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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435055	A. BUILDING _____ B. WING _____	C 01/27/2022

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

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F 000	INITIAL COMMENTS Surveyor: 32332 A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 1/26/22 through 1/27/22. Areas surveyed included pressure injuries and neglect. Avantara Ipswich was found not in compliance with the following requirement F686.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, record review, and policy review, and information submitted to the South Dakota Department of Health (SD DOH), the provider failed to: *Identify and treat a deep tissue injury (DTI) for one of two residents (1) with identified deep tissue injuries. *Have ongoing skin assessments for one of two residents (1) with pressure injuries.	F 686	1. No immediate corrections could be made to past lack of DTI identification and skin assessments for resident 1. Resident 1 Care Plan was updated after readmission 2/2/22 to reflect his current needs. Resident 1 was discharged on 2/8/22. Resident 2's Care Plan was reviewed and reflected Resident requires assistance of two with repositioning. The Care Plan was revised to refelct at times is able to reposition self independently in bed, wheelchair and recliner and at times requires assistance of two with repositioning. 2. All residents are at potential risk for skin breakdown and residents with actual pressure injuries are at risk for worsening of those pressure injuries. The skin program policy was reviewed with no revisions needed. The DON, a licensed nurse, and/or a wound care certified nurse will complete Braden scales on all residents to identify risk level and put appropriate interventions into place by February 25, 2022. All residents will receive skin assessments by the DON, a licensed nurse, and/or a wound care certified nurse by February 25, 2022 All residents with actual skin breakdown will be evaluated by Wound Consultant Team to ensure assessments were accurate, and treatments and interventions were appropriate by February 25, 2022. 3. The DON, Administrator, and IDT team, in collaboration with the medical director, will educate all licensed and unlicensed care staff, including LPN D per directed in-service about their roles and responsibilities to ensure anyone who does not have pressure injuries does not develop them and anyone who has developed pressure injury(s) does not worsen but is able to heal. DON, Administrator, and IDT team will educate staff on reporting identified skin conditions to appropriate staff, documentation of reported skin conditions, following and updating care plans and physician orders. Education will occur no later than February 25, 2022. Those not in attendance will be educated prior to their first shift worked.	

LABORATORY DIRECTOR'S OR ~~PROVIDER/SUPPLIER~~ REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 2-25-22

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.

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F 686	Continued From page 1 *Update the care plans for two of two residents (1 and 2) with pressure injuries who required extensive assistance with repositioning. Findings include: 1. Review of documents provided to the SD DOH prior to the 1/26/22 complaint survey regarding resident 1 revealed: *He was admitted on 12/15/21 to [name of hospital] after notifying the physician of a change in status. The provider staff had reported lethargy, weakness, increased bowel and bladder incontinence, and audible wheezing. *When he arrived at the hospital the nursing staff assessed his skin and found significant breakdown. Areas identified included: *His medial posterior coccyx had blanchable redness, black, purple or maroon bruising and necrotic tissue. The area was open with a red wound bed. -The coccyx wound was identified as an unstageable pressure sore injury. *His sacrum had blanchable redness. *His left foot had a diabetic ulcer with a scabbed wound to his left partial foot amputation. *His right ear pressure point was open with a red wound bed. *Pressure point integrity with noted redness to both heels, both shoulders, and both elbows. A 12/15/22 Braden scale (used for determining residents who may be at risk for pressure ulcers) was done on admission to the hospital with a score of ten indicating the resident was at high risk for skin breakdown. Braden scale interventions identified at the time of the above skin assessment were: *A pressure redistribution mattress.	F 686	4. Administrator, DON and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and training for 4 weeks, then biweekly for 1 month and monthly for 2 months. Results of audits will be presented by the Administrator and/or DON or designee at the monthly QAPI meeting for discussion of effectiveness and recommendations. Administrator contacted the South Dakota Quality Improvement Organization on 2/11/22 and discussed the above corrective measures based on root cause analysis using the 5-why's method, communication between nurses and unlicensed staff, assessing skin prior to transfers, timely and accurate documentation, facility skin program, education plan, QAPI and the GPQIN performance auditing tracking tool.	2/25/22

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F 686	Continued From page 2 *Repositiong every two hours. *Off-loading his heels. *Managing moisture. *Frequent repositioning/shifting his weight in a chair. Diagnoses identified had included: *Rhabdomyolosis - present on admission - suspect secondary to the sacral deep tissue injury (DTI). -The above diagnosis could cause possible kidney damage and dark reddish urine. *Elevated potassium level. *Acute kidney injury. *Bilateral pneumonia. *Fatigue. *Poor appetite. *Shortness of breath. *Right pulmonary embolus. *Right pleural effusion. Further review of the hospital medical records revealed: *A 12/15/21 consult note by advanced practice registered nurse - certified nurse practitioner (APRN-CNP) (wound care specialist) F assessment for resident 1 revealed he had a: -Diabetic ulcer to the left midfoot associated with type II diabetes mellitus with muscle involvement and without evidence of necrosis. -DTI to the sacrum. *A 12/16/21 attending physician note indicated "Has been noted to have a deep sacral unstageable ulcer." *The resident told her he did not know how long the sacral wound had been present. A 12/21/22 hospital discharge summary by the attending physician indicated skin concerns:	F 686		

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F 686	Continued From page 3 *Chronic ulcer left foot. *"DTI continuous area buttock and sacrum open area measures 7 cm [centimeters] X [by] 4 cm X unmeasured depth due to eschar [dead tissue] and DTI extends to approx [approximately] 20 cm X 15 cm area." Resident 1 was discharged back to the provider on 12/21/21. Physician's discharge orders had included: *Skin/wound care: -Betadine wet to dry dressing to sacrum and the lower extremity two times daily. -Foam dressing for protection of the bony prominence over the sacrum for those residents identified as high risk. *Skin Breakdown Risk: -Assess bony prominence's and check skin integrity in areas under all medical devices, such as TED hose. -Turn/reposition the resident every two hours. -Keep heels up and off the bed. -Protect skin - keep clean and dry. -Moisture barrier for incontinence. -Use a lift pad or Maxi Slide for moving the resident. Interview on 1/26/22 at 8:30 a.m. with director of nursing (DON) B revealed: *Resident 1 was sent to the hospital on 12/15/21 due to weakness, poor food and fluid intake, and overall declines in his status, including changes in physical and cognitive abilities. *He returned on 12/21/21 with a DTI to his sacrum/coccyx. *The nursing staff had reported the resident did not have a skin problem on his sacrum/coccyx before he was sent to the hospital. *Skin was assessed weekly by licensed practical	F 686		

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nurse (LPN)/wound nurse D. She had also been working on the floor on 12/15/21 when he was sent to the hospital.
*He:
-Had a chronic left foot ulcer that had been treated since he had been first admitted to the facility in April.
-Had a fall on 11/23/21 requiring sutures to his head.
-Had gradual declines over a period of weeks.
-Was performing his own cares prior to his illness.
-Did not like to have staff assist him with his cares.
-Refused his medications and dressing changes at times.
-Spent almost all of his time in his room and very rarely attending meals outside of his room.

Further interview on 1/26/22 at 9:15 a.m. with DON B and administrator A regarding resident 1 revealed:
*He was transported to the emergency department (ED) on 12/26/21 due to a urinary tract infection and returned back to the provider on the same day.
*On 12/28/21 he was seen by his primary physician and discussed the coccyx wound.
-DON B stated the primary physician had instructed her to use the provider's corporate wound team for recommendations on the wound.
*On 12/29/21 LPN/wound nurse D called the provider's corporate wound care representative and received the following recommendations:
-Provide an alternating pressure air bed with a flat sheet disposable underpad and leave the coccyx wound open to air.
-Have the wound surgically debrided, a reversible colostomy surgery and a Foley catheter as soon

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as possible to prevent further skin breakdown.
*LPN/wound nurse faxed the recommendations to his primary physician for approval and the orders were approved for a wound debridement, as well as discontinuing the Betadine wet-to-dry treatment to his coccyx, keep wound open to air, and the alternating pressure air bed.
-The air bed was received on 12/29/21.
*On 1/5/22 he was brought to the hospital for a consultant appointment to have a surgical wound debridement.
*He had not returned. Communication with the hospital staff confirmed the resident was not stable enough to return the the provider.

Interview on 1/26/22 at 12:30 p.m. with certified nursing assistant (CNA) C and DON B regarding resident 1 revealed CNA C stated:
*The resident had been declining for several weeks.
*He:
-Had stopped eating and drinking except for supplements.
-Was not taking his medication as ordered.
-Preferred to be in his room with the curtains and door closed.
-Did not like staff to assist him will personal cares.
-Was not assisted to the toilet because he toileted himself.
-Did not require repositioning because he repositioned himself.
-Did not like bathing, but she gave him a shower at least once a week.
*She had not recalled resident 1 having any falls.
*The CNA's were expected to observe the residents' skin and would tell the nurse if there was a concern with the resident's skin.
*There were paper forms for the CNA's to fill out

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F 686	Continued From page 6 after each bath to give to the nurse. Continued interview at that above time revealed DON B stated: -The nurses did not keep the forms after they documented any concerns into the medical record. The forms were thrown away. -CNA's did not have a repositioning program and did not document when he was repositioned. -The nursing staff assessed each resident's skin after a fall to look for skin concerns. -"We really had no idea he had those areas." *CNA C confirmed: -She had been working on 12/15/21, the day resident 1 had been hospitalized. -The ambulance had arrived and resident 1 had an incontinent bowel movement so she had to change his brief. -She had observed the skin on his bottom at that time and there were no open areas present. -She had identified the bottom was red and discolored, but not open. Interview on 1/26/22 at 1:15 p.m. with CNA E regarding resident 1 revealed: *She had been gone from 12/8/21 until 12/18/21. *Resident 1 had completed most of his own cares. *He did have some bowel incontinence had then would require assistance. *She had not: -Bathed him. -Remembered any falls. -Seen any skin concerns. Interview on 1/26/22 at 2:15 p.m. with LPN/wound nurse D and DON B regarding resident 1 revealed: *LPN/wound nurse D had taken the role of wound	F 686		

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F 686	Continued From page 7 nurse in April 2021. *She used the provider's corporate wound team to guide how to decide which wound care items that company sold were to have been used to treat each resident. *The provider also used APRN-CNP F if the physician ordered a wound consultant. *Resident 1 had been seeing APRN-CNP F for the diabetic ulcer on the bottom of his foot/heel. *LPN/wound nurse D performed wound observations and measurements weekly for all residents with skin concerns. *DON B also did skin rounds with her most of the time. *The DON did not sign off on the wound evaluations LPN/wound nurse D had performed, but stated she should have been signing the evaluations. *LPN/wound nurse D: -Was working on 12/15/21 the day resident 1 went to the hospital. -Had not known of the skin concerns on his coccyx and sacrum. -Had not been told by CNA C of the discoloration she had identified on his bottom. -Had not observed the coccyx/sacrum when he returned on 12/21/21. Phone interview on 1/26/22 at 2:45 p.m. with APRN-CNP F regarding resident 1's sacral/coccyx DTI revealed she: *Had been caring for resident 1's foot/heal prior to the sacral wound. *Understood the resident could be difficult to treat due to refusals. *Stated when she saw the DTI on his hospital admission it was very dark and had the beginnings of a DTI. The skin was not leathery like the DTI's get as they age; that would show up	F 686		

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later. The DTI was a stage 4.
*Stated "Now the area has become larger, as DTI's do."
*Could not say how the injury occurred, "But there was something that happened to cause pressure or shear or trauma."

Review of resident 1's medical record revealed:
*Braden scores identified on:
-9/20/21: 8.
-1/21/11: 11.
-12/28/21: 12.
-1/4/22: 12.
--All of the above Braden scores indicated the resident was at high risk for skin breakdown.

*The November 2021 Treatment administration record (TAR) identified the twice daily treatment for his left foot wound had been left unsigned on 11/3 a.m., 11/4 a.m., 11/5 p.m.; 11/11 a.m., 11/14 p.m., 11/16 p.m., 11/19 p.m.; 11/20 p.m., 11/21 a.m., 11/26 p.m., and 11/28 p.m.

*The December 2021 TAR identified:
-The twice daily treatment for his left foot wound had been left unsigned on 12/12 p.m., 12/13 a.m., and 12/14 a.m.
-The 12/22/21 hospital return treatment orders for "Sacrum and lower extremity: Cleanse with normal saline solution, pat dry, and apply Betadine wet to dry. Cover with foam dressing.
-"Apply skin barrier to perimeter of dressing every day and every evening."
--The above treatment order on the TAR had been left unsigned on 12/22 p.m., 12/26 p.m., 12/27 p.m., and 12/29 p.m.
--That order had been discontinued on 12/29/21.
-A 12/30/21 order on the TAR for "Lower extremity: Cleanse with normal saline solution,

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pat dry, and apply Betadine wet to dry. Cover with foam dressing for protection. Every day and every evening."
--The above treatment order had been been left unsigned on 12/30 a.m. and p.m., and 12/31 a.m. and p.m.

*The January 2022 TAR identified:
-The twice daily lower extremity treatment had been left unsigned on 1/3 for both a.m. and p.m.
-There were no treatment instructions on the January 2022 TAR to indicate how the coccyx/sacrum wound was to have been treated.

Interview on 1/27/22 at 8:30 a.m. with DON B regarding the missing treatment signatures revealed her expectation was the nurse should have signed the TAR to indicate the treatment had been given.

Review of resident 1's Skin Alteration Evaluation forms revealed:
*The November left foot wound had been measured and had a description of the wound on 11/10/21, 11/15/21, 11/23/21, and 11/29/21.
*A new skin area was noted on his right ankle on 12/5/21. A physician's order was received on 12/6/21 for a dressing to cover the reddened area.
*The November forms had not contained the question of whether the resident had difficulty repositioning himself.

*The December 2021 skin evaluations had identified:
-The left foot wound had been measured and had a description of the wound on 12/7/21 and 12/12/21. New orders had been obtained for the foot due to wound changes.

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F 686	Continued From page 10 -The reddened right ankle had been identified on 12/6/21: --A skin evaluation for the ankle had not been completed in December. --There were no skin orders for the ankle on the December TAR for the right ankle. *Resident 1 had been transferred to the hospital on 12/15/21 and returned on 12/21/21. *A readmission form had been completed after his return on 12/21/21 . The skin section of the form indicated: -A coccyx "pressure" measuring 10 cm X 12 cm. There was no further description of the wound. -A left plantar diabetic ulcer. No measurements were provided. No other description was provided of the wound. -The dietary evaluation had identified "Ulcer to left plantar foot." The dietician had recommended pro-stat supplement for wound healing. *A 12/22/21 Skin Evaluation form: -Identified "sacrum pressure" as 12 cm X 8 cm X 0.4 cm. "Unstageable", with no further description of the wound. -The question "Does the resident have difficulty repositioning self and therefore require staff to assist with redistributing body weight?" was answered yes. *A 12/28/21 Skin Evaluation form: -Identified a sacrum wound, but had not identified skin measurements or any other description of the wound or treatments. -The left foot ulcer had not been identified on the form. -The right ankle redness had not been identified. -The question "Does the resident have difficulty	F 686		

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repositioning self and therefore require staff to assist with redistributing body weight?" was answered yes.

*A 12/31/21 skin evaluation form had no wound measurements and no wound descriptions for the foot or sacrum.
-The question "Does the resident have difficulty repositioning self and therefore require staff to assist with redistributing body weight?" was answered yes.

The resident returned to the hospital on 1/5/22 and had remained there.

Review of resident 1's revised 12/2/21 Skin integrity care plan revealed:
*The resident had a chronic skin impairment to the plantar area of the left foot.
*Goals included:
-"Intact skin free of blisters, or discoloration caused by pressure."
-The wound to his foot would be managed without complications.
-A forehead laceration would heal without difficulty.
*Interventions:
-Ointment to the head laceration.
-Transfer to wound care as ordered.
-Provide treatments as ordered.
-Update the physician with any skin concerns.
-A pressure redistributing mattress.

The above care plan had not been updated with 12/21/21 skin orders from the hospital discharge for:
*DTI wound treatments.
*An alternating pressure air bed.
*Assessing bony prominence's and checking skin

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AVANTARA IPSWICH	617 BLOEMENDAAL DRIVE IPSWICH, SD 57451

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integrity in areas under all medical devices, such as TED hose.
*A turning/repositioning program every two hours.
*Keeping heels up and off the bed.
*Protecting skin by keeping it clean and dry.
*Moisture barrier for incontinence.
*Using a lift pad or Maxi Slide for moving the resident.

Review of resident 1's revised 1/3/22 physical functioning care plan revealed he required:
*Extensive assistance of two staff with bed mobility.
*Total assistance of two staff and a mechanical lift for transfers.
*Extensive assistance of two staff with toileting.
*Physical assistance with bathing and hygiene.
*"Abilities can vary. [Resident 1] may require more assistance on some days. Provide care as needed."

2. Observation and interview on 1/26/22 at 10:00 a.m. during skin rounds with DON B and LPN/wound nurse D regarding resident 2 revealed:
*A suspected DTI on his right heel had been identified on 11/1/21.
*Physician's orders were received for a foam dressing.
*The resident was to have worn heel boots when in bed.
*The identified blister had opened up the next week and staff treated the blister with dressings.
*Weekly skin evaluations were completed by LPN/wound nurse D.
*At the time of the above observation the stage II right heel had closed with fresh skin intact.
*When asked if the resident was repositioned routinely LPN/wound nurse D stated the resident

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had not required a routine positioning program because he moved around in bed.

Review of resident 2's skin evaluation 11/1/21 through 1/24/21 forms revealed:
*The following skin evaluation forms indicated 'yes' to the question: "Does the resident have difficulty repositioning self and therefore require staff to assist with redistributing body weight?": 11/16/21, 11/19/21, 11/26/21, 12/7/21, 12/17/21, 12/28/21, 1/1/22, 1/13/22, and 1/16/22.
*The only skin evaluation form to identify the resident did not have difficulty repositioning himself was the 1/24/22 form.

Review of resident 2's care plan revealed:
*A revised 12/9/21 physical functioning deficit care plan revealed a 1/26/22 bed mobility intervention stating he had required extensive assistance of two staff for bed mobility.
*A revised 1/26/22 impaired skin integrity care plan revealed:
-The goals were to remain free of further redness, blisters, or skin discoloration and to have the right heel heal without complications.
-Interventions included:
--Offloading heels and the use of the heel boot when in bed.
--A pressure reducing mattress.
--Wound care as ordered.
-A repositioning program had not been included as an intervention.

3. Interview on 1/27/22 at 10:00 a.m. with DON B confirmed:
*There were no repositioning programs for residents' 1 or 2.
*The skin observation forms the CNA's used to identify skin concerns were not retained.

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*Wounds had not been consistently evaluated.
*Resident 1 returned to the building on 12/21/21, but a low-airloss bed had not been ordered until 12/29/21.
-When she was asked why the bed had not been ordered earlier she reported his discharge orders had not been delivered at the time the resident had returned to the building.
*LPN/wound nurse D did not have any formal wound care training.
-She was given the job after she assisted with a skin sweep in the building in April 2021.
-She received booklets and some wound care videos from the provider's corporate wound care representative.
-The DON was not always there to monitor the skin.

4. Review of the provider's April 2021 Skin Program policy revealed:
*The program was developed to provide care and services to prevent pressure injury development, to promote healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds.
*A baseline assessment of the residents' skin status should have been completed on admission/readmission by completing the admission/readmission assessment form.
*The form should have included a physical examination of the resident's skin, a risk assessment, and a comprehensive assessment of the resident's history and physical condition and should have been completed on admission/readmission, annually and with a change in condition.
*Risk assessments (Braden or PUSH tool) should have been completed with admission/readmission and weekly for four

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weeks, and then monthly thereafter.
*Nursing personnel should have used the above information to determine an individualized pressure injury prevention program to protect skin against the effects of pressure, friction, and shear, protect skin from moisture, encourage optimal nutrition and fluid intake, educate staff, residents, and families, train front-line care givers, and provide an immediate prevention plan when potential areas were identified.
*A comprehensive wound assessment should have been completed to identify:
-When a pressure injury was identified, and should have included the site, stage, size, appearance of the wound bed, use percentages to identify undermining, depth, drainage amount, color, type, consistency, and odor, and the status of the peri-wound tissue.
-The type of pressure injury treatment required.
-A review of the resident's current care plan and medical status, any other possible risk factors or impaired healing due to diagnoses.
-The type of wound injury according to the physician, and provide skin treatment orders.
*When a skin injury was noted a skin evaluation should have been completed. Those areas were to have been monitored on the TAR until healed.
*A nursing plan of care (POC) should have been developed with interventions consistent with resident preferences, goals, and abilities. The POC was to have included: impaired mobility, pressure relief, nutritional status, and interventions, incontinence, skin condition checks, treatment, pain, infection, education for the resident and family, possible causes of the skin injury, and what interventions had been put into place.
*Routine skin checks should have been completed at least weekly by a licensed nurse.

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

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F 686	Continued From page 16 *Nursing personnel who provided care should have received pressure injury training to include checking potential pressure areas and recognizing pressure injuries in at-risk residents and to notify the nurse when the risks were observed. Nursing personnel should have periodically monitored the POC to ensure implementation of the plan.	F 686		