 5/7/21 |

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| F 867 | Continued From page 87<br>meeting minutes revealed:<br>*"For 3/31/21 There was a concern of:<br>-1 of 8 residents were not content with the care given by staff"<br>*"Department response: (Include dates of proposed or completed actions. Describe actions taken and results expected. Social worker visited with resident who had concern. Said it was same aid as his prior complaint in the same time frame. Feels things have been better. Education has been provided to aid on tone of voice or approach can seem snappy with some residents."<br>*The resident stated: "smart [exploitative] when something was requested went on to say the resident requested milk and the staff response made the resident feel like they were making fun or talking down to them"<br>*Department response: "Social worker visited with resident who had concern. He voiced it was a young female in the morning who had an attitude. 'The lady who has the round thing on her face' He feels she 'has calmed down since and nicer.'"<br>*There was another concern of:<br>-"1 of 8 residents were not content with privacy provided when staff do things."<br>--Resident stated: "I walked into the office and staff didn't let me say what was on my mind"<br>*Department response: "Social worker visited with resident who had complaint. She stated she was able to say what she wanted in my office. She wasn't upset about the door but couldn't remember what it was. SW [social worker] prompted what she was in my office for the last time if that was it. She agreed it was. She was upset because I suggested she have some of her clothes stored for the season at her sisters as they keep bringing her more clothes and there is not room in her closet. She agreed through no issue with privacy." | F 867 | | |

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| F 867 | Continued From page 88<br>*3 of 8 residents felt that:<br>-"There is not enough night staff: 'running too much' 'they have a good attitude' 'only one on staff"<br>*Department response:<br>-"Education [at symbol] Resident council that as census increases/staff increase. Positive staff noted."<br>*There was a concern from 2 out of 8 residents:<br>-Residents stated that they are woken up by staff at night. "Resident yelling down the hallway, Staff talking in the hallway sounds like a party. Pills brought in at 5 am and make noise that wake me up."<br>*Department response: "Education [at symbol] all staff to be quiet in hall. Encourage residents to inform as what time they would prefer medication [at symbol] resident council."<br><br>Review of January 2021 resident council meeting grievances revealed:<br>*3 out of 8 residents (1 abstained and 1 was sleeping) expressed concern: "Sitting on the toilet for extended lengths of time- 2/3 of residents expressing the concern are not always oriented to time. Not satisfied with resolution/response: Call Light audit done 12/17"<br>*Department response: "Call light audits have been completed on 1/28 & 1/29. All lights that have been audited were between 2-3 minutes for response time.<br>*There was no mention of how the call light audits were completed and by who.<br>*Surveyors were told by staff that the facility was unable to audit call lights due to their old system.<br>*There was no mention of how long call lights were audited for each day.<br>*The response was due back to resident council by 2/3/21. | F 867 | | |

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| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

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| F 867 | Continued From page 89<br>Department response was given to resident council on 2/24/21.<br>*4 out of 8 residents (2 abstained) had a concern:<br>-"C.N.A telling resident 'it's not my job' or not completing the request made by the resident, no explanation given. Examples give are: requests to clean an item/location in resident room and request to make the resident bed."<br>*Department response:<br>-"Interview of residents who had a BIMS [brief interview for mental status] of 8 or more on 1/25 an 1/26 asking about cares. How they have been treated, and if they feel safe here. No concerns were found."<br>*They also had 4 out of 8 (2 abstained) residents share:<br>-"Disrespect from C.N.A at night-female staff member."<br>*Department response was:<br>-"-"Interview of residents who had a BIMS [brief interview for mental status] of 8 or more on 1/25 an 1/26 asking about cares. How they have been treated, and if they feel safe here. No concerns were found."<br>*5 out of 8 (2 abstained) residents had a concern of:<br>-"Cleanliness of the bathroom floor and stool is poor."<br>*Department response: "Reminded house keeping staff of the importance of keeping the resident rooms clean and paying attention to things that may get overlooked."<br><br>Review of November 2020 resident council meeting minutes revealed:<br>*2 out of 10 residents had a concern of:<br>-"CNA staff is physically rough- example given shared rough handling during changes."<br>Department response: | F 867 | | |

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| F 867 | Continued From page 90<br>-"Education to direct staff, reminder to slow down."<br>*3 out of 10 residents had a concern of:<br>-"Sitting on the toilet for extended lengths of time- 2/3 of the residents expressing the concern are not always oriented to time."<br>-- Three residents gave examples: "30 min, 45 min, 2 hr."<br>*Department response:<br>-"Call light audit 12-1700 [5 p.m.] 10 min, 6 min, 3 min, 3 min."<br>*5 out of 10 residents had a concern of:<br>-"Not satisfied with resolution/response: staff name tags"<br>--"New information: 5/8 residents state they do not see name tags on staff members and would like to. One resident was sleeping and one abstained so the voting resident number is 8 instead of 10 who were present at the meeting."<br>*Department response:<br>-"Additional education & visual audit"<br><br>Review of resident grievances filed in the last 6 months revealed:<br>*A dietary aid submitted a grievance stating: "Dietary aid noticed [resident's name] almost in tears. When CNA M [CNA's name] walk by, she said she can't take it anymore. "She is so rough: directing comment towards [CNA's name]."<br>*Resolution: "[CNA's name] in question encouraged to slow down with resident's care. Will continue to monitor [CNA's name] progress in this."<br>*Investigation: "I did interview [CNA's name] regarding this grievance. [CNA's name] denies getting [residents name] up on morning of 11/23/2020. She states 'it must have been [another staff member's name] because resident had a bath that day.' She also stated 'that | F 867 | | |

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| F 867 | Continued From page 91 | F 867 | | |

resident doesn't understand why she cannot be in her chair or needs to use the hoyer.' '[staff member's name] does not always remember to use the hoyer for her.' In interviewing other staff, it was found that [staff members name] was on MR [unsure of what MR is], [staff member's name] was on north hall, [staff members name] was on baths, no other staff had gotten resident up on 11/23/2020, and [CNA's name] did confirm that [resident's name] was not a bath that day and she does not know who got her up."
*On 1/24/21 a resident filed a grievance stating:
-"Resident asked DON [director of nursing] for complaint. Per resident night aide/[staff member's name]. walked up to her door and asked very rudely what do you want! And then left without returning. Resident stated she felt like she shouldn't put her light on unless it was an emergency because aide was so rude to her [and symbol] resident also felt afraid of her due to her tone of voice. After another staff visited with her she said [staff member's name] had talk to her about the different men she took home to have sex with. 'It was like she got off of work from the bar and took these guys home for sex.'"
*Administrator G sent an email to the staff member in question and asked for an explanation and solution, so it did not happen again.
*The staff member replied:
-"I'm pretty sure that had not happen[ed] [resident's name] has how my love life is and I tell her its going I don't go into anything farther and the only resident I have said what do you want is to [another resident's name] after standing there for 5 minutes trying to get an answer out of him."
*The resolution to the grievance was education provided via email to staff member on how to talk to residents.
*In the past month there had been 13 grievances

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| F 867 | Continued From page 92<br>filled out by staff on behalf of residents regarding the care they had been receiving.<br>-None of them had any investigations.<br>*In the past month there have been 2 grievances filled directly by residents.<br>-One was due to the resident not being toileted, ended up urinating on herself and had to lay there for about 6 hours.<br>-The other was due to CNA M being rude and harsh to her.<br>--The investigation consisted of the social worker talking to the residents.<br>*There have been 12 grievances filed directly by staff regarding personnel and staffing concerns.<br>-There was not a thorough investigation for the grievances.<br><br>Interview on 4/9/20 at 1:07 p.m. with social services director E revealed:<br>*Administrator G handles the staff grievances, she worked with administrator G on resident grievances.<br>*They work together for solutions to the grievances.<br><br>Review of the provider's 12/1/19 Director of Social Services job description revealed mediated issues that arise among residents, families, and staff.<br><br>Interview on 4/9/20 at 2:08 p.m. with administrator G regarding their QAPI committee revealed:<br>*They have meeting monthly.<br>*They currently do not have any PIP's (process improvement plans) in place.<br>*They had one PIP in place in January of this year due to mandatory reporting and abuse and neglect. | F 867 | | |

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| F 867 | Continued From page 93<br>-This was a result of some abuse allegations.<br>*The QAA committee knows of problems based on QAI report from grievances.<br>*The process to address the grievances is:<br>-Develop a plan.<br>-Do the plan.<br>-Monitor the plan.<br>*Regarding staffing they had an informal discussion in February to come up with some ideas to free up the nurses on the floor.<br><br>Review of the provider's January 2017 Grievance policy revealed:<br>*"It is the policy of this facility to investigate all grievances registered by, or on behalf of a resident, without the threat of reprisal in any form. Residents are encouraged to express grievances on behalf of themselves or others to the facility's Administrator, the Resident Council, State or Government Agencies, or other persons. The Administrator shall provide all residents or their representatives with the name, address and telephone number of the appropriate state government office where complaints may be lodged."<br>*"5. The grievance official shall confer with persons involved in the incident and other relevant persons and within three (3) days of receiving the grievance shall provide a written explanation, upon request, of findings and proposed remedies to the complainant and the aggrieved party, if other than the complainant and legal party, an oral explanation shall accompany a written one.<br>*"6. During the investigation, the facility will put in place immediate action to prevent potential violation of resident's rights."<br>*"7. If the grievance involves abuse, neglect, injury of unknown source, and misappropriation of | F 867 | | |

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| F 867 | Continued From page 94<br>property, abuse and protocol will be followed."<br>*"8. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken to be taken by the facility as a result of the grievance, and the date the decision was issued."<br>*"9. If grievance is confirmed, the facility will take appropriate corrective action."<br>*"Recognizing a concern as a grievance early in the process is crucial to an effective and useful resolution. Each grievance must be taken seriously and submitted in a timely manner. Understanding what a grievance is, where the grievance can come from and who brings grievance to us will help ensure a strong grievance process is in place."<br>*"Examine (investigate): One you have recognized the grievance, initiated a grievance form and the Administration has assigned responsibility (investigator), it is time to examine all the information related to the identified grievance. Gathering data, conducting interviews and analyzing information will occur during this step of the process."<br>*"Establish and investigate the Facts:"<br>-"The first objective is to determine who was involved, what happened and the circumstances surrounding the issue. Asking the "who, what, when, where, why and how" of an issue helps establish facts and clarify information.<br>-"Next, determine the root cause of the issue based upon the information that you have received. It is important to note that failure to accurately determine the root cause will inevitably | F 867 | | |

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| F 867 | Continued From page 95<br>affect satisfactory resolution of the grievance. Incorrectly identifying the root cause is one of the most common mistakes made in managing the grievance process."<br>-"Verify the facts and determine the truths. Remember that even though a grievance may not be able to be verified as real, there is a perception that is real by the customer."<br>-"Based upon the facts determine if your investigation needs to be expanded to identify any other potential "like" residents."<br>-"Decide what course of action will be taken to produce resolution to the grievance that will satisfy the customer. Discuss your findings with the customer." | F 867 | | |
| F 880<br>SS=F | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment | F 880 | 1. Time cannot be turned back to a time prior to the identification of multiple breaches in infection control and prevention. Interim DON (IDON), maintenance and housekeeping supervisor, and administrator will be provided re-education about appropriate and necessary changes to the facility infection control and prevention plan no later than May 7, 2021 by the Regional Nurse Consultant (RNC) or designee.<br>The medical director was unavailable for review at the time of plan of correction, but had reviewed and approved Infection prevention and infection control policies prior to survey. The provider in consultation with the RNC reviewed infection prevention and control policies. No revisions to policies and procedures were necessary as they are in line with CDC and CMS recommendations about:<br>*Appropriate hand hygiene and glove use during resident cares.<br>*Appropriate cleaning and disinfection of resident rooms.<br>*Appropriate cleaning and maintenance of tub rooms.<br>*Necessary infection control and prevention plan that includes effective antibiotic stewardship.<br>All staff licensed and unlicensed who provide above services to residents will be educated by the Administrator, DON, RNC or designee no later than May 7, 2021. | |

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| F 880 | Continued From page 96<br>conducted according to §483.70(e) and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of | F 880 | Identification of Others:<br>2. *ALL residents have the potential to be affected when hand hygiene and glove use is not done as trained.<br>*ALL residents who have their room space cleaned and disinfected have the potential to be affected.<br>*All residents who receive whirlpool tub bathing have the potential to be affected if the tubs and surrounding area is not maintained in a clean and kept manner.<br>*ALL staff completing the assigned tasks have potential to be affected.<br>ALL residents and staff have potential to be affected if antibiotic stewardship program is just about recording numbers, data needs to be tracked and trended with appropriate follow-up for individual scenario.<br><br>Policy education/re-education about roles and responsibilities for the above identified assigned task(s) will be provided by the Administrator, DON, RNC or designee no later than May 7, 2021.<br><br>System Changes:<br>Root cause analysis was conducted on 4/16/21 by the DON and the RNC, using the 5 Why's system: Hand hygiene, PPE use, resident room and tub room cleaning was not being done properly.<br>*Why? staff were not following Infection prevention and infection control policies.<br>*Why? Staff were not consistently monitored for proper hand hygiene, PPE use, resident room and tub cleaning.<br>*Why? The Infection Preventionist/Interim DON (IP/IDON) had received infection prevention and control training, but did not effectively carry out the functions and duties of that role.<br>*Why? The IP/IDON was ill-equipped for the responsibilities of the role of the infection preventionist.<br>*Why? The IP/IDON did not utilize the education that was provided to her.<br>Since survey exit, a new Infection Preventionist (IP) has been appointed and has completed the CMS Nursing Home Infection Preventionist Training modules. The Administrator, IP, DON, maintenance housekeeping supervisor, and any others identified as necessary, will ensure ALL facility staff are responsible for following infection prevention and infection control policies. The RNC contacted the South Dakota Quality Improvement Organization (QIN) on 4/30/21. The 2567, the root cause analysis and this plan of correction were discussed, and the QIN agreed with this plan of correction and provided links for tools that may be used in continued staff education. | |

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| F 880 | Continued From page 97<br>infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on observation, interview, and policy review, the provider failed to follow appropriate infection control procedures including:<br>*Hand hygiene by one of one certified nursing assistant (CNA) H and nursing assistant (NA) L while caring for one of one (19) resident.<br>*Cleaning and disinfection of residents rooms for one of one housekeeper D.<br>*Ensuring one of two facility bathing rooms (100 hall) remained clean and free of clutter.<br>*Maintaining an effective infection control program.<br>Findings include:<br><br>1. Observation and interview on 4/6/21 at 4:45 p.m. on facility's north wing with CNA H and NA L revealed:<br>*CNA H and NA L left resident 19's room.<br>*They did not perform hand hygiene after leaving resident 19's room.<br>*After CNA H came out of resident 19's room she had her used gloves in her hand.<br>*She then went into another resident's room with those same soiled gloves in her hands.<br>*There were two hand sanitizers in the hallway.<br>-One was not working.<br>*Staff began delivering room trays at 5:27 p.m.<br>*CNA H went back to the facility green zone.<br>-The green zone was where two newly admitted/readmitted residents were.<br>–There was a plastic barrier set up. | F 880 | Monitoring:<br>3. Administrator, Interim DON, maintenance housekeeping supervisor and any others identified as necessary will conduct auditing and monitoring for areas identified as well as any items identified through Root Cause Analysis. Monitoring of determined approaches to ensure effective infection control and prevention include at a minimum weekly for 8 weeks, administrator, DON, and/or infection prevention nurse making observations across all shifts to ensure staff compliance with:<br>*Appropriate hand hygiene and glove use.<br>*Appropriate cleaning and disinfection of resident rooms.<br>*Appropriate cleaning of whirlpool tubs and maintenance of surrounding area.<br>*Any other areas identified thru the Root Cause Analysis.<br>After 8 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to monthly. Monthly monitoring will continue at a minimum 4 months.<br>Monitoring results will be reported by administrator, Interim DON, and/or maintenance housekeeping supervisor to the QAPI committee and continued for no less than 4 months of monthly monitoring that demonstrates sustained compliance then as determined by the committee and medical director.<br><br>4. | 5/7/21 |

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| F 880 | Continued From page 98<br>*CNA H was in the green zone, and her cart was right outside of the plastic barrier.<br>-The two resident's doors were opened.<br>*She delivered a resident's food into the first opened door.<br>*She was reaching from inside the plastic barrier to outside the plastic barrier with soiled gloves on.<br>-She came back to the cart to grab salt, pepper, and silverware.<br>*After CNA H went back into the first resident's room, she:<br>-Took off her gown and gloves.<br>-Cleaned off her eye wear.<br>-She did not perform hand hygiene.<br>-She did not change her mask.<br>*Surveyor asked about changing her mask after contact with their green zone residents<br>-She said she has never changed her mask.<br>--She gets a new one when she comes into work and discards it when she leaves the facility.<br>*Surveyor asked NA L if he changed his mask.<br>-He stated he never changes his mask after contact with their green zone residents.<br><br>Observation on 4/6/21 at 5:48 p.m. of the facility's 200 hallway tub room revealed:<br>*There was a tub with many particles in and around the drain.<br>*The room was very cluttered and did not appear to be in use.<br>*There were lifts, soiled linen containers, and shower chairs in the tub room.<br>*There were multiple open bottles of shampoo, body spray, deodorant, and lotion.<br>-Most of them did not have any resident names on them.<br>*There was an electric razor laying on the shelf with the opened bottles.<br>*There was a fingernail clipper laying on the side | F 880 | | |

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| F 880 | Continued From page 99<br>of the tub.<br><br>Observation and interview on 4/7/21 at 9:32 a.m. with housekeeper D revealed:<br>*He had worked in his current role for about six or seven years.<br>*He put on a pair of gloves and grabbed a clean rag.<br>-He placed that rag in an opened bucket of cleaning solution on top of the housekeeping cart.<br>--He said it is a Sunburst Sani Clean chemical.<br>*Starting from outside the room he cleaned:<br>-The door frame around the shared room.<br>-Cleaned off the dressers, cabinets, and beside table.<br>-Wiped off pictures that had been hanging on the wall.<br>-Wiped off resident's fan and knick knacks.<br>-Cleaned off first resident's oxygen concentrator and bedside table, moving personal belongings and water cup.<br>-After wiping off the top of the bedside table he wiped of the wheels and bottom of the cart.<br>-While wiping off the wheels and the bottom of the cart his rag was on the ground.<br>-He then moved on to the other resident's side of the room and repeated the same process.<br>-He did not get a new rag or change his gloves.<br>*He grabbed the trash from the residents' shared bedroom and placed it in their shared bathroom.<br>*He then took the same rag and began cleaning the bathroom.<br>-He had not changed his gloves, grabbed a new rag or applied new or more chemical.<br>*He started cleaning the shared bathroom:<br>-Started outside of the bathroom and wiped around the door frame.<br>-Wiped off the towel bars inside the bathroom.<br>-Shelving unit with residents shared personal | F 880 | | |

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| F 880 | Continued From page 100 | F 880 | | |

hygiene items.
-Wiping off shared residents' sink.
-Placed the resident's drinking cup on bottom of the housekeeping cart.
-Grabbed the sprayer from the bottom of the cart.
-The chemical was the Sunburst sani chemical in a sprayer bottle.
-Went back to the bathroom and sprayed the chemical into the sink.
-Immediately wiped the chemical out with the same rag he had been using above.
-Sprayed the toilet with the chemical by lifting the seat.
-He cleaned the toilet tank, then seat, then underneath the seat and inside the bowl.
-Cleaned underneath the toilet and the bottom of the toilet.
-Accidentally dropped a plastic lid into the shared toilet.
-Reached in and grabbed the piece of plastic out of the toilet bowl water.
-He then used toilet bowl cleaner to clean the inside of the toilet bowl.
-He then went back to his cart and to put away the toilet bowl cleaner.
-He removed his soiled gloves, did not perform hand hygiene.
-He grabbed a roll of toilet paper off the cart.
-He replaced the toilet paper in the shared residents' bathroom.
-He then grabbed the trash that he had placed in the bathroom and brought it back to his housekeeping cart.
-He then swept and mopped the shared room.
*Surveyor asked if he cleans all the rooms with the same process.
-He replied "It depends"
--He continued, "Some rooms aren't as messy as others. You just kind of know what rooms you

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| F 880 | Continued From page 101<br>need to do it with and which ones you don't."<br><br>Observation on 4/8/21 at 7:50 a.m. with resident 19's wife revealed:<br>*She was showing this surveyor the dried urine underneath the resident's bed.<br>*She also showed the surveyor the dirty fall mat and soiled trash can.<br>*She voiced concerns about hand hygiene being performed by the staff.<br>*She does not see them perform hand hygiene.<br>*She said she used to work in nursing home so she knows when staff should perform hand hygiene.<br>-She had not observed staff doing that in this facility.<br>Refer to F690, finding 1.<br><br>Review of providers February 2021 infection prevention program policy revealed:<br>*"The goals of the infection prevention and control program are to:"<br>-"A. Decrease the risk of infection to residents/patients and personnel."<br>-"B. Prevent, to the extent possible, the onset and spread of infection."<br>-"C. Monitor for occurrence of infection and control outbreaks and cross-contamination."<br>-"D. Monitor for occurrence of infection and implement appropriate control measures."<br>-"E. Identify and correct problems relating to infection prevention practices."<br>-"F. Maintain compliance with state and federal regulations and standards of practice relating to infection prevention and control."<br>*"The comprehensive infection prevention and control program addresses detection, prevention and control of infections among residents and personnel. It is designed to provide a safe, | F 880 | | |

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sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections."
*"The major activities of the program are:"
-"A. Surveillance of infections with implementation of prevention of infections and control measures. There is on-going monitoring and identifying infections and communicable diseases among residents, personnel, visitors and others providing services at facility; subsequent documentation and investigation of infections that occur. Analysis of data is done on-going and documentation is completed and reported to the Infection Prevention Committee.
Antibiotic Stewardship Program will be part of the Infection Prevention Program and will follow the Core Elements of Antibiotic Stewardship per the CDC guidelines.
Prevention of spread of infections is accomplished by use of hand hygiene, standard and transmission precautions and other barriers (PPE-personal Protective Equipment), appropriate treatment and follow-up, and employee health.
Staff and resident education focuses on risk of infection and practices to decrease risk. Policies, procedures and aseptic practices are followed by personnel in performing procedures, in cleaning/ disinfection of equipment, and cleaning and handling of linens. Immunizations are offered as appropriate to residents and personnel to decrease the incidence of preventable infectious diseases."
*"Infection prevention and control committee/Quality assurance and performance improvement (Q.A.P.I)
Infection prevention and control is a component of the facility's quality assurance and performance improvement program. Infection

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| F 880 | Continued From page 103<br>prevention and control reports are made to the Infection Prevention committee at the QAPI committee meeting. In addition, infection prevention rounds are made to assess the level of quality provided and actions for improvement are taken as needed. The infection prevention and control committee meet on a regular basis and provides input and direction for the infection prevention and control program. Policies and procedures relating to infection prevention and control are approved by the committee. Reports of infections are presented to the committee which recommends actions as well as prevention and control measures as needed. Antibiotic Stewardship activities and feedback are reported to QAPI. Minutes of the Infection Prevention and Control Committee meetings are maintained."<br>*"The infection preventionist (IP) serves as a resource for all staff and all departments relating to prevention and control of infections. Outside facility consultation will be utilized as needed."<br>*"The administrator is responsible for the infection prevention and control program."<br>*"Responsibility is delegated to the IP to carry out the daily functions of the infection prevention program by working sufficient hours. The IP has knowledge, competence, interest in infection prevention and control, and appropriate qualifications including training beyond his/her degree in infection Prevention. Responsibilities may include:"<br>-"Collecting, analyzing, and providing infection data and trends to nursing staff and health care practitioners-surveillance and outbreak management."<br>-"Consulting on infection risk assessment, prevention, and control strategies."<br>-"Providing education and training."<br>-"Implementing evidence-based infection control | F 880 | | |

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| F 880 | Continued From page 104<br>practices, including those mandated by regulatory and licensing agencies, and guidelines from the CDC [centers for disease control and prevention], SHEA [The Society for Healthcare Epidemiology of America] and APIC [Association for Professionals in Infection Control and Epidemiology], or other recognized experts/organizations in infection prevention..."<br>*"A. Resident infection cases and antibiotic use are monitored by the IP. The IP completed the line listing of infections and the monthly report forms and:<br>1. Reports to the Infection Prevention Committee.<br>2. Provides feedback to staff and others as needed."<br>*"C. Compliance with infection prevention prevention and control practices is monitored and documented by: 1. Staff evaluation<br>2. Observation of practices."<br>*"D. The IP/DON and appropriate department managers review the compliance monitoring and initiate appropriate actions."<br><br>Review of provider's November 2019 infection prevention program plan policy revealed:<br>*"To determine what resources are necessary to care for our residents competently and to assist with the review and updating of the Infection Prevention and Control Program. A current written infection prevention and control plan will be formulated and implemented by the Infection Prevention Committee."<br>*"The facility will conduct and document a facility-wide assessment that includes infection prevention and control facility and community risk. The results of this assessment will be used in part to establish and update the Infection Prevention and Control program, its policies activities and/or protocols. Activities scoring the | F 880 | | |

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| F 880 | Continued From page 105<br>highest scores would be the priority for the infection prevention team. This assessment will be reviewed and updated as necessary and at least annually."<br><br>Review of the provider's September 2011 cleaning bathrooms and toilets policy revealed:<br>*According to the maintenance director/housekeeping supervisor I this is the policy that they use.<br>*"To insure that all bathrooms and toilets are cleaned daily with non-acid bowl cleaner to prevent fungus and mildew build-up, paying special attention to cleaning shower stalls and shower rooms."<br>*"1. Clean lavatories with bowl cleaner. Particular attention should be given to pipes under bowl."<br>*"2. Use long-handled Johnny Mop to clean toilet bowls and urinals. Use bowl cleaner to wash inside and outside of toilets, including the toilet seat. An abrasive sponge might be needed to remove heavy film or gross soil."<br>*"3. Spray bowl cleaner on toilet. Use the Johnny Mop to clean under rim and the interior of the bowl completely.<br>-Rinse by flushing the toilet.<br>-Johnny mops must be cleaned in sanitizing solution between rooms."<br>*"4. Spray shower walls and doors, including fixtures, with bowl cleaner. Use damp cloth or sponge to wipe off excess moisture and restore shine."<br>*"5. Sponge mop floor with disinfectant solution (2 oz. disinfectant to 2 gallons of water) and pick up the dirty solution.<br>-Solution should remain on the floor for 5 minutes to complete disinfection."<br>*"6. Restock toilet paper in dispenser. Do not leave loose rolls of paper." | F 880 | | |

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| F 880 | Continued From page 106<br>*"7. Restock paper towel dispensers."<br>*"8. Replace spa[ as necessary."<br>*"9. Use rags to clean equipment. Rinse and clean mops when finished."<br><br>Review of providers September 2011 cleaning resident rooms daily (non-isolation) housekeeping policy revealed:<br>*"To sanitize the environment, aid prevention of cross-contamination, and maintain acceptable appearance levels."<br>*"Products and equipment needed:"<br>-"1. Maids cart"<br>-"2. Equipment for damp wiping..."<br>-"3. Equipment for floor cleaning..."<br>-"4. Equipment for toilet cleaning..."<br>-"5. Detergent/disinfectant"<br>*"1. Before entering the room, knock on door (if door is closed), greet resident, and check if room is available for cleaning."<br>*"2. Enter room and perform the following work procedures by working your way around the room, going from left to right."<br>-"Empty ash trays into wastebasket, spray with detergent/disinfectant solution in trigger sprayer. Wipe dry and replace in original location."<br>-"Empty all trash receptacles into the trash container on the cart. Damp wipe daily, or as needed. Do not put bare hands into wastebaskets or trash containers. Sharp objects might be present. Also, when emptying trash receptacles, hold them close to the trash container on the cart so the dust doesn't become airborne."<br>*"3. By using the damp wiping procedure, damp wipe all furniture, window sills, ledges, radiators, air conditioners, doors, open shelving, lights over the bed, tables, lamps, etc. Wipe all wood furniture with a dry cloth." | F 880 | | |

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| F 880 | Continued From page 107<br>Review of provider's resident daily room checklist revealed:<br>*"Bathroom/Toilet/commode Sweep/Mop"<br>*"Medicine cabinet top/sink"<br>*"Soap dispenser/refill-Mirrors"<br>*"Towel bars/ hand rails/ call light cord"<br>*"baseboard-heater Underneath/corners"<br>*"Clean/wipe down/ move dressers & nightstands"<br>*"Move bed away from wall-clean"<br>*"Outlet covers-baseboard/heater-underneath"<br>*"Overbed table"<br>*"Empty trash"<br>*"TV's/clocks/pictures"<br>*"window sills"<br>*"vinyl base"<br>*"door frames & knobs"<br>*"spot clean walls"<br>*"check dividers"<br>*"Chairs-move to be cleaned"<br>*"bedrails"<br>*"Bed control/call button"<br>*"Bathroom/Toilet/commode Sweep/Mop"<br>*"T.V. remote"<br><br>Review of provider's July 2020 personal protective equipment (PPE) on receiving unit during COVID-19 Pandemic revealed:<br>*"To protect the health of our employees and other residents while caring for new admissions and re-admissions on the Receiving designated unit/area."<br>*"Masks or respirators and eye protection may be used for re-use on designated Receiving unit/area. Gowns and gloves can only be used in one resident room. These items need to be removed and disposed of/placed in laundry while in resident room and then hand hygiene should be removed. | F 880 | | |

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| F 880 | Continued From page 108<br>N95/equal to N95 respirator or higher protection may be used if the HCP [health care personnel] is fit tested for its use and supply allows. The decision to use respirators instead of medical facemasks will be made at the facility on a case by case basis. If supplies are low, respirator use will be designated for aerosol generating procedures. Respirators may be re-used for a maximum of 5x unless otherwise indicated by the manufacturer..."<br>*"Extended/Uninterrupted Use: Will not be used in the Receiving unit/area."<br>*"Careful Re-Use: Involves removing the mask/respirator, eye protection as needed, placing mask/respirator and eye protection in a paper bag (one for each item); then re-donning (putting on) the mask/respirator, eye protection again."<br>*"Face Mask/respirator, Eye Protection, Gown and Gloves- Initial Donning for shift: Perform hand hygiene. Double check gown for defects. (Can use disposable or cloth gown). Don the gown by inserting arms into the sleeves and opening to the back. Tie the neck and waist tied in bows for easy release. Don mask/respirator, trying not to touch the front of the mask/respirator. Perform hand hygiene. Apply eyewear. Perform hand hygiene. Apply gloves. Ensure gloves completely cover gown cuffs. Ensure gown and gloves allow for full range of motion and remain correctly covered. Enter room."<br>*"Face Mask/Respirator, Eye Protection Doffing [removing of] for Re-Use: Remove gloves and perform hand hygiene. Carefully untie the gown at the neck and waist. Leaning forward, place hand inside cuff, pull cover over fingertips; reach to opposite cuff, pinch outside of cuff and pull hand back into sleeve. Pull gown forward off shoulders, | F 880 | | |

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| F 880 | Continued From page 109<br>touching only the outside of the gown, folding the gown away from body, so the clean side is facing you and the dirty side is folded towards wall. (May remove gloves and gown at the same time if utilizing a disposable gown: Grasp the down in the front and pull away from body so that the ties break, touching outside of gown only with gloved hands. While removing the gown, fold or roll the gown inside out into a bundle. As you are removing the gown, peel off gloves at the same time, only touching the inside of the gloves and gown with bare hands. Place the gown and gloves into the waste container.) While still wearing mask and eye protection, perform hand hygiene and put on new pair of gloves. Place a N list approved disinfectant wipe on a table/isolation cart outside of the room. Clean face shield/goggles using N list approved disinfectant wipe(s) as follows: Wipe front and back of shield/lens. Wipe earpieces of goggles. Wipe elastic band, foam band of face shield. Place goggles on clean table to dry. Place shield upside down to dry. Wipe the outside of face shield/goggles with clean water or alcohol to remove residue. Full air dry or use clean absorbent towels. Remove gloves, perform hand hygiene and apply new pair of gloves Remove medical facemask. The front is potentially contaminated, so remove by holding by ear loops. Carefully fold so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. Place the folded mask/respirator in a paper bag with the staff. person's name on it. When dry, place eye protection in another paper bag with the staff person's name on it. Remove gloves and perform hand hygiene."<br>*"1. All staff/employees who work on the Receiving unit will be provided one Medical | F 880 | | |

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| F 880 | Continued From page 110<br>Facemask or respirator and one eye protection for each individual resident being quarantined on the Receiving Unit. The expectation is that staff will wear the mask (or respirator for 5 uses) and eye protection for that individual resident for one shift."<br>*"2. Gloves and gowns will be worn with direct care of residents. Do not re-use gloves or gowns."<br>*"3. Whenever possible, staff should be dedicated to Receiving unit/area."<br>*"4. If the mask/respirator and eye protection need to be removed, staff should follow the Careful Re-use Steps as outlined above."<br><br>Interview on 4/8/21 at 1:53 p.m. with maintenance and housekeeping supervisor I revealed:<br>*HA D was aware when he needed to change gloves and cleaning rags when cleaning residents rooms.<br>*They have gone over the appropriate room cleaning procedure with him multiple times.<br>*He does not complete audits.<br>*He agreed with the surveyors concerns regarding how HA D cleaned the resident's rooms.<br><br>Interview on 4/9/21 at 11:42 a.m. with clinical care coordinator N.<br>*She has been the interim director of nursing (DON).<br>*She is also in charge of minimum data set assessments and care plans.<br>*When surveyor asked who oversaw infection control for the facility.<br>-She stated, "I guess that would be me."<br>*Surveyor asked if infection control is discussed during quality assurance performance improvement (QAPI) meetings. | F 880 | | |

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| F 880 | Continued From page 111<br>-She replied: "Not really."<br>*She does not complete any infection control audits or monitoring.<br><br>Interview on 4/9/21 at 2:08 p.m. with Administrator G revealed:<br>*Clinical care coordinator N is the person responsible for infection control for the facility.<br>*He thought she was active in her infection control role.<br>*He agreed with surveyors concerns with hand hygiene, cleaning of resident rooms, and staff removing masks when leaving the receiving unit.<br>Refer to F881 | F 880 | | |
| F 881 SS=D | Antibiotic Stewardship Program<br>CFR(s): 483.80(a)(3)<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.<br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 42477<br>Based on interview and record review the facility failed to have an ongoing Antibiotic Stewardship program. This failure placed all residents at risk for potential adverse outcomes, associated with the inappropriate and/or unnecessary use of antibiotics. Findings included:<br><br>1. Interview on 4/9/21 at 11:42 a.m. with clinical care coordinator N revealed: | F 881 | 1. All residents who are on antibiotics have been evaluated for the appropriateness of the antibiotic. All residents are potentially at risk for potential adverse outcomes associated with inappropriate and/or unnecessary use of antibiotics. Since survey exit, a new Infection Preventionist (IP) has been appointed and has completed the CMS Nursing Home Infection Preventionist Training modules.<br><br>2. Policy was reviewed with no revisions needed. The new IP received antibiotic stewardship program training by a Certified Infection Preventionist on 4/28/21.<br><br>3. The Regional Director of Operations (RDO) or the Regional Nurse Consultant (RNC) or designee will audit all residents on antibiotics each week to ensure daily tracking of antibiotics are recorded, Antibiotic time out is completed, labs are reviewed, and pharmacist is involved in antibiotic usage reviews. Results of audits will be presented by the RDO or RNC at the monthly QAPI meeting for discussion of the effectiveness of the correction and recommendation.<br><br>4. | 5/7/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 881 | Continued From page 112<br>*She has been the interim director of nursing (DON).<br>*She was also in charge of minimum data set assessments and care plans.<br>*When surveyor asked who was in charge of infection control for the facility.<br>-She stated, "I guess that would be me."<br>*Surveyor asked if infection control is discussed during quality assurance performance improvement (QAPI) meetings.<br>-She replied: "Not really."<br>*Surveyor asked who was in charge of antibiotic stewardship for the facility.<br>-She stated, "probably me."<br>*She said the antibiotic stewardship program consists of:<br>-Her highlighting infections on a facility map and listing what antibiotics residents are on.<br>*She did not know if the pharmacist was involved or the physician.<br>*She said that they do not meet as a committee or talk as a committee.<br><br>Review of providers 11/2017 antibiotic stewardship policy revealed:<br>*"It is the policy of this facility to follow an Antibiotic Stewardship program."<br>*"The purpose of the program is to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events."<br>*"Antibiotic Stewardship is part of our Infection Control Program."<br>*"The facility will track antibiotic use daily."<br>*"The facility will communicate with the physician(s) prescribing antibiotics with an "Antibiotic Report Card" on a monthly basis and as needed."<br>*"All nurses, upon hire and as needed, will be educated regarding proper assessment for | F 881 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

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|---|---|---|---|---|
| F 881 | Continued From page 113<br>infection prior to calling physician."<br>*"The facility will ensure the pharmacy reviews all antibiotic usage for appropriateness."<br>*"Antibiotic use will be calculated on a monthly basis for QAPI purposes."<br>*"The facility will monitor for all adverse reactions/outcomes related to antibiotic therapy."<br>*"The facility will involve the laboratory in our QAPI meetings as applicable.<br>*"Information gathered will be communicated to all staff."<br>Refer to F880. | F 881 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING _____ B. WING _____ | 04/09/2021 |

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| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE IPSWICH, SD 57451 |

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|---|---|---|---|---|
| E 000 | Initial Comments<br><br>Surveyor: 26632<br>A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 4/6/21 through 4/9/21. Avantara Ipswich was found in compliance. | E 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 4/30/21 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 04/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE<br>IPSWICH, SD 57451 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>Surveyor: 40506<br>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/7/21. Avantara Ipswich was found not in compliance with 42 CFR 483.70 (a) requirement for Long Term Care Facilities.<br><br>The building will meet the requirement of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at K754 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 754 SS=D | Soiled Linen and Trash Containers<br>CFR(s): NFPA 101<br><br>Soiled Linen and Trash Containers<br>Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended.<br>Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent.<br>18.7.5.7, 19.7.5.7<br>This REQUIREMENT is not met as evidenced by: | K 754 | 1. The 3 compartment bin was removed from the hallway when not in use for longer than 20 minutes.<br><br>All residents have the potential to be affected by this process.<br><br>2. Administrator will provide education to all staff on the removal of the 3 compartment bin when not in use. Education will occur no later than May 5, 2021.<br><br>3. The Administrator or designee will perform weekly observation audits on different days and different times to ensure the 3 compartment bin is not left in the hallway not in use for 20 minutes. Audits will be weekly for four weeks, and then monthly for 2 months. Results of audits will be discussed by the Administrator at the monthly QAPI meeting for discussion of the effectiveness of the correction and recommendation to adjust correction plan, reduce frequency of audit or discontinue audit based findings.<br><br>4. | 5/7/21 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | Administrator | 4/30/21 |

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435055 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 04/08/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DRIVE<br>IPSWICH, SD 57451 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 754 | Continued From page 1<br>Surveyor: 40506<br>Based upon observation at 9:50 a.m. on 4/7/21 , the provider had placed three 20 gallon containers in an attached wheeled frame, within the protected exit corridor on the 100 resident wing and on the 200 resident wing. The containers were labeled to contain trash (one 20-gallon container) and soiled linen (two 20-gallon containers). Sixty gallons exceeds the limited amount of trash or soiled linen allowed within an exit corridor. Though the carts were wheeled, they were not moved during the five hour survey.<br><br>This deficiency has the potential to affect 100 percent of residents in each of the two smoke compartments at Avantara Ipswich. | K 754 | | |

South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10635 | A. BUILDING: _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DR POST OFFICE BOX 728 IPSWICH, SD 57451 |

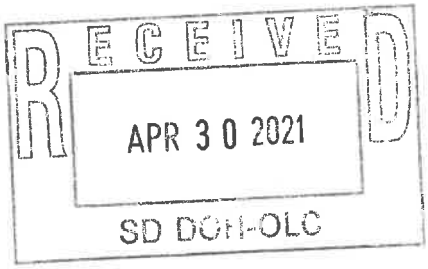
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 40506<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted 4/06/2021 through 4/09/2021. Avantara Ipswich was found not in compliance with the following requirement(s): S165. | S 000 | | |
| S 165 | 44:73:02:18 Occupant Protection<br><br>Each facility shall be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the residents admitted to the facility.<br><br>This Administrative Rule of South Dakota is not met as evidenced by:<br>Surveyor: 40506<br>Based on observation and interview, the provider failed to maintain a weather-tight enclosure throughout the facility. Findings include:<br><br>1. Observation at 9:50 a.m. on 4/07/21 revealed leaks above the entry corridor. Ceiling was saturated.<br>2. Observation at 10:15 a.m. on 04/07/21 revealed leaks above the service corridor and within the boiler room. Ceiling and walls were saturated.<br>3. Observation at 10:45 a.m. on 4/07/21 revealed leaks above the physical thrapy room equipment. Ceiling and wall was saturated.<br><br>Interview with the maintenance supervisor throughout the tour on 4/7/21 confirmed that finding. He revealed that the project had been | S 165 | 1. The Maintenance Supervisor will ensure the floor is dry and remove saturated ceiling tiles.<br><br>All residents have the potential to be affected by this process.<br><br>2. The Maintenance Supervisor will obtain quotes to repair and/or replace the roof as soon as possible.<br><br>3. The Administrator or designee will perform observation audits weekly to ensure the floor remains dry to prevent slips and falls.<br><br>Results of audits will be presented by the Administrator or designee at the monthly QAPI meeting for discussion of the effectiveness of the correction and recommendation and updates on roof repair and/or replacement.<br><br>4. | 5/7/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 4/30/21





South Dakota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10635 | A. BUILDING: _____ B. WING _____ | 04/09/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AVANTARA IPSWICH | 617 BLOEMENDAAL DR POST OFFICE BOX 728 IPSWICH, SD 57451 |

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|---|---|---|---|---|
| S 165 | Continued From page 1<br>scheduled two years prior to the present, but after evaluation the funding was eliminated. | S 165 | | |
| S 000 | Compliance/Noncompliance Statement<br><br>Surveyor: 26632<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 4/6/21 through 4/9/21. Avantara Ipswich was found in compliance. | S 000 | | |