

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

PRINTED: 12/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/02/2021
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212
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F 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/30/21 through 12/2/21. Avantara Arlington was found not in compliance with the following requirements: F559, F656, F661, F685, F686, F690, F761, F880, and F881. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/30/21 through 12/2/21. Areas surveyed included nursing services. Avantara Arlington was found not in compliance with the following requirements: F656 and F686.	F 000		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on interview, record review and requested	F 559		12/30/21 1/5/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 1/5/22
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 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 559	<p>Continued From page 1</p> <p>policy review the provider failed to provide written notice to one of one resident (14) before the resident's room in the facility was changed. Findings include:</p> <p>1. Interview with resident 14 on 11/30/21 at 3:34 p.m. in her room 211 revealed: *She admitted on 8/17/21. *Her current room was the third room she had since her admission this past summer. *She currently was in the room by herself. *She stated that the last room change caught her off guard. -"I went to lunch that day and came back to find my stuff was already moved." -"I was a little upset." -"it would have been nice to get a notice."</p> <p>Review of resident 14's medical record revealed: *Two social service progress notes on 9/20/21 regarding room change to room 210 on 9/21/21. *A room change to room 211 on 9/24/21 noted in the census portion of her medical record. *No progress note relating to the 9/24/21 room change was found. *A late entry social service progress note created on 9/28/21 for 9/27/21 at 11:30 a.m. noting an appointment with resident 14's sister on 9/28/21 who "expressed concern over resident's move to another room."</p> <p>An attempted phone interview with resident 14's sister on 12/1/21 at 3:06 p.m. to discuss concerns she had with resident's room moves. This conversation did not occur as resident's sister did not answer the phone nor reply to the voice message left.</p> <p>Interview with social service designee (SSD) D on</p>	F 559	<ol style="list-style-type: none"> Resident #14 continues to reside in room 211-2. She states she is happy with her current location and does not wish to move, at this time. All residents have the potential to be affected by the deficient practice. All employees involved in the process of room change notifications will receive education, presented by the DON or designee, related to a resident's right to be notified of a room change in writing. Facility will begin using the Point Click Care tool for Room Change notification immediately. Residents and/or significant others, will be provided with a copy of the room change notification prior to the change taking place. In-service education completed 12/21/2021. The Administrator, Director of Nursing or designee will perform audits to ensure the Room Change Notification process is being utilized correctly. Audits will occur weekly for 3 months then biweekly for 3 months. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. <p>Addendum:</p> <p>#3. All individuals requiring training attended on 12/21/2021.</p> <p>#4. DON will present audits to QAPI committee.</p>	12/30/21 SP 1/5/22	

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F 559	<p>Continued From page 2</p> <p>12/1/21 at 3:30 p.m. revealed and confirmed: *She had started her position 8/21. *On 9/21/21 resident 14 and another resident had moved into room 210. *Resident 14's new roommate in room 210 expressed some concerns to SSD D over resident 14's habits. *SSD D stated the 9/24/21 room move to room 211 was discussed with resident 14 but was not documented. *On 9/24/21 a resident admission into room 210 occurred quickly, with little notice, which caused resident 14's room change out of room 210 into room 211 to happen right away. *SSD D confirmed she did not inform resident 14 on 9/24/21 either before or during the noon meal of the room change occurring that day. *The resident's 9/24/21 room move was the provider's request.</p> <p>Interview with director of nursing (DON) B and regional nurse consultant (RNC) C on 12/2/21 at 11:04 a.m. revealed: *DON B stated the room change was discussed with resident 14 prior to the room move, but was not documented. *Resident 14 has anxiety and probably did not get notified the day the room change actually occurred, which caused her to be upset.</p> <p>Interview with administrator A on 12/2/21 at 1:55 p.m. revealed: *His expectation for room changes was a 24-hour notice of room change. -Communication with the resident and/or family. -A progress note entered into the resident's medical record. *He was not aware of the resident's right to receive written notice, including the reason for the</p>	F 559		12/30/21 7/5/22	

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F 559	<p>Continued From page 3</p> <p>change, before the resident's room in the facility is changed.</p> <p>Interview with RNC C on 12/02/21 at 2:20 p.m. revealed:</p> <ul style="list-style-type: none"> *The provider had a room transfer notification within their electronic health record's assessment section. *The room transfer notification stated once the form was completed, print, and give a copy of the form to the resident, family, and/or responsible party. *The previous social service director had used this form for resident room changes. *SSD D may need to be informed of the room transfer notification form and its use. <p>Record review of the provider's Room Transfer Notification 1.2 form revealed the form contained areas that would have provided the needed areas of notification when printed and provided to the resident.</p> <p>Interview with administrator A on 12/2/21 at 2:40 p.m. revealed:</p> <ul style="list-style-type: none"> *He had just found a policy on resident room moves. *He had not reviewed or educated staff on the policy. *The policy was not in effect at the time of survey. 	F 559		12/30/21 sp 1/5/22
F 656 SS=D	<p>Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)</p> <p>§483.21(b) Comprehensive Care Plans §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</p>	F 656		12/30/21 sp 1/5/22

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F 656	<p>Continued From page 4</p> <p>§483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -</p> <p>(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</p> <p>(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).</p> <p>(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.</p> <p>(iv) In consultation with the resident and the resident's representative(s)-</p> <p>(A) The resident's goals for admission and desired outcomes.</p> <p>(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.</p> <p>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, record review,</p>	F 656	<ol style="list-style-type: none"> Care plans for residents #2 and #7 updated to reflect current needs and interventions. Resident #26 no longer resides in the facility. All residents have the potential to be affected by the deficient practice. Care plans for all residents will be reviewed, and updated, according to their MDS schedule and PRN. All staff responsible for developing, implementing, and updating resident care plans will receive education, from the DON or designee, on the importance of frequent reviews and timely updating of resident care plans. In-service education will take place on 12/28/2021. The Administrator, Director of Nursing or designee will perform audits to monitor the timely revision of care plans and CNA task records. Audits will be done by reviewing care plans of 5 residents per week x 2 months, 5 residents biweekly for 2 months and monthly for 2 months. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. <p style="text-align: right;">(12-30-21) JF 1/5/22</p>

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F 656	<p>Continued From page 5</p> <p>and policy review, the facility did not develop comprehensive person-centered care plans for 3 of 12 sampled residents (2, 7, and 26) whose care plans were reviewed. Findings include:</p> <p>1. Review of resident 2's medical record revealed he had hearing loss and impaired skin integrity to his bilateral feet. His 12/28/20 admission care plan revealed:</p> <ul style="list-style-type: none"> *His hearing loss and use of hearing aids had only been addressed under the activities of daily living interventions. The intervention was informational only. It was not triggered as a task to assist him with his hearing aids. *The only area that had addressed his actual skin alteration had been included in the focus area for bowel and bladder elimination. *There were no interventions related to his chronic skin breakdown to his bilateral feet. <p>Review of resident 2's November 2021 and December 2021 treatment administration records revealed staff were to:</p> <ul style="list-style-type: none"> **Remove hearing aids and put in treatment cart. The treatment was initiated on 12/28/20. **Moisturize (lotion) feet and lower extremities daily every day shift for dryness. The treatment was initiated on 3/1/21. **Left Second Toe Wound Treatment: Cleanse with wound cleanser and cover with bandage. Monitor for signs of infection. every day shift for open areas. The treatment was initiated on 9/8/21 and discontinued on 11/3/21. **Monitor for redness, warmth, & temperature. every day shift." The treatment was initiated on 9/15/21. **Vaseline gauze and ADB [ABD-abdominal dressing] to right shin blister/open area and Band-Aid to 4th metatarsal skin tear every day 	F 656	<p>Addendum:</p> <p>#3. Staff identifying changes in resident cares will either update the care plan and notify the MDS Nurse/DON or given written information to the MDS Nurse/DON so changes can be made. All resident care plans are reviewed and revised with each MDS assessment, as well as PRN, and approved by the care plan team. Any staff not present at in-service received education prior to their next scheduled</p>	12/30/21 3 1/5/22
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F 656	<p>Continued From page 6</p> <p>shift." The treatment was initiated on 10/12/21 and discontinued on 11/12/21.</p> <p>**Check feet frequently and if skin under toes becomes macerated or moist start Betadine gauze again. every day shift for wound monitor." The treatment was initiated on 10/13/21.</p> <p>**Vaseline gauze and ADB [ABD-abdominal dressing] to right shin blister/open area every day shift." The treatment was initiated on 11/13/21 and discontinued on 11/15/21.</p> <p>**Betadine soaked gauze in between toes until closed then dc. every day shift for maceration to right third toe." The treatment started on 11/13/21 and was discontinued on 11/29/21.</p> <p>**Apply Vaseline gauze and kling to right shin skin tear until closed then dc [discontinue] every day shift for skin tear." The treatment was initiated on 11/25/21.</p> <p>Interview on 12/2/21 at 11:15 a.m. with director of nursing B revealed:</p> <p>*His treatments had changed on 11/29/21 as some of it was now healed.</p> <p>*She was the only person who updated the care plans.</p> <p>*This was done when information was given to her.</p> <p>*Minimum Data Set/registered nurse (MDS) (RN) coordinator K did not revise the care plans.</p> <p>*The nurses did not update the care plans.</p> <p>2. Review of resident 26's medical record revealed:</p> <p>*Was hospitalized for a left hip fracture and readmitted on 10/19/21. He had not pressure injuries at that time.</p> <p>*10/23/21 a stage two pressure injury to his left buttock was found measuring 1 centimeter (cm) length x 1 cm width x 0.1 cm depth .</p>	F 656		12/30/21 S 1/5/22	

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F 656	<p>Continued From page 7</p> <p>*10/27/21 the documentation reflected an increase in measurements to 4.2 cm length x 4.5 cm width x 0.4 depth.</p> <p>*11/3/21 the documentation indicated it was now a stage four pressure injury that measured 7 cm length x 5 cm width x 0 cm depth.</p> <p>*A additional suspected deep tissue injury wound had developed to his left heel and measured 4 cm length x 9 cm width x 0.0 cm depth.</p> <p>Interview on 12/2/21 at 2:00 p.m. with the MDS/RN coordinator K revealed she:</p> <p>*Did most of the care planning.</p> <p>*Revised the care plan based on the care care assessment (CAA) with annual and significant change of condition MDS assessments only.</p> <p>*Had been instructed not to make the care plans very long.</p> <p>*Did not care plan for altered skin integrity as his pressure injuries had occurred after his admission assessment.</p> <p>*Did complete dressing changes during the week day mornings when needed.</p> <p>Refer to F686 finding 1.</p> <p>Surveyor: 45383</p> <p>3. Record review of resident 7's progress notes from socials services dated 1/6/21 revealed:</p> <p>*Her mother had died 12/26/20, and it had been difficult for her.</p> <p>Record review of social services note 1/6/21 revealed :</p> <p>*She had gone with her mother to the casino and always had a good time.</p> <p>Record review of resident 7's care plan dated 1/2/21 revealed:</p> <p>*She was at risk for isolation due to her lack of</p>	F 656	<p>12/30/21 Jr 4/5/22</p>

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F 656	Continued From page 8 Interest in independent or one to one activities. *She did not like to participate in any group activities. *She required assistance to participate in leisure time activities such as: watching TV, listening to music, and talking on the phone with her family. *No interventions included playing cards. *No interventions included using handheld gaming devices. Interview with social services designee D on 12/1/21 at 8:45 a.m. revealed: *She had been at her current position since August 2021. *Stated she had tried to go in and visit with resident 7. *Had not known she and her mother went to the casino together. *Had not tried playing cards with resident. Had not offered any handheld gaming device for resident. Review of provider's September 2019 Care plan policy revealed individual , resident centered care plans would have been initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while living here.	F 656		12/30/21 5/4/22	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,	F 661		12/30/21 5/4/22	

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F 661	<p>Continued From page 9 radiology, and consultation results.</p> <p>(ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on record review and interview, the provider failed to ensure: *A summary of stay was completed for one of one sampled discharged resident (27). *Documentation for an accurate accounting of disposal of or medications for one of one sampled discharged residents (27). Findings include: 1. Review of resident 27's medical record revealed: *She was discharged home on 10/6/21. *A brief 12:00 p.m. discharge statement that did not include an interdisciplinary summary of her stay.</p>	F 661	<ol style="list-style-type: none"> Resident #27 no longer resides in the facility. All residents have the potential to be affected by the deficient practice. All members of the Interdisciplinary Team (IDT), and other staff responsible for assisting residents to discharge, will receive training, presented by the DON or designee, on the utilization of the Point Click Care Discharge Summary tool and proper disposition of medications. Tool will be initiated immediately with copies to be provided to the resident and/or their significant others. Medication Disposition Records will be kept in the resident's medical record upon discharge. Education completed 12/21/2021. Administrator, DON or designee will perform weekly audits of discharge planning documentation for all residents planning to discharge, or who have discharged. Audits will occur weekly for 3 months and then biweekly for 3 months. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. <p>Addendum:</p> <p>#3. All individuals requiring training attended on 12/21/2021.</p> <p>#4. DON will present audits to the QAPI committee.</p>	12/29/21 SP Yshz
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/02/2021
NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212	
(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 661	Continued From page 10 *No disposition summary of the medications sent home with her. *No physician's order to send medications with her. Interview on 12/1/21 at 3:00 p.m. with director of nursing B revealed: *The discharge summary was in the interdisciplinary notes. *They did not have a separate discharge summary form that included all disciplines documentation. *Agreed no disposition of medications had been completed. *There was no policies for a discharge summary or the disposition of medications.	F 661		12/30/21 jr Y5/22
685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation, interview, and record review, the provider failed to ensure one of one sampled resident (2) with a moderate hearing	F 685		12/30/21 SP Y5/22

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F 685	<p>Continued From page 11</p> <p>loss had been offered the use of his hearing aids. Findings include:</p> <p>1. Review of resident 2's November 2021 treatment administration record revealed he was to have his hearing aids placed in his ears in the morning and removed in the evening. The hearing aids were stored in the treatment cart. There was documentation the hearing aids had been put in and taken out on 11/30/21 and 12/1/21.</p> <p>Random observations on 11/30/21 from 8:30 a.m. through 4:30 p.m. revealed resident 2 did not have his hearing aids placed in his ears. .</p> <p>Observation and interview on 12/1/21 at 8:15 a.m. regarding resident 2 with certified nursing assistant (CNA) L revealed resident 2 did not have his hearing aids placed in his ears. CNA L stated she did not know that he wore any hearing aids.</p> <p>Observation and interview on 12/1/21 at 9:15 a.m. of resident 2 with licensed practical nurse I revealed: *He had been at breakfast, so she had not put the hearing aids in. *She looked in the treatment cart and took them out of the case and realized the batteries were not working. *She realized they were the rechargeable kind and took them to director of nursing (DON) B to find out how to charge them.</p> <p>Observation on 12/2/21 from 8:30 a.m. through 10:30 a.m. revealed resident 2 did not have his hearing aids placed in his ears.</p>	F 685	<ol style="list-style-type: none"> 1. Treatment Record and CNA Task Sheets updated for resident #2 to address hearing aid insertion, removal, and storage when not in use. 2. All residents have the potential to be affected by the deficient practice. All residents with hearing aides will have documentation cues provided to care givers on what assistance they require with insertion, removal, and storage of the device. 3. Staff responsible for assisting residents with insertion, removal, and storage of hearing devices will receive education from the DON or designee, on how these tasks will now be documented in the Treatment Record as well as through the CNA Task lists on 12/28/2021. 4. Administrator, DON or designee will perform audits 3 times per week for 2 months, biweekly for 2 months and monthly for 2 months, of all residents who require a hearing device. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. 	12/30/21 * 1/5/22

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F 685	Continued From page 12 Interview at 10:00 a.m. with Minimum Data Set coordinator, registered nurse (MDS) (RN) K revealed she: *Had not put resident 2's hearing aids in his ears as he was lying down after breakfast. *Went to get them out of the treatment cart and they were not there. *Was not sure where the hearing aids were located. Interview on 12/2/21 at 11:04 a.m. with DON B and regional nurse consultant (RNC) C regarding resident 2's hearing aids revealed: *There had been confusion of where the hearing aids were this morning and yesterday morning. *They had to be charged and the activities department were the only ones who had the correct cord to plug them in. *DON B did not respond regarding the documentation had indicated he had his hearing aids in on 11/30/21 and 12/1/21. Review of resident 2's 12/28/20 care plan focus for his need for assistance with his activities of daily living due to cognitive impairment, stroke with right side weakness, and balance problems revealed one intervention for his hearing. *Hearing minimal difficulty hearing with bilateral hearing aides....." There were no other interventions regarding his hearing and who would assist him with the placement. A policy on hearing aids and hearing impairment had been requested on 12/2/21 from RNC C. She stated they did not have a policy regarding to hearing aids.	F 685	Addendum: #3. Any staff not present at in-service received education prior to their next scheduled shift. #4. DON will present audits to the QAPI committee.	12/30/22 JF 1/5/22
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(I)(II)	F 686		

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F 886	<p>Continued From page 13</p> <p>§483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-</p> <p>(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</p> <p>(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Surveyor: 45383 Based on observation, interview, record review, and policy review, the provider failed to ensure:</p> <p>*One of one sampled discharged resident (26) with a facility acquired pressure ulcer received care, on-going assessments, and interventions to prevent the pressure ulcer from worsening.</p> <p>*One of one sampled resident (7) with an pressure ulcer received care, on-going assessments, and interventions to assist with the healing process.</p> <p>*One of one sampled resident (2) with chronic wounds to his bilateral toes received care, on-gong assessments, and interventions to prevent further impaired skin integrity.</p> <p>Findings include:</p> <p>1. Review of resident 26's discharged electronic medical record revealed: *Hed fallen on 9/14/21. *Transferred to emergency room (ER) and had a left hip fracture.</p>	F 886	<p>12/30/21 x 1/5/22</p> <ol style="list-style-type: none"> 1. Resident #26 no longer resides at facility. Resident #7 has had care plan and Point of Care (POC) charting updated to reflect repositioning at least every 2-3 hours. Air mattress functioning without issue and continues to be checked every shift by a nurse. Resident #2's wounds noted during survey have resolved. 2. All residents have the potential to be affected by the deficient practice. All residents requiring assist with repositioning have had care plans updated and POC charting updated for CNA documentation. Air mattresses checked by nurse every shift and documented on Treatment Record. Pressure reducing devices checked and replaced where needed. 3. All staff providing resident cares will receive education from the DON or designee, on how to prevent and/or heal pressure ulcers and other skin conditions. Education will occur on 12/28/2021. Education will include repositioning, air mattress management, skin assessments and documentation of the same.

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F 886	<p>Continued From page 14</p> <p>*Returned from the hospital on 9/20/21.</p> <p>*Admission assessment noted an incision to his left hip.</p> <p>*Weekly skin assessments performed revealed:</p> <p>*On 9/24/21 to 10/19/21 left hip incision.</p> <p>*On 10/23/21 stage 2 pressure ulcer to left buttock measuring 1 centimeter (cm) length x 1 cm width x 0.1 cm depth.</p> <p>*On 10/27/21 stage 2 pressure ulcer to left buttock measuring 4.2 cm length x 4.5 cm width x 0.4 depth.</p> <p>-The wound had deteriorated, drainage was present, and the resident had pain with the dressing changes.</p> <p>*On 11/3/21 stage 4 pressure wound to left buttock measured 7 cm length x 5 cm width x 0 cm depth.</p> <p>-The wound had continued to deteriorate, drainage was present, and the resident had pain with the dressing changes.</p> <p>*An Additional suspected deep tissue injury wound noted to left heel measured 4 cm length x 9 cm width x 0.0 cm depth.</p> <p>-The resident had pain with the dressing change.</p> <p>Readmission Nursing Assessment dated 9/20/21 revealed:</p> <p>*It had been documented as a right hip surgical incision. "</p> <p>*His incision was on his left hip.</p> <p>*Skin assessment had not addressed monitoring of his skin integrity with mobility and incontinence.</p> <p>*The non-pressure ulcer section is where the left hip dressing had been documented.</p> <p>Interview on 12/2/21 at 11:00 a.m. with director of nursing (DON) B regarding repositioning resident 26 revealed:</p> <p>*Stated he was up in his wheelchair for meals.</p>	F 886	<p>4. Administrator, DON or designee will perform weekly audits. Skin assessments will be audited weekly for 5 residents for 2 months, biweekly for 2 months, monthly for 2 months. Repositioning audits to take place 4 x per week for 2 months, biweekly for 2 months, monthly for 2 months. Audits to be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease.</p> <p>Addendum:</p> <p>#1- Resident #2 has daily monitoring in place to observe for any changes in skin condition of his feet. Monitoring is performed by the daily treatment nurse.</p> <p>#3. Any staff not present at in-service received education prior to their next scheduled shift.</p> <p>#4. DON will present audits to the QAPI committee.</p>	12/30/21 X 1/5/22

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F 686	<p>Continued From page 15</p> <ul style="list-style-type: none"> *Encouraged him to lie down after meals. *Would be taken to the bathroom for toileting before and after meals. *States that he was repositioned more than every 2 hours with meals and toileting. *Unable to provide documentation for repositioning. *Had no response for nighttime repositioning. <p>2. Observation and interview on 11/30/21 at 8:25 a.m. with resident 7 revealed:</p> <ul style="list-style-type: none"> *She was lying in her bed that had an air mattress. *The air mattress was not fully inflated in the middle section. *Wore egg crate heel protectors. *Had indentations to the top of her feet from the heel protectors. *Did not use call light for help. *She was waiting for her breakfast that she eats in bed. *She denied any pain. <p>Observation and interview on 11/30/21 at 11:19 a.m. with resident 7 revealed:</p> <ul style="list-style-type: none"> *She was lying on her back in bed. *Stated she was somewhat comfortable . <p>Observation and interview on 11/30/21 at 2:13 p.m. with resident 7 revealed:</p> <ul style="list-style-type: none"> *The head of her bed was in a high position. *Stated she does not have that much pain. *She had finished eating lunch in her bed. <p>Observation 11/30/21 at 3:00 p.m. resident 7 was sitting with the head of her bed in a high position.</p> <p>Interview 11/30/21 at 4:20 p.m. with DON B regarding resident 7 and her pressure ulcers</p>	F 686		12/30/21 to 1/5/22	

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F 686	<p>Continued From page 16 revealed:</p> <ul style="list-style-type: none"> *Resident was admitted with the sacral ulcer and the ulcer to her left foot. *She had the air mattress on her bed since she had been admitted. *Was not aware the air mattress was not fully inflated. *Stated it was to be checked every shift to make sure of Inflation and functioning. *Was not aware that resident had egg crate heel protectors on. *Had known that the resident had indentations on her left foot from the egg crate heel protectors. *Stated that resident was to have been repositioned every two hours. *There was no turning and repositioning document that was filled out by staff. *Was not aware that resident had the head of her bed elevated since lunch time. *Lunch had been served at 12:00 p.m. <p>Observation and interview on 12/1/21 at 8:45 a.m. with resident 7 revealed:</p> <ul style="list-style-type: none"> *The head of her bed was elevated. *She was eating breakfast. <p>Observation on 12/1/21 at 12:45 p.m. of resident 7 revealed:</p> <ul style="list-style-type: none"> *She was lying on her back in bed eating lunch. *The head of her bed was not elevated. <p>Observation of wound care on 12/1/21 at 3:00 p.m. for resident 7 revealed:</p> <ul style="list-style-type: none"> *She was lying in the same position as the previous observation at 12:45 p.m. *When the resident was rolled to her left side grooves were noted to her back from the wound vacuum tubing and from the wrinkles from the soaker pad. 	F 686		12/30/21 SP 1/5/22	

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F 686	<p>Continued From page 17</p> <ul style="list-style-type: none"> *Staff changed the dressing to her left foot. *Her bilateral feet had dry flaky skin. *Her toenails were longer than her toes on both feet. *The Foley catheter tubing pulled tight with no securing device. <p>Interview on 12/1/21 at 4:00 p.m. with licensed practical nurse (LPN) I and RN J revealed:</p> <ul style="list-style-type: none"> *Resident 7 should be repositioned every 2 hours even though she is on an air mattress. *Were not aware that there was no repositioning task. *Were not aware that catheter care was not a task. <p>Interview on 12/2/21 at 2:00 p.m. with MDS coordinator/RN K revealed:</p> <ul style="list-style-type: none"> *She was responsible for most of the care planning. *The care plan was updated based on the CAA's. *She only updated the care plan annually or with a significant change. *Agreed the resident did not have a person centered care plan regarding her frequent infections. *A turning and repositioning schedule had not been initiated as an intervention on the care plan. *That was due to fear of non-compliance if task was not completed on time. <p>Surveyor: 26632</p> <p>3. Observation and interview on 12/1/21 at 9:15 a.m. of resident 2 with LPN I during treatments to his bilateral feet revealed:</p> <ul style="list-style-type: none"> *His toenails on both of his great toes were long and thick. They extended more than a quarter of an inch beyond the end of his toes. 	F 686		12/30/21 8/4/22
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F 686	<p>Continued From page 18</p> <p>*The second joints of his 2nd, 3rd, and 4th toes on both feet had scabbed areas.</p> <p>*Has diabetic shoes but mostly use gripper socks to prevent falls.</p> <p>*Had not seen a podiatrist regarding his feet.</p> <p>*She stated this has been ongoing with his toes since his admission December 2020.</p> <p>*The skin on his legs and feet were very dry and flaky.</p> <p>Review of resident 2's medical record revealed:</p> <p>*He had diagnoses that included diabetes mellitus with diabetic polyneuropathy.</p> <p>*He had received Keflex 500 milligram twice a day for seven days, from 11/15/21 at 6:00 p.m. through 11/23/21 at 8:00 a.m. dose for red warm toes on his right foot.</p> <p>*A 11/22/21 monthly nursing summary revealed:</p> <ul style="list-style-type: none"> -He did not require a referral to a podiatrist. -He had a medical diagnoses of insulin dependent diabetes mellitus that required advanced foot care. -He did not require a referral for a nursing intervention or for advanced foot care. -"Currently receiving treatment with Betadine between right foot toes due to MASD [moisture associated skin damage] to right lateral third toe with area almost dry." <p>*A 11/22/21 foot and oral health evaluation revealed he:</p> <ul style="list-style-type: none"> -Did not have any cracks between or beneath his toes. -Did not have any open sores on his legs or feet. -Had dry flaky skin. -Did not have overgrown or thickened toenails. -Did not require a podiatrist evaluation. <p>Interview on 12/2/21 at 11:30 a.m. with DON B revealed:</p>	F 686		12/30/21 5/15/22	

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F 686	<p>Continued From page 19</p> <p>*There was no podiatrist that came to the facility. *She had thought of trying to find a podiatrist to come to the facility. *The open area on resident 2's foot had been healed on 11/30/21. *Was not aware of the condition of his toenails or the tops of his toes.</p> <p>Review of the provider's revised April 2021 Skin Program policy revealed: **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 included interventions to: a) Protect skin against the effects of pressure, friction, and sheer, b) Protect skin from moisture, c) Encourage optimal nutrition and fluid intake, d) Educate staff, residents and families, 3) Train front-line caregivers, and f) Immediate prevention plan instituted when potential areas are identified." **When a pressure injury, bruise or skin tear is noted, a Skin Evaluation UDA [user defined assessments] should be completed, and the injury entered into Risk Management in PCC [point click care]. These areas will be monitored on a Treatment Administration Record (TAR) until healed." *Skin checks were to be completed at least weekly by a licensed nurse.</p>	F 686		12/30/21 JP 4/5/22
F 690 SS=G	<p>Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)</p> <p>§483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to</p>	F 690		12/30/21 JP 4/5/22

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F 690	<p>Continued From page 20</p> <p>maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.</p> <p>§483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-</p> <p>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;</p> <p>(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</p> <p>(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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview, record review, and policy review, the provider failed to ensure: *One of one sampled resident (7) with an indwelling urinary catheter had been monitored for frequent urinary tract and vaginal infections. *One of one sampled discharged resident (27)</p>	F 690	<ol style="list-style-type: none"> 1. Resident #27 no longer resides in the facility. Resident #7 has had catheter care added to the POC CNA documentation with nurse double-check documented on Treatment Record. 2. All residents with catheters have the potential to be affected by the deficient practice. 3. All staff responsible for working with urinary catheters will receive education from the DON or designee, regarding appropriate diagnosis, catheter care importance and frequency, positioning of catheter tubing for prevention of UTIs and skin breakdown on 12/28/2021. 4. Administrator, Director of Nursing, or designee will perform catheter diagnosis, care and positioning audits on all residents with catheters weekly x 2 months, biweekly x2 months, monthly x 2 months. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. 	12/30/21 SP 1/5/22	

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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212	
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F 690	<p>Continued From page 21</p> <p>had a physician documented diagnosis for the use of an indwelling urinary catheter. Findings include:</p> <p>1. Record review of resident 7's nursing progress note on 3/4/21 revealed: *Resident was noted to have discharge from her vaginal area. *A fax had been sent to the resident's doctor. *An order had been received to start Bactrim DS orally twice a day for five days.</p> <p>Record review of resident 7's nursing progress notes revealed on: *5/13/21 at 3:27 p.m. "dried blood on foley [urinary catheter]. No active bleeding noted. Anchored foley." *8/27/21 at 8:50 a.m. she had dried blood between her legs and urine in her bed. Catheter appeared to still be in place. *9/2/21 at 8:11 a.m." Resident had thick, milky discharge from vagina during the night. CNA [certified nursing assistant] this a.m. noted blood by vaginal area as well as thick white discharge. Foley catheter leaking." *9/2/21 at 3:20 p.m. order was received to start Fluconazole 100 mg (milligrams) orally every other day for three days. -Physician wrote "if continue vaginal bleeding with no history of a hysterectomy, may need pelvic imaging." -Resident 7 would need further evaluation if no improvement from medication. *10/8/21 at 8:42 p.m. Foley catheter was changed due to clogging. *10/10/21 at 6:46 p.m. urine was noted to have more mucous. -Fax was sent to the doctor. *10/12/21 at 1:23 p.m. no urine was noted.</p>	F 690	<p>Addendum:</p> <p>#3. Any staff not present at in-service received education prior to their next scheduled shift. #4. DON will present audits to the QAPI committee.</p> <p>12/30/22 P 1/5/22</p>

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F 690	<p>Continued From page 22</p> <ul style="list-style-type: none"> -The catheter was irrigated, but it had not helped. -Foley catheter changed due to leaking urine. *10/12/21 at 7:46 p.m. urine was yellow and thick with mucous in the tubing. *10/13/21 resident had thick mucus urine noted in Foley catheter tubing. -Resident had no fever or complaints of discomfort. -Fax was sent to the resident's doctor. -A physician's order had been received on 10/13/21 at 2:00 p.m. to start Ciprofloxacin 250 mg orally twice a day for five days and Fluconazole 100 mg oral daily for three days. <p>Interview on 11/30/21 at 4:20 p.m. with director of nursing (DON) B regarding urine/vaginal cultures and antibiotic stewardship revealed:</p> <ul style="list-style-type: none"> *Had not done a urinalysis prior to starting the antibiotic *Had not collected a vaginal swab and culture prior to starting an antibiotic *Would hope that cultures had been obtained prior to starting antibiotics. *Resident did not exhibit any other symptoms. <p>Interview on 12/2/21 at 11:00 a.m. with DON B about monitoring antibiotic use:</p> <ul style="list-style-type: none"> *No cultures had been obtained before starting antibiotic therapy. *Catheter care was not on the task list for staff to sign off. *Catheter care was on cardex and care plan. *Repositioning was not on the task list for staff to sign off. *DON B had not been following antibiotic stewardship. *Had not been concerned with the number of vaginal infections resident 7 had been treated for. 	F 690		12/30/21 SP 1/5/22	

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F 690	Continued From page 23 Surveyor: 26632 2. Review of resident 27's medical record revealed: *She had been admitted on 8/11/21 with no urinary catheter. *Her hospital discharge summary revealed overactive bladder was the only diagnosis related to the urinary tract. *She had a large wound on her leg from a fall at home. *Nurses health status notes on: -8/12/21 at 7:40 a.m. revealed: "Resident insisted she needed to use a bed pan, but her urine runs places other than the bed pan." -8/12/2021 at 10:10 a.m. she was assisted off the bedpan. Due to decreased lack of motion in her hips to move her legs urine tended to flow up and over her legs. "Resident states she wouldn't mind having a catheter. Writer states she will contact physician to see what he thinks." -8/12/2021 at 4:25 p.m. "Order received allowing insertion of indwelling catheter temporarily. Resident showing signs of urinary retention and/or obstruction. Foley 16Fr [French] 10ml [milliliter] urinary catheter inserted after 2 attempts. Urine flowing freely into collection bag, pale yellow without sediment. Resident encouraged to drink fluids to help prevent infection related to catheter placement." -9/5/2021 at 10:20 a.m. "FAX sent to provider to see if Foley should be discontinued as mobility has increased. This was discussed with resident and she verbalizes understanding. Resident did ambulate from bed to recliner this morning with assist of one. Encouraged to rest in recliner, instead of wheelchair, unless she is going to meals or activities." -9/9/2021 at 11:25 a.m. "Foley catheter	F 690		12/30/21 jr 1/5/22

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F 690	<p>Continued From page 24 discontinued per MD [medical doctor] order.</p> <p>Review of an 8/12/21 physician's order for the insertion of a urinary catheter revealed the order had been received from the resident's primary physician and there were no diagnosis indicated on the order by the physician. DON B had sent the request to the primary physician and had indicated resident 27 had urinary retention.</p> <p>Interview on 12/1/21 at 3:00 p.m. with regarding the diagnosis of urinary retention for resident 27 revealed: *The urologist had given the order when she asked for the catheter. *She had stated she had faxed the urologist for the order. *She confirmed the order had been received from resident 27's primary physician and not the urologist as she had stated above. *She agreed she had put the diagnosis of urinary retention in even though there had been no physician documentation of that diagnosis.</p> <p>Review of the provider's September 2019 Catheter Care policy and Catheter Care competency and interview with regional nurse consultant C revealed those were the only documents related to urinary catheter use.</p>	F 690		12/30/21 JP YS/22
F 761 SS=D	<p>Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)</p> <p>§483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when</p>	F 761		12/30/21 JP YS/22

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F 761	<p>Continued From page 25 applicable.</p> <p>§483.45(h) Storage of Drugs and Biologicals</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on observation and interview, the provider failed to ensure controlled medications were secured for one of two medication carts (evening/night cart). Findings include:</p> <p>1. Observation on 11/30/21 at 8:13 a.m. of the evening/night medication cart revealed the drawer that held the controlled medications was not locked. It contained blister packs of the following medications: *Tramadol 50 milligram (mg) 15 tablets. *Tramadol 50 mg 20 tablets. *Tramadol 50 mg 19 tablets. *Tramadol 50 mg 29 tablets. *Hydrocodone extended release (ER) 10 mg 11 capsules. *Oxycodone 5 mg/325 mg 30 tablets.</p>	F 761	<ol style="list-style-type: none"> 1. Pharmacy was notified of cart malfunction on 11/30/2021 upon discovery. Parts were delivered to facility and drawer was repaired prior to the end of business day on 11/30/2021. 2. All residents could be affected by the deficient practice. 3. All staff responsible for medication administration will receive education from the DON or designee, regarding reporting of malfunctioning medication delivery equipment on 12/28/2021. 4. Administrator, Director of Nursing or designee will audit all medication and treatment carts for signs of malfunctioning 1 time per week for 2 months, biweekly x2 months, monthly x2 months. Audits will be reviewed by the QAPI Committee where it will be determined if continued auditing should occur or if audits may cease. <p>Addendum.</p> <p>#3. Any staff not present at in-service received education prior to their next scheduled shift. Education included how to intervene if a non-authorized individual should attempt to access the Medication carts.</p> <p>#4. DON will present audits to the QAPI committee.</p>	12/30/21 SP 1/5/22
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F 761	<p>Continued From page 26</p> <ul style="list-style-type: none"> *Oxycodone 5 mg 3 tablets. *Hydrocodone 10 mg/325 mg 7 tablets. *Hydrocodone 5 mg/325 mg 13 tablets. *Lorazepam 1 mg 21 tablets. *Clonazepam 0.5 mg 7 tablets. <p>While documenting the above medications registered nurse (RN) N came to the cart and retrieved something out of the top drawer. She did not inquire why the controlled medication drawer was open.</p> <p>Interview on 11/30/21 at 8:45 a.m. with RN N revealed:</p> <ul style="list-style-type: none"> *She was the nurse from the night shift. *There were two medication carts the day medication cart and the evening/night medication cart. *The medication cart that had been unlocked was the evening/night medication cart. <p>Interview on 11/30/21 at 9:22 a.m. director of nursing (DON) B revealed:</p> <ul style="list-style-type: none"> *There had been problems with the drawer slides on medication carts. *She was going to call the pharmacy, who provided the medication carts, today 11/30/21. *She knew the day medication cart had problems with the drawer slides. *She had worked a night shift last week and the evening/night cart did not have that problem. <p>Interview on 12/2/21 at 11:00 a.m. with DON B and regional nurse consultant C revealed there was no policy for medication control.</p>	F 761		12/30/21 JP 1/5/22
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/20/21 JP 1/5/22

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F 880	<p>Continued From page 27</p> <p>§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.</p> <p>§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:</p> <p>§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;</p> <p>§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 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,</p>	F 880	<p><u>Directed Plan of Correction</u></p> <p><u>Avantara Arlington</u></p> <p><u>F880 & F881</u></p> <p>Corrective Action:</p> <p>1. For the identification of lack of:</p> <p>*Comprehensive infection control program that includes an Antibiotic Stewardship program.</p> <p>Ensure DON completes infection control training and provides training and guidance to staff about Antibiotic Stewardship. The administrator, DON, and/or designee in consultation with the medical director will review, revise, create as necessary policies and procedures for dressing change and ensure continuation of removal plan.</p> <p>All facility staff who provide or are responsible for the above cares and services will be educated/re-educated on 12/28/2021 by the Director of Nursing.</p>	12/30/21 1/5/22

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F 880	<p>Continued From page 28</p> <p>depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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: Surveyor: 26632 Based on interview and policy review, the provider failed to have a comprehensive infection control program. Findings include:</p> <p>1. Interview on 12/2/21 at 11:46 a.m. with director of nursing B revealed: *She was in the process of taking the infection preventionist course. *Kept a list of residents who had used antibiotics. *Did not track or trend infections.</p>	F 880	<p>Identification of Others:</p> <p>2. ALL residents and staff have the potential to be affected if infection control and antibiotic stewardship not adhered to. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 12/30/2021 by the Director of Nursing.</p>	12/30/21 21 1/5/22
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F 880	<p>Continued From page 29</p> <p>Review of the provider's November 2019 Infection Prevention Surveillance policy revealed: *The infection preventionist/designee would complete surveillance of infections for residents and employees. The surveillance activities included: -Review of culture reports and other pertinent laboratory data. -Review of the infections and antibiotic use tool kit, multi-drug resistant organisms (MDRO) line listing, employee infection record, 24-hour report, progress notes and/or morning start-up meeting. -Physician consultation. -Observations of infection prevention practices.</p>	F 880	<p>System Changes:</p> <p>3. Root cause analysis conducted answered the 5 Whys. Initial discussion held by Interdisciplinary Team held on 12/23/2021.</p>	12/30/21 SP 1/5/22
F 881 SS=E	<p>Antibiotic Stewardship Program CFR(s): 483.80(a)(3)</p> <p>§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:</p> <p>§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: Surveyor: 26632 Based on interview and policy review, the provider failed to have an ongoing Antibiotic Stewardship program. This failure placed residents at risk for potential adverse outcomes, associated with the inappropriate and/or unnecessary use of antibiotics. Findings included:</p> <p>1. Interview on 12/2/21 at 11:00 a.m. with DON B about monitoring antibiotic use:</p>		<p>Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) of ensuring infection control practices and antibiotic stewardship have received education/training with demonstrated competency and documentation. Guidance on completion of "5 Why Root Cause Analysis" process and how it will be presented upon revisit by State Surveyors received from the South Dakota Quality Improvement Organization (QIN) on 12/23/2021.. Resources available through the Great Plains QIN website to assist with program formation and maintenance.</p>	

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F 881	<p>Continued From page 30</p> <p>*DON B had not been following antibiotic stewardship.</p> <p>*She tried to keep a list of what residents were on antibiotics.</p> <p>*She confirmed the use of antibiotics had not been included in the quality assurance performance improvement plan.</p> <p>Review of the provider's November 2019 Infection Prevention Surveillance policy revealed no mention of an antibiotic stewardship program.</p> <p>Core elements of antibiotic stewardship for nursing homes is as follows:</p> <p>*Improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority.</p> <p>*Antibiotic stewardship refers to a set of commitments and actions designed to "optimize the treatment of infections while reducing the adverse events associated with antibiotic use."</p> <p>Sited from CDC website: cdc.gov/antibiotic-use/core-elements/nursing-homes.</p>		<p>Monitoring:</p> <p>4. Administrator, DON, and/or designee will conduct auditing and monitoring to ensure appropriate infection control practices by all staff and antibiotic stewardship is practiced. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment.</p> <p>*Staff compliance in the above identified area.</p> <p>*Any other areas identified through the Root Cause Analysis.</p> <p>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 administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.</p> <p>Date certain 12/30/2021.</p> <p>Addendum:</p> <p>#3. Any staff not present at in-service received education prior to their next scheduled shift.</p>	<p>12/30/21 1/5/22</p>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 436060	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON			STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212	
(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
E 000	Initial Comments Surveyor: 16385 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 11/30/21 through 12/2/21. Avantara Arlington was found in compliance.	E 000		/

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



TITLE

Administrator

(X6) DATE

1/5/22

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.

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

PRINTED: 12/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435050	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/30/2021
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD ARLINGTON, SD 57212
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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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K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/30/21. Avantara Arlington was found in compliance with 42 CFR 485.623 (d) (1) requirements for Long Term Care Facilities.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Administrator

(X6) DATE

1/5/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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.

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/30/21 through 12/2/21. Avantara Arlington was found not in compliance with the following requirement: S296.	S 000		
S 296	44:73:07:11 Director of Dietetic Services A full time dietary manager who is responsible to the administrator shall direct the dietetic services. Any dietary manager that has not completed a Dietary Manager's course, approved by the Association of Nutrition & Foodservice Professionals, shall enroll in a course within 90 days of the hire date and complete the course within 18 months. The dietary manager and at least one cook must shall successfully complete and possess a current certificate from a ServSafe Food Protection Program offered by various retailers or the Certified Food Protection Professional's Sanitation Course offered by the Association of Nutrition & Foodservice Professionals, or successfully completed equivalent training as determined by the department. Individuals seeking ServSafe recertification are only required to take the national examination. The dietary manager shall monitor the dietetic service to ensure that the nutritional and therapeutic dietary needs for each resident are met. If the dietary manager is not a dietitian, the facility shall schedule dietitian consultations onsite at least monthly. The dietitian shall approve all menus, assess the nutritional status of residents with problems identified in the assessment, and review and revise dietetic policies and procedures during scheduled visits. Adequate staff whose working hours are	S 296	<ol style="list-style-type: none"> 1. No individual resident was found to be affected by the deficient practice. 2. All residents have the potential to be affected by the deficient practice. 3. Dietary Manager will choose 1-2 dietary employees to complete the ServSafe Certification course. Students will be enrolled in an approved ServSafe training program no later that 12/30/2021. 4. Dietary Manager is establishing training date. Administrator to monitor to ensure education dates are met. 5. Date Certain 12/30 2021. 	12/30/21 JP Y/g22

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

John Paulson

TITLE

Administrator

(X6) DATE

1/5/22

JAN 06 2021

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10692	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2021
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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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) COMPLETE DATE
S 296	<p>Continued From page 1</p> <p>scheduled to meet the dietetic needs of the residents shall be on duty daily over a period of 12 or more hours in facilities.</p> <p>This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on interviews and record review the provider failed to ensure at least one cook possessed a current ServSafe Food Protection Program certificate. Findings include:</p> <p>1. Interview on 11/30/21 at 9:26 a.m. with dietary manager (DM) E revealed: *He had been the provider's dietary manager since 10/21/19. *He was the only staff person in the kitchen that had a current ServSafe certificate. *He had been aware the dietary manager and at least one cook needed to have a current ServSafe certificate. *He was working on getting two other staff ServSafe certified.</p> <p>Interview on 12/1/21 at 2:40 p.m. with DM E regarding plans for ServSafe certification for staff revealed and confirmed he needed to: *Ask staff about ServSafe certification and their interest. *Set up dates for ServSafe training and exam with his staff. *Establish definite plans for obtaining ServSafe certification for staff.</p> <p>Interview on 12/1/21 3:19 p.m. with administrator A revealed and confirmed: *He had been aware the dietary manager and at least one cook needed to have a current ServSafe certificate. *He was aware the regulation for at least one</p>	S 296		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10592	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/02/2021
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NAME OF PROVIDER OR SUPPLIER AVANTARA ARLINGTON	STREET ADDRESS, CITY, STATE, ZIP CODE 120 CARE CENTER ROAD POST OFFICE BOX 280 ARLINGTON, SD 57212
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S 296	Continued From page 2 cook to have a current ServSafe certificate had not been followed.	S 296		
S 000	Compliance/Noncompliance Statement Surveyor: 26632 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 11/30/21 through 12/2/21. Avantara Arlington was found in compliance.	S 000		

