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	435051	A. BUILDING ______ B. WING ______	C 11/30/2022

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AVANTARA ARROWHEAD	2500 ARROWHEAD DR RAPID CITY, SD 57702

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/29/22 through 11/30/22. Areas surveyed included quality of care, resident rights, infection control, and nursing services. Avantara Arrowhead was found not in compliance with the following regulations: F580, F658, F835, F880, F881, and F882.	F 000		
F 580 SS=F	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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.	F 580	1. No immediate correction could be made for the forty-four residents' families or representatives not being notified of residents' change in condition. No immediate corrective action could be made for resident 9's respresentative not being notified of a change in condition that resulted in resident 9 needing to be transported to the hospital. 2. All residents have the potential to be affected by the facility's faillure to notify families or representatives of residents' change in condition. 3.The Director of Nursing (DON) will educate all nurses on the Notification of Change policy to ensure families or representatives are notified of all resident change in conditions. Education will occur no later than January 9, 2023. Those not in attendance at education sessions due to vacations, sick leave, or casual work status will be educated prior to their first shift worked. Additionally, the DON and/or designee will review progress notes each weekday to ensure all changes in condition have documented	1/9/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Malys	Administrator	12/23/2022

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 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) 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). This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of a South Dakota Department of Health (SD DOH) complaint intake, and policy review, the provider failed to ensure: *Forty-four of approximately fifty-seven residents' families or representatives had been notified when their resident was experiencing symptoms indicative of a lab confirmed communicable disease. *One of one resident (9) representatives had been notified of a change in condition requiring hospital transport. Findings include: 1. Review of a "GI [gastrointestinal] Illness: Data	F 580	notifcation to families or representatives. 4. The DON and/or designee will audit five random resident charts weekly to ensure all change in conditions include family or representative notification. Audits will be weekly for four weeks, and then monthly for two months. Results of audits will be discussed by the DON at the monthly Quality Assessment Process Improvement (QAPI) meeting with the Interdisciplinary Team (IDT) and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on audit findings.	

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F 580	Continued From page 2	F 580		

Collection Line Listing" revealed:
*Beside the names of 44 residents were GI symptom onset dates and the type of symptoms each of those residents had exhibited (vomiting, nausea, and diarrhea/rash).
-The symptom onset date range for those residents was between 11/12/22 and 11/16/22.
*Every resident on that list had the word "Noro" (norovirus) listed under the "Suspected Illness" column of that form.

Interview on 11/29/22 at 9:00 a.m. with administrator A and infection control nurse/assistant director of nursing (IC nurse/ADON) D revealed:
*On 11/12/22 administrator A was notified a handful of residents had begun experiencing symptoms of nausea, vomiting, and/or diarrhea.
*Gastrointestinal lab work ordered for two of those residents by on-call medical provider E confirmed those residents had norovirus.
-He recommended that administrator A to assume all other residents who began experiencing similar symptoms had the virus as well.
*Forty-four of the approximate total census of fifty-seven residents experienced norovirus symptoms including nausea, diarrhea, and/or vomiting.
*Random review of residents 2, 3, 4, 5, 6, and 7s' care records revealed:
*There was no documentation their family members or representatives had been contacted about the norovirus outbreak or their medical condition.
-Their names appeared on the GI Illness: Data Collection Line Listing report referred to above.

Follow-up interview on 11/29/22 at 11:00 a.m. with

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F 580	Continued From page 3 administrator A revealed: *She confirmed the families and representatives of residents affected by the norovirus including residents 2, 3, 4, 5, 6, and 7 had not been notified about the outbreak or their residents' medical condition. -Nurse managers had been responsible for making those notifications, but that had not occurred. 2. Review of the SD DOH complaint intake and resident 9's care record revealed: *She had a sudden decline in condition on 9/21/22 at 1:30 a.m. which required the nurse to call the resident's medical provider for instruction. -A physician's order had been received on 9/21/22 at 1:34 a.m. to transfer the resident to the emergency room (ER) by ambulance for evaluation. *She had been admitted to the hospital that evening. -She remained in the hospital from 9/21/22 until 9/26/22. *There was no documentation the power of attorney (POA) had been notified of the decline in condition or of the transfer and admit to the hospital. Interview on 11/30/22 at 1:51 p.m. with director of nursing (DON) B regarding resident 9's change in condition and transfer to the hospital revealed: *All resident changes of condition, transfers, and discharges were documented in the resident's care record by the nurse in charge of that resident. -The POA/responsible family member was to be notified of these changes immediately and it would be documented in the care record. *She had been unable to find documentation the POA was notified, but said she would do some	F 580		

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F 580	Continued From page 4 further looking into resident 9's records. Further interview on 11/30/22 at 3:54 p.m. with administrator A and DON B regarding resident 9 revealed: *They were unable to find any documentation the POA had been notified of resident 9's decline and subsequent hospitalization on 9/21/22. -The nurse in charge of resident 9 on 9/21/22 had been a travel nurse who was no longer employed at their facility. --They had no way to contact this nurse for an interview. *It was their expectation the POA should have been notified of the resident's decline in condition and transfer to the hospital. Review of the December 2019 Notification of Change Policy revealed: "1. 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:" -"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); -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 -d. A decision to transfer or discharge the resident from the facility as specified in 483.15(c)(1)(ii)."	F 580		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658	1. No immediate corrective action could be taken for the catheter change refusal that had not been properly documented by RN H, as she was terminated from the facility on October 20, 2022. No immediate corrective	1/9/2023

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F 658 Continued From page 5

The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(i) Meet professional standards of quality.
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, review of a South Dakota Department of Health complaint intake, and policy review, the provider failed to ensure:
*A catheter change refusal by one of one sampled resident (1) had been properly documented by one of one registered nurse (RN) H.
*A physician's order for a monthly catheter change had been followed for one of one sampled resident (1).
*One of one RN (G) had contacted one of one sampled resident's (1) physician to discuss changing that resident's catheter size prior to inserting a catheter size that had not been ordered.
*One of one RN (G) had appropriately documented a catheter change for one of one sampled resident (1).
Findings include:

1. Review of resident 1's September 2022 Treatment Administration Record (TAR) revealed:
*An order started on 8/30/22 to change his indwelling 16 French (Fr) catheter.
-That referred to the ize of catheter ordered for the resident.
*RN H initialed and placed a checkmark in the 9/3/22 box beside the catheter order referred to above.
-That checkmark indicated "Drug Administered" per the TAR legend.
*"NN" was beside the RN H's initials and the

F 658

action could be taken for RN G's failure to contact the physician to discuss changing resident 1 catheter size prior to inserting a catheter size that had not been ordered. RN G was immediately educated upon identification at the time of survey on the expectations for following physician orders and accurately documenting catheter changes.

2. All residents with indwelling catheters are at risk for improper documentation of catheter changes, failure to contact physicians to discuss changing a resident's catheter size prior to inserting a catheter size that had not been ordered and failure to follow physician orders and accurately documenting catheter changes. The DON or designee will complete an audit of all resident with catheters to ensure correct foley size, ensuring those residents have an order for catheter changes, verifying the catheter order was followed regarding inserting the correct catheter size, ensuring all catheter changes have been completed per physician orders and documentation is present in the residents medical record no later than December 24, 2022.

3. The DON will educate all nurses, to include RN G, on the Catheter Care policy and Following Physician Orders Policy to ensure catheters are changed per physician's order to include the appropriate catheter size and catheter changes are documented appropriately in the resident's medical record. Education will occur no later than January 9, 2023. Those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked.

4. The DON or designee will audit 5 residents with catheters weekly to ensure catheter orders are being followed, any clarification on orders is obtained and documented in the resident medical record, all catheter changes have been documented in the resident's treatment administration record (TAR), and if necessary,

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checkmark in that box.
-That meant a nurse progress note by RN H was linked to that 9/3/22 TAR entry.
*That note read, "Resident refused-will attempt cath [catheter] change again tomorrow."
*No other documentation on that TAR indicated resident 1's catheter had been changed during the month of September.

Interview on 11/30/22 at 9:10 a.m. and 2:00 p.m. with director of nursing (DON) B revealed she:
*Expected RN H had marked "DR" for drug refused and not placed a checkmark in the 9/3/22 box on the TAR.
-Documenting "DR" would have alerted subsequent nursing shifts that resident 1's catheter still needed to be changed.
*Confirmed the physician's order for a monthly catheter change had not been followed during September 2022.

2. Review of resident 1's care record revealed:
*A progress note by RN G dated 10/12/22 indicating his catheter was leaking urine so she replaced 16 Fr catheter with a 22 Fr catheter.
*His October 2022 TAR revealed no documentation on 10/12/22 that his catheter was changed.

Interview on 11/30/22 at 12:15 p.m. with RN G revealed she:
*Had not contacted resident 1's physician about using a catheter size different than what was ordered (16 Fr) before inserting a 22 Fr.
-Agreed she had not followed the physician's order for resident 1's catheter care.
*Had not documented on his TAR that she changed his catheter on 10/12/22, but she should have.

F 658

all provider notifications have been completed and documented int the residents' medical record. Audits will be weekly for four weeks, and then monthly for two months. Results of the audits will bediscussed by the DON or designee at the monthly QAPI meeting with the IDT and medical director for analysis and recommendations for continuation/ discontinuation/revision of audits based on audit findings.

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F 658	Continued From page 7 Interview on 11/30/22 at 1:50 p.m. with the DON B revealed she expected RN G had contacted resident 1's medical provider if there were concerns about his catheter size, followed the physician's order for resident 1's catheter care, and documented the catheter change on resident 1's TAR after performing that care. A policy related to the provider's expectations for documenting and following a physician's order for changing a Foley catheter was requested on 11/30/22 at 3:30 p.m. from DON B. The following policies were provided: *A September 2019 Catheter Care policy related to preventing catheter-associated urinary tract infections. *A revised May 2021 Following Physician Orders policy regarding receiving and transcribing physician's orders. -Neither of these policies specifically addressed expectations for following physician orders and documenting catheter care.	F 658		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. 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 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, review of a South Dakota Department of Health complaint intake, job description review, and policy review, the provider failed to ensure the facility was operated and	F 835	1. Immediate corrections have been made for all residents affected by the deficiant practice. 2. All residents are at a risk of service lapses because of an ineffective leadership team to ensure infection prevention and control processes have been implemented. The Regional Infection Preventionist and Clinical Education Specialist educated the Administrator and DON on the key elements of infection control on December 20, 2022. 3. The Regional Nurse Consultant (RNC) and/or the Regional Infection Preventionist and Clinical Education Specialist will meet with the Administrator, DON, and facility	1/9/2023

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F 835	Continued From page 8 managed by administrator A to ensure infection prevention and control processes had been implemented for all fifty-seven residents in the facility. Findings include: 1. Interviews on 11/29/22 at 9:00 a.m. and 11:00 a.m. and on 11/30/22 at 5:15 p.m. with administrator A and regional nurse consultant C revealed administrator A had not: *Initiated or overseen an investigation into the root cause of the November 2022 norovirus outbreak that affected 44 residents knowing the likely source of that illness was food-borne, but should have. *Ensured on-going identification, documentation, monitoring, and investigation of infections had occurred under the direction of infection control (IC) nurse/assistant director of nursing (ADON) D, but should have. *Ensured the provider's policy for an antibiotic review process (antibiotic time-out) to review appropriate antibiotic use and optimization of infection treatment had been implemented, but should have. *Expected IC nurse/ADON D had completed specialized infection prevention and control training to enhance her ability to effectively and consistently carry out her job responsibilities, but should have. Review of the 12/1/19 administrator job description revealed: *"Summary/Objective": -"In keeping with our organization's goal of improving the lives of the residents we serve, the Administrator provides overall direction for all activities related to administration, personnel, physical structure, information systems, office management and marketing of the entire facility.	F 835	Infection Preventionist every week, either in person or by phone to review infection control and prevention, discuss infection trends, any infection control concerns, or any follow-up regarding infection prevention and will offer support and training as needed. 4. The RNC and/or the Regional Infection Preventionist and Clinical Education Specialist will reevaluate the need for weekly visits after three months. Results of the visits and any associated action plans or auditing needed will be reported to the QAPI meeting by the RNC and/or designee each month.	

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F 835	Continued From page 9 The Administrator works closely with all members of the management team and others to ensure their responsibilities are effectively and consistently discharged. The Administrator will ensure all facility operations are in compliance with federal, state and local regulations." Refer to F880, F881, and F882.	F 835		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §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 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	1. No immediate corrective action could be made for lack of an appropriate process for investigating potential/probable food borne illnesses. The Administrator, DON, and/or designee in consultation with the medical director will review policies and procedures for implementing a process for investigating potential/probable food borne illness. The Regional Infection Preventionist and Clincial Education Specialist will educate the Administrator, DON, and IDT on the Infection Prevention and Control program and implementing an outbreak investigation for all facility acquired infections no later than December 29, 2022. Those not in attendance at the education session due to vacation, illness, or casual work status will be educated prior to their first shift worked. 2. All residents and staff have the potential to be affected by the lack of appropriate processes and follow through for not implementing an appropriate process for investigating potential/probable food borne illnesses. Policy education/re-education about roles and responsibilities for implementing an appropriate process for investigating potential/probable food borne illnessess will be provided by the Regional Infection Preventionist and Clinical Education Specialist and/or designee no later than December 29, 2022.	1/9/2023

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possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(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
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on review of a South Dakota Department

F 880

Root cause analysis (RCA) was conducted and answered the 5 whys which revealed the Assistant Director of Nursing/Infection Preventionist (ADON/IC) was not familiar with the procedure during an outbreak, the ADON/IC did not reach out to the regional team for support or look up the infection control policy, ADON/IC was new in her role and did not receive proper education and the ADON/IC failure to prioritize the required training in order to be an effective infection control nurse. The Regional Infection Preventionist and Clinical Education Specialistt educated the Administrator, DON, ADON/Wound Care, ADON/Infection Control on tracking facility outbreaks, managing outbreaks, and proper reporting of data on December 14, 2022. The Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on December 19, 2022 and discussed the importance of involving food service employees in an outbreak investigation to determine if the cause of the infection came from the kitchen, they recommended the nursing staff to utilize SBAR assessments as a tool for tracking infections

4. The Administrator, DON, and/or designee will conduct auditing and monitoring to ensure the key elements of the infection prevention program are being implemented to include were any communicable diseases or infections identified, if so, was the disease/infection reported to the ADON/IC or designee, if an infection was identified ensuring proper precautions were implemented in order to prevent the spread of infection, ensuring ALL staff understand the type and duration of the isolation, and a proper monitoring and surveillance program was initiated

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AVANTARA ARROWHEAD	**2500 ARROWHEAD DR RAPID CITY, SD 57702**

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F 880	Continued From page 11 of Health complaint intake, interview, record review, and policy review, the provider failed to implement a process for investigating one of one outbreak of norovirus. Findings include: 1. Review of a "GI [gastrointestinal] Illness: Data Collection Line Listing" revealed: *Beside the names of 44 residents were GI symptom onset dates and the type of symptoms each of those residents had exhibited (vomiting, nausea, and diarrhea/rash). -The symptom onset date range for those residents was between 11/12/22 and 11/16/22. *Every resident on that list had the word "Noro" (norovirus) listed under the "Suspected Illness" column. Interview on 11/29/22 at 9:00 a.m. with administrator A and infection control nurse/assistant director of nursing (IC nurse/ADON) D revealed: *On 11/12/22 administrator A was notified a handful of residents had begun experiencing symptoms of nausea, vomiting, and/or diarrhea. *Gastrointestinal (GI) lab work ordered that day for two of those symptomatic residents by on-call medical provider E confirmed those residents had norovirus. -He advised administrator A to assume all other residents who began experiencing similar symptoms had it too. -The likely source of the virus was food-borne. *Administrator A's immediate response to the illness included: -Separating symptomatic residents from asymptomatic residents, placed signage outside of symptomatic residents' rooms reminding staff to wear and appropriately discard personal protective equipment (PPE) when caring for	F 880	to reduce the risk of further infection during the outbreak. Monitoring will be conducted 2-3 times weekly over all shifts. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. After 4 weeks of monitoring and demonstrating expectations are being met, monitoring may be reduced to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by the Administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee.	Type text he

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F 880		F 880		

Continued From page 12
affected residents, and to perform proper hand hygiene.
*Administrator A returned to work on 11/13/22 as the scheduled "manager-on-duty" for that day.
-More residents had become symptomatic.

Interview on 11/29/22 at 10:00 a.m. with cook/interim dietary manager F revealed he:
*Had worked on 11/12/22.
*Confirmed at no point during or following the norovirus outbreak had administrator A or IC nurse/ADON D discussed with him possible food service-related breeches that may have caused or contributed to the outbreak.
*Thought "everything food-wise was ok" on 11/12/22.
*Provided food borne-illness education at the October 2022 All-Staff meeting.

Follow-up interview on 11/29/22 at 11:00 a.m. with administrator A and IC nurse/ADON D revealed:
*After GI lab work confirmed the presence of norovirus and knowing the likely source was food-borne neither administrator A or IC Nurse/ADON D had:
-Investigated whether or not on around 11/12/22 any kitchen staff or other staff had come to work ill.
-Looked into what and how food had been handled, prepared, cooked and stored around that time.
-Interviewed cook/interim dietary manager F about food service practices.
*IC nurse/ADON D stated "I truly don't know why" an investigation of the root cause of the outbreak source had not occurred.
*Administrator A expected the IC nurse/ADON D had overseen the outbreak investigation with the support of other interdisciplinary team members.

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F 880	Continued From page 13 -Administrator A was responsible for ensuring an investigation had occurred, but it had not. Telephone interview on 11/30/22 at 3:30 p.m. with on-call medical director E revealed: *After GI testing confirmed residents were positive for norovirus he: -Provided recommendations in his progress notes for those positive residents' care that was applicable to all symptomatic residents. -Provided other medical literature resources regarding the norovirus illness. *Knew one of the two residents (2) with lab confirmed norovirus had already been in quarantine due to COVID-19. -This reinforced to him the outbreak was food borne since she had not been outside of that room while she was on quarantine. Follow-up interview on 11/30/22 at 4:00 p.m. with IC nurse/ADON D confirmed: *At the time of resident 2's norovirus symptom onset (11/12/22), she had already been quarantined in her room because she had COVID-19. -She agreed this reinforced the physician's suspicion the cause of this outbreak was food-borne. Review of the 2/26/21 Infection Prevention Program policy revealed: *The primary functions of the Infection Prevention Program included: -Surveillance of infections and implementation of measures to prevent and control infections. -Investigation disease outbreaks.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881	1. Immedicate corrective action was taken upon discovery of the lack of implementing	1/9/2023

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F 881	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, review of a South Dakota Department of Health complaint intake, record review, and policy review, the provider failed to implement their antibiotic stewardship program. This failure placed all residents at risk for potential adverse outcomes associated with the use of inappropriate and/or unnecessary use of antibiotics. Findings include: 1. Review of the provider's 11/29/22 Centers for Medicare and Medicaid Services (CMS) form 802 resident matrix revealed seven residents were identified as receiving an antibiotic medication. Interview on 11/29/22 at 9:15 a.m. with administrator A regarding the provider's antibiotic stewardship program revealed: *An antibiotic review process was expected to occur after any antibiotic medication was started. -That process included completion of an algorithm ("72-Hour Antibiotic Time-Out") to assess the choice of antibiotic prescribed and its continued appropriateness. *The antibiotic time-out process had not been implemented because administrator A had not known about it until last week. *Infection control (IC) nurse/assistant director of	F 881	an antibiotic stewardship program. The Regional Infection Preventionist and Clinical Education Specialist educated the Administrator, DON, ADON/IC, ADON/ Wound Nurse, and Clinical Care Coordinator on the Antibiotic Stewardship Program policy and incorporating it into daily clinical meetings on December 14, 2022. The Administrator, DON, and/or designee in consultation with the medical director will review policies and procedures for antibiotic review process after an antibiotic is initiated. 2. All residents and staff have the potential to be affected by the lack of appropriate processess and follow through for a facility's lack of not implementing an antibiotic stewardship program. Policy education/re-education about roles and responsibilities for implementing an antibiotic stewardship program will be provided to the Interdisciplinary Team (IDT) by the Region Infection Preventionist and Clinical Education Specialist and/or designee no later than December 29, 2022.Those not in attendance at education session due to vaction, illness, or casual work status will be educated prior to their first shift worked. 3.Root cause analysis (RCA) was conducted and answered the 5 whys which revealed the facility did not have an effective infection control program, the facility did not have an experienced and/or educated infection control nurse, designated infection control nurse did not complete the required training in order to comprehend what the role entailed, there was lack of oversight by direct supervisor to ensure the infection control nurse was completing essential job duties in the facility, and failure by DON,	

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F 881

Continued From page 15
nursing (ADON) D completed monthly tracking and trending of residents' use of antibiotics.
-That information was brought forward monthly for review, discussion, and recommendations by the Quality Assurance (QA) team.

Review and interview on 11/29/22 at 4:45 p.m. of the antibiotic stewardship binder with IC nurse/ADON D revealed:
*Monthly "Antibiotic Tracking Forms."
*The column titles arranged horizontally at the top of those forms included:
-Resident (name).
-Date.
-Notified responsible party/documented.
-Site infection.
-McGeer started. (criteria used for infection surveillance)
-Meets criteria y/n (yes or no).
-Culture results entered. McGeer closed.
-ATB (antibiotic) progress note initiated.
-Monitor only at this time no ATB.
-3 day look back note done.
-Care planned.
*IC nurse/ADON D had completed antibiotic tracking information using that form for August and September 2022, but not for October 2022 or November 2022.
-She thought director of nursing (DON) B had assumed this responsibility in October 2022 because she had specialized infection prevention and control training.
*Antibiotic surveillance data she provided to the QA team included a monthly report of the type and numbers of monthly infections.

Continued interview on 11/30/22 at 8:30 a.m. with IC nurse/ADON D regarding the antibiotic time-out process revealed:

F 881

and Administrator to ensure ADON/IC was performing her essential job duties. The Administrator, DON, medical director, and Regional Infection Preventionist and Clinical Education Specialist will ensure all facility staff responsible for the Antibiotic Stewardship Program have received education/training with demonstrated competency and documentation. The Administrator and the DON contacted the South Dakota Quality Improvement Organization (QIN) on December 19, 2022, and discussed the importance of invilving food service employees in an outbreak investigation to determine if the cause of the infection came from the kitchen, they recommended the nursing staff to utilize the SBAR assessment tool for tracking infections.

4. The DON, ADON/IC, and/or designee will conduct auditing and monitoring of the Antibiotic Stewardship program 2-3 times weekly over all shifts to ensure the key elements of the Antibiotic Stewardship program are being implemented to include monitoring infections and antibiotic usage, monitoring residents on antibiotics for potential adverse outcomes, ensuring a McGeers assessment is completed following an order received to initiate an antibiotic, if an antibiotic is started that the antibiotic time-out (ATO) was completed 72 hours after the antibiotic was started to determine continued appropriateness of the antibiotic. Monitoring for determined approaches to ensure effective implementation and ongoingsustainment. After four weeks of monitoring and demonstrating expectatios are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results

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F 881	Continued From page 16 *It included completion of a tool to assess the appropriateness of antibiotic use. -That process was not currently being used. *An e-mail received on 11/25/22 from regional nurse consultant for infection prevention/clinical education specialist J indicated that process should not have been stopped and was expected to be occurring now. *IC nurse/ADON D was uncertain whose responsibility it was to make sure that time-out process was re-instituted. Interview on 11/30/22 at 4:45 p.m. with DON B revealed she: *Had not assumed any infection control duties from IC nurse/ADON D. *IC nurse/ADON D was responsible for antibiotic tracking, trending, and surveillance as well as the antibiotic time-out process. Review of the revised January 2021 Antibiotic Stewardship Program policy revealed: *"2. Accountability": -"a. The ASP [antibiotic stewardship program] may consist of: ASP Physician Champion and/or Medical Director, Administrator, Director of Nursing and/or Assistant Director of Nursing, Infection Preventionist (IP), pharmacy consultant, and Resident or Family Representative, if able. As a team they will: i. Review infections and monitor antibiotic usage patterns on a regular basis ii. Obtain and review, state, regional or facility-specific antibiograms for trends of resistance or facility-specific empiric guidelines. iii. Monitor antibiotic resistance patterns. iv. Report on number of antibiotics prescribed and the number of residents treated each month. v. Include a separate report for the number of	F 881	results will be reported by the Infection Preventionist, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee.	

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F 881	Continued From page 17 residents on antibiotics that did not meet criteria for active infection. vi. Utilize an antibiotic review process also known as "antibiotic time-out" (ATO) for all antibiotics in the facility."	F 881		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP)(s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview, review of a South Dakota Department of Health complaint intake, record review, job description review, and policy review, the provider failed to ensure one of one infection control nurse/assistant director of nursing (IC nurse/ADON) (B) had: *Implemented a monitoring and surveillance program to reduce the risk of further infection during one of one communicable disease outbreak.	F 882	1. No immediate corrective action could be made for ensuring the infection control nurse implemented a monitoring and surveillance program to reduce the risk of further infection during a communicable disease outbreak and ensuring the infection control nurse completed specialized training in infection control as required by the Centers for Medicare and Medicaid Services (CMS). The Administrator, DON, and/or designee in consultation with the medical director will review policies and procedures for ensuring a monitoring and surveillance program is implemented during a communicable disease outbreak to reduce the risk of further infection. The Administrator, DON, and ADON/IC were educated on implementing an outbreak investigation for all facility acquired infections on December 14, 2022, by the Regional Infection Preventionist and Clinical Education Specialist. The ADON/IC will complete necessary training in infection prevention and control no later than January 9, 2023. 2. All residents and staff have the potential to be affected by the facility's failure to implement a monitoring and surveillance program during a communicable disease outbreak. Policy education/re-education about roles and responsibilities for implementing a monitoring and surveillance program during a communicable disease outbreak was provided by the Regional Infection Preventionist and Clinical Education Specialist to the Administrator, DON, ADON/IC, ADON/Wound nurse, and Clinical Care Cooordinator on December 14, 2022. 3. Root cause analysis (RCA) was conducted and answered the 5 whys which revealed the Administrator and ADON/IC did not follow the norovirus outbreak policy, the Administrator	1/9/2023

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F 882 Continued From page 18

*Completed specialized training in infection prevention and control as required by the Centers for Medicare and Medicaid Services (CMS).
Findings include:

1. Review of the Novemer 2022 "GI [gastrointestinal] Illness: Data Collection Line Listing" revealed:
*The names of 44 residents.
-Beside those names were GI symptom onset dates and the type of symptoms each of those residents had exhibited (vomiting, nausea, and diarrhea/rash).
-The symptom onset date range for those residents was between 11/12/22 and 11/16/22.
*Every resident on that list had the word "Noro" (norovirus) listed under the "Suspected Illness" column.

Interview on 11/29/22 at 11:00 a.m. with administrator A and IC nurse/ADON D revealed:
*After GI lab work confirmed the presence of norovirus and knowing the likely source was food-borne neither she nor IC Nurse/ADON D had:
-Investigated whether around 11/12/22 any kitchen staff or other staff had come to work ill.
-Looked into what and how food had been handled, prepared, cooked and stored around that time.
-Interviewed cook/interim dietary manager F about food service practices.
*IC nurse/ADON D stated "I truly don't know why" an investigation to determine the root cause of the outbreak source had not occurred.
*Administrator A expected the IC nurse/ADON D had overseen the outbreak investigation with the support of other interdisciplinary team members, but she had not verified that was occurring.

F 882

and ADON/IC did not reach out to the regional team for support and guidance on how to manage an outbreak, ADON/IC nurse not familiar with the processes and procedures of the infection prevention program, ADON/IC nurse did not complete specialized training/education, the Administrator failed to ensure proper policies and regulations were being implemented for an effective infection prevention program which included ensuring ADON/IC completed specialized training. The Administrator, DON, medical director, will ensure the ADON/IC has received education/training with demonstrated competency and documentation. The Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on December 19, 2022, and discussed the importance of involving food service employees in an outbreak investigation to determine if the cause of the infection came from the kitchen, they recommended the nursing staff to utilize SBAR assessment as a tool for tracking infections.

4. Administrator, DON, and/or designess will conduct auditing and monitoring to ensure surveillance and monitoring of active infections in the facility is being implemented, and the ADON/IC is receiving specialized education and training. After 4 weeks of monitoring demonstrating expectations are being met monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by the Administrator, DON, and/or designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by the committee.

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F 882	Continued From page 19	F 882		

Telephone interview on 11/30/22 at 3:30 p.m. with on-call medical director E revealed:
*He knew one of the two residents (2) with lab confirmed norovirus had been in quarantine for COVID.
-This reinforced to him the likelihood that food or drink brought into that resident's room should have been a suspected cause of the virus since she had not been outside of that room while she was on quarantine.

Follow-up interview on 11/30/22 at 4:00 p.m. with IC nurse/ADON D confirmed:
*At the time of resident 2's symptom onset (11/12/22), she was quarantined in her room because she had COVID-19.
-She agreed this reinforced the physician's suspicion the cause of this outbreak was food-borne.

2. Interview on 11/29/22 at 1:30 p.m. and on 11/30/22 at 4:00 p.m. with IC nurse/ADON D revealed she:
*Had been in her current position since May 2022.
*Knew about CMS's on-line infection prevention and control (IPC) training, but had not completed it because "life had gotten in the way."
*Was invited to attend an IPC training hosted by regional nurse consultant for infection prevention (IP)/clinical education specialist I in July 2022, but was unable to attend.
-Had periodically called the consultant about infection precaution questions she had about new admissions.
*Stated director of nursing (DON) B, who was hired in September 2022, had completed specialized IPC training and DON B assumed

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F 882	Continued From page 20	F 882		

some of her IP responsibilities because of that training.
*Expected a new nurse that had recently been hired with IPC training would assume the role of IP nurse.

Interview on 11/30/22 at 4:45 p.m. with DON B revealed she:
*Confirmed having completed specialized IPC training in January 2022.
*Was unaware any IP responsibilities had been assigned to her.
*IC nurse/ADON D was responsible overseeing the IPC program.

Interview on 11/30/22 at 5:15 p.m. with administrator A and regional nurse consultant C revealed administrator A confirmed DON B had not assumed any responsibilities previously assigned to IC nurse/ADON D.

Review of the 10/1/16 Infection Control Nurse job description revealed:
*"GENERAL PURPOSE":
-"Supervise and coordinate the multiple facets of the Infection Control Program serving under the Director of Nursing Services.
-Assure a high quality of resident care by: eliminating infection risks to residents and personnel through surveillance of multiple activities and practices, teaching information pertinent to infection control and isolation to all involved employees and implementing monitoring and surveillance programs in an effort to identify and reduce infection hazards in the facility."

Review of the 2/26/21 Infection Prevention Program revealed:
*A." INFECTION PREVENTIONIST (IP)":

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F 882	Continued From page 21 -"Responsibilities may include: collecting, analyzing, and providing infection data and trends to nursing staff and health care practitioners-surveillance and outbreak management." -"The IP has knowledge, competence, interest in infection prevention and control, appropriate qualifications including training beyond his/her degree in Infection Prevention."	F 882		