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
	435051	A. BUILDING ______ B. WING ______	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR RAPID CITY, SD 57702

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 3/6/22 through 3/9/22. Avantara Arrowhead was found not in compliance with the following requirements: F658, F755, F849, and F880.	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure resident cares had been implemented and followed professional standards of practice for: *Complete and accurate skin assessment that included wound measurement for one of one sampled resident (41). *Eye drop administration by one of one licensed practical nurse (LPN) (C) for one of one observed resident (35). *Appropriate medication administration documentation by one of LPN (C) for one of one resident (35). *Order clarification for crushing medication if approved by pharmacy by one of one registered nurse (RN) (E) prior to medication administration for one of one observed resident (29). *Topical cream application by one of one RN (E) for one of one observed resident (11). *Physician orders implemented and followed for scheduled blood glucose checks and scheduled	F 658	1. Staff members C and E were immediately educated upon identification on finishing complete and accurate skin assessments that include the wound measurements. All residents are at risk for having inaccurate skin assessments. Staff member C was immediately educated upon identification on appropriate eye drop administration. All residents who receive eye drops are at risk for having eye drops administered incorrectly. Staff, including staff member C, on duty were immediately educated upon discovery on accurate documentation of medication administration. All residents are at risk for incorrect documentation of medication administration if the nurse does not witness the administration. Staff member E was immediately educated upon identification on obtaining approval from the pharmacy prior to administering medication with a crush and combine order. All residents requiring medication to be crushed are at risk for having medication crushed and combined without appropriate approval from the pharmacy. Staff member E was immediately educated upon identification that medication that were not prepared by her were not allowed to be administered. All resident are at risk for having medication administered that were prepared at an unknow time and by an unknown nurse. No immediate corrective action could betaken for the missed glucose checks, not administering oral medication as stated in the physician order with documented interventions of attempts for resident 47. All resident, regardless of cognitive ability, are at risk for not following physician orders and not administering oral medications as scheduled by the provider. Resident 35's code status was updated per her wishes on 03/28/2022. All residents are at risk and have the right to choose their code status.	04/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Malys
TITLE: NHA
(X6) DATE: 04/07/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 oral medication administration for one of one resident (47). *Maintaining up to date resident code status for one of one sampled resident (36). *Complete and accurate skin assessment that included wound measurement and recent skin tear detailed for one of one sampled resident (21). Findings include: 1. Observation and interview on 3/7/22 at 10:15 a.m. with certified nurse assistant (CNA) I and registered nurse (RN) E regarding resident 41 revealed: *She was laying in her bed and the CNA was providing personal cares. *She was not up in her chair for "too long" due to sores on her buttocks. *She was repositioned every two hours. *A pressure reduction mattress was on her bed and a pressure reduction cushion was in her wheelchair. *The nurse removed two old dressings from her right buttocks, cleansed the two areas one to the upper right buttocks that was red and the other to her lower, outer buttocks that was open with normal saline and gauze and placed borderfoam dressings over the two areas on her buttocks. Record review for resident 41 revealed: *She was admitted to the facility on 7/21/16. *Her 2/3/22 Brief Interview For Mental Status (BIMS) was 0, indicating severe cognitive impact. *Medical diagnoses included; multiple sclerosis, muscle wasting and atrophy, and contracture of lower leg muscle. *The care plan initiated 6/16/20 and updated on 2/17/22 had goals and interventions related to "potential for impairment of skin."	F 658	2. A full house skin audit will be conducted on all residents to ensure each resident has an accurate skin assessment in their medical record to include wound measurements if applicable no later than April 15, 2022. The Director of Nursing (DON) or designee will educate all licensed nurses on the facility's Skin Program policy to ensure accurate skin assessments are completed, to include wound measurements no later than April 7, 2022. The DON or designee will educate all nurses and medication aides on the Medication Administration Eye Drops for eye drop administration to ensure eye drops are being administered appropriately no later than April 7, 2022. All nurses and medication aides will complete an eye drop administration competency to ensure eye drops are being administered appropriately no later than April 15, 2022. The DON or designee will educate all nurses and medication aides on the Medication Administration General Guidelines policy to ensure medications are administered at the time they are prepared and by the person who prepared the dose for administration, all crush and combine orders have the appropriate approval from the pharmacy prior to administering the medication, and the physician's will be notified if two consecutive doses of a vital medication was withheld or refused no later than April 7, 2022. All residents' room will be checked to ensure there are no medications left in the resident rooms that do not have self administered order no than April 15, 2022. A full house audit was conducted on 03/30/2022, on all crush and combine orders to ensure the appropriate approval from the pharmacy had been obtained. The residents that do not require their medications to be crushed will have the order removed from their chart. The order "crush and combine order if approved by the pharmacy" was an automatically generated with all new admissions. This order will no longer be auto populated and will be entered when necessary. All resident Advance Directives will be reviewed with the resident and/or representative to ensure the residents code status wishes are indicated in their medical record and plan of care no later than April 15, 2022. The Administrator will educate the Social Service Designee and Clinical Care Coordinator on the Advance Directives policy to ensure the resident's code status is reviewed with the resident an/or representative with each quarterly MDS or significant change of condition MDS. They will also be educated to ensure the code status is correct in medical record and matches the plan of care. All education will occur no later than April 7, 2022, and those not in attendance for the training due to vacation, illness, or casual work status will	

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*A 2/22/22 Braden Scale score of 14 indicating moderate risk for skin breakdown.
*Minimum Data Set (MDS) assessments 6/11/21, 9/10/21, 12/10/21, and 2/3/22 revealed no pressure ulcers or wounds.
*A Physician order dated 4/6/21 for "Wound Care to R. buttocks: cleanse with NS or wound cleaner; apply sorbact and foam dressing every day shift every Tue/Th/Sun for wound care d/c when resolved completed by the wound nurse.
*The treatment administration record was signed off for wound care provided every Tuesday, Thursday and Sunday from 4/6/21 to 3/8/22.
*The CNA daily task documentation dated 2/7/22 through 3/8/22 stated "no" for "Does the resident have a skin alteration?"
*Weekly skin assessments dated 12/25/21, 12/31/21, 1/21/21, 2/4/21, 2/11/21, 2/22/21, 2/25/21, 3/5/21 indicated "no" for alteration in skin integrity with no documentation of wound description or measurements.
*Intermittent skin assessments revealed "yes" for alteration in skin integrity with no documentation of wound description or measurements.
*The only wound assessment report in the medical record or provided by the facility was dated 3/7/22 at 4:20 p.m. with wound description and measurements of one wound identified as a unstageable pressure ulcer.
*There were no diagnoses in the resident record for skin alterations, current or history of pressure ulcers.

Interview on 3/8/22 at 1:42 p.m. with CNA I regarding resident 41 revealed:
*She stated she charts "no" to alteration in skin as she had felt this was an old issue and it had already been reported to nursing.
*She would have checked yes if she had

F 658 complete the training prior to their first shift worked.

3. The wound care nurse and/or designee will audit 5 skin assessments to ensure the documentation in the skin assessment is accurate and include measurements of wounds. The DON or designee will audit 5 random eye drop administrations to ensure they are being administered correctly. The DON or designee will audit five random medication passes to ensure accurate documentation of administration of the medication was recorded in the medical record. The DON or designee will audit five residents with a crush and combine order to ensure the proper approval has been obtained by the pharmacy for the medications. The DON or designee will audit five random medication passes to ensure medications are administered at the time they are prepared by the nurse who prepared the dose. This audit will include reviewing five random resident rooms to ensure no medications have been left in the room of residents who do not have a current order for self-administration. The DON or designee will audit five random residents' medical record to ensure blood glucose checks were completed as prescribed and any medication consecutively refused x 2 has documentation of physician notification and interventions or alternative strategies that were attempted. The Administrator or designee will audit 5 residents' medical records to ensure the correct code status is in the medical record and matches the plan of care. Audits will be weekly for four weeks, and then monthly for two months. Results of the audits will be discussed by the Administrator, DON, or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation, for continuation/discontinuation/revision of audits based on findings.

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F 658	Continued From page 3 observed a new skin alteration. *Reported resident (41) had the opening on her buttocks for at least "a couple months." *It started out smaller and had gotten bigger. *A wound dressing had been placed daily for at least a couple weeks since she had been on this hallway. *She believed a wound dressing had been placed daily for longer than the two weeks she had been on this hallway. *Stated the wound appeared to not be getting worse in the two weeks she had been assigned to this hallway. *CNA's reposition resident (41) every two hours. *Stated physical therapy had started to work with resident (41) and they had planned to work with her more to help with her range of motion and bending of her legs. *Confirmed resident (41) had a pressure reduction bed mattress and a wheelchair pressure reduction cushion. Interview on 3/8/22 at 1:55 p.m. with RN E regarding resident 41 revealed; *She stated the upper wound on resident 41's right buttocks had a protective dressing being placed and had been there since she started working at the facility in January. *She stated it had opened and closed. *The lower buttock unstageable wound was fairly new and to the best of her recollection she started covering it last week. *She stated weekly skin assessments were completed weekly by nursing. -The skin assessments were started by the bath aide and then the nurse finished the skin assessment. *If the nurse had found a wound they were to measure it.	F 658		

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*She could not remember measuring any of resident 41's wounds.
*She may have had up to 28 skin assessments in a day and she had not been able to remember.
*RN G the floor nurse completed the wound assessment if she had been made aware of the resident's wounds.
*She stated she had started at the facility in December and went to working the floor in January so she "did not have all the facts surrounding this patients wound care."

Interview on 3/9/22 at 11:50 a.m. with director of nursing (DON) B and registered nurse (RN) G regarding resident 41 revealed:
*Skin assessments were scheduled weekly for every resident.
-The nurse should have been the only one doing the weekly skin assessments.
-Any alteration in skin integrity whether new or old should have been documented by RN's in the skin assessments and by CNA's in the daily task documentation.
*If a new wound was identified the staff nurse was to complete wound documentation to include a wound description, measurements and contact the provider for initial wound orders.
-The staff nurse was to notify RN G, the nurse assisting the DON with wound care, verbally, and then RN G would have completed wound care on Tuesday's, documented in the chart under wound rounds and followed up with the physician for updates and orders.
-RN G only followed pressure ulcers, non-pressure ulcer wounds were the responsibility of the staff nurse.
*Resident 41 had a reddened area to her upper right buttocks that was from a old healed pressure ulcer.

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-They covered it with borderfoam to protect it.
-A new unstageable pressure ulcer to her right lower, outer buttocks developed recently.
--RN G called the physician for wound care orders for the new pressure ulcer on 3/7/22.
*RN G had no formal wound care training.
-She and RN G had been scheduled for a wound care course but it was canceled due to a Covid outbreak in the facility.
*They utilized the Genteel wound care nurse as a resource.
-The wound care clinic provider rounded at the facility.
*She was in the process of scheduling an upcoming wound care training for her and RN G through Legacy.

Review of the 12/1/19 "Treatment Nurse" job description revealed;
*"The Treatment Nurse is responsible for performing skin treatments for all guests under their care. This position will obtain treatment orders from the attending physicians and assist with modifying the treatment regimen in accordance with established policies and procedures."
-"1. Consults with Nursing team concerning assessment evaluations and assist in planning and developing the skin care treatment to be performed."
-"7. Carry out direct contemporaneous charting in your shift. Chart detailed monthly evaluations of each guest that reflect his/her condition and progress."
-"11. provide wound care when needed."

Review of the 4/21 Legacy "Skin Program" policy revealed:
*"Policy:"

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F 658	Continued From page 6 -"To provide care and services to prevent pressure injury development, to promote the healing of pressure injuries/wounds that are present and prevent development of additional pressure injuries/wounds." *"Procedure:" -"2. Comprehensive skin assessments will be completed admission/readmission, annually, and with change in condition." -"5. A comprehensive wound assessment will be completed: --A) When a pressure injury is identified: This assessment will include, ---a)site, stage, size, appearance of wound bed, (use%) undermining, depth, drainage, (amount, color, type, consistency, and odor), and status of peri-wound tissue. ---d) Type of skin injury (MD/Provider is asked to identify type of injury, if needed. Reassess the wound at least weekly (if the wound has not improved within 2-3 weeks, contact the MD/Provider for a change in treatment." -"6. When a pressure injury, bruise or skin tear is noted, a Skin Evaluation UDA should be completed, and the injury entered into Risk Management in PCC. These areas will be monitored on Treatment Administration Record (TAR) until healed. Following identification of a skin issue, the Skin Alteration Evaluation UDA will be completed weekly until resolved. Those facilities using Wound Rounds program may document findings in thee Wound Rounds assessment in lieu of the UDA, -"9. Nursing personnel who will be providing care for the resident will receive pressure injury training, to include checking potential pressure areas and recognize pressure injuries in "at risk" residents, (skin- reddening that does not disappear after pressure removed) and instructed	F 658		

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to notify the nurse when this is observed. They will also be instructed in individual interventions for each resident. Nursing personnel will periodically monitor response to the POC, to ensure implementation of the POC."
2. Observation and interview on 3/6/22 at 9:25 a.m. with LPN C in resident 35's room revealed she:
*Entered the room after performing hand hygiene and applying her gloves.
*Instilled eye drops in the innermost corner of each of the resident's eyes.
*Stated that was how she had been taught to administer eye drops.

Review of the May 2016 Eye Drops policy revealed: With a gloved finger, gently pull down lower eyelid to form "pouch," while instructing resident to look up. Hold inverted medication bottle between the thumb and index finger, and press gently to instill prescribed number of drops into "pouch" near outer corner of eye.

3. Observation and interview on 3/6/22 between 9:30 a.m. and 9:35 p.m. with LPN C upon exiting resident 35's room revealed:
*The resident had consumed 75% of the contents of a plastic cup that contained a mixture of laxative powder mixed with water left on the over-bed table.
LPN C had:
*Documented the resident consumed 100% of that laxative in the medication administration record.
-Known only 75% of that laxative mix had been consumed and should have been documented.
*Left the room prior to resident 35 taking all of that medication.
-Known she was responsible for ensuring all

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medications had been taken by the resident prior to leaving the room.

Review of the September 2018 Medication Administration General Guidelines revealed: "20. The resident is always observed after administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR, and action is taken as appropriate."

4. Observation, interview, and review of resident 29's medication order summary on 3/8/22 at 9:40 a.m. with RN E revealed:
*She crushed and combined that resident's pain and anti-anxiety pills then stirred them together with applesauce in a medication cup.
*A 2/22/22 order read: "May crush and combine medication if approved by pharmacy."
*She had not known if pharmacy had approved crushing and combining those medications referred to above.
-"Assumed it was ok" to combine those medications since it had been done before.

Review of the September 2018 Medication Administration General Guidelines revealed:
*Medication Administration:
-Medications are administered in accordance with written orders of the prescriber.
-The nurse calls the provider pharmacy or the prescriber for clarification prior to medication administration if there is question regarding a medication order.
--That interaction and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate.

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Interview on 3/8/22 at 11:00 a.m. with DON B revealed she expected a nurse to contact and clarify with pharmacy or the prescriber any medication order that was unclear prior administering that medication.

5. Observation and interview on 3/8/22 at 9:45 a.m. with RN E revealed she:
*Entered resident 11's room with a medication cup she had prepared containing white colored medicated cream used on that resident's abdomen.
*Noticed an uncovered medication cup containing a white colored cream already sitting on a bedside table in that room.
-Applied the entire contents of that unmarked and uncovered medication cup onto the resident's abdomen prior to using the contents of that second medication cup she had prepared.
*Was uncertain how long that uncovered medication cup had been in the resident's room.
-Assumed the white colored cream in that unmarked cup was the same cream she had prepared prior to entering that room.
*Knew she should not have administered any type of medication that she had not prepared herself.

Review of the September 2018 Medication Administration General Guidelines policy revealed:
*"4. Medications are to be administered at the time they are prepared."
*"5. The person who prepared the dose for administration is the person who administers the dose."

Interview on 3/9/22 at 11:00 a.m. with DON B regarding the observations above revealed

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professional standards and the provider's policy and procedures for medication administration and documentation had not been followed by LPN C or RN E.

6. Review of resident 47's care record revealed her:
*Admission date was 5/25/17.
*Diagnoses included dementia with behavioral disturbance, bipolar disorder, vitamin B and D deficiency and type 2 diabetes mellitus.
*Physician order 12/3/20 for glucose checks twice a week before lunch. Notify provider if less than 60 or greater than 400.
*Brief interview for mental status score of 0, indicating severe cognitive impairment.

Review of resident 47's 2/4/22 to 3/8/22 nurse progress notes revealed:
*Five out of nine glucose checks were not performed.
*Oral medications were given at 12:00 p.m. and evening.
-Eleven out of twenty-one days medications were charted not given and resident refused.
--Nurse progress notes documented no interventions tried or alternative strategies.

Review of resident 47's 3/1/22 revised care plan revealed:
*The resident had refused medications and blood sugars at times.
*Check blood glucose twice a week and notify doctor if outside of parameters.
*If resident refused to take medications, they offer her time, education and multiple attempts.

Interview on 3/8/22 at 2:35 p.m. with RN K revealed:

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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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*If resident refused to take medication provider is to be notified.

Interview on 3/9/22 at 12:00 p.m. with DON B revealed:
*The provider was to be notified, if resident refused or missed medication.
*Nurses were to do documentation when medications was refused and interventions were used.
*Management and family were to be notified of medications refused.
*Vital medication was any medication that was prescribed to resident.

Review of the September 2018 Medication Administration policy revealed: the physician was to be notified if two consecutive doses of a vital medication was withheld or refused.
7. Review of resident 35's care plan regarding her code status revealed:
*Her electronic medical record (EMR) first page showed her code status as do not resuscitate (DNR).
*Her care plan stated she was a FULL CODE (cardiopulmonary resuscitation - CPR).
*A 2/22/22 physician order for DNR.
*A 8/20/20 resuscitation designation order for CPR to be performed.
-This form was signed by resident 35, a facility representative, and resident 35's healthcare provider.

Interview on 3/8/22 at 8:29 a.m. with registered nurse regarding the process to for reviewing a resident's code status revealed:
*Code status is reviewed with the resident with each quarterly care plan.
-The care plan document is scanned into the

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EMR, as an attachment.
*The physician would be notified of change.
-She is not sure who would update the EMR if there was a change in code status.

Interview on 3/8/22 at 8:40 a.m. with resident 35 revealed she had wanted her code status to be full code.

Interview on 3/8/22 at 9:08 a.m. with certified nursing assistant (CNA) I regarding code status for resident 35 revealed:
*She though the code status had been changed to do not resuscitate (DNR) at one time because she had gotten weaker.
-She thought this might have been about 4 months ago.
*If a resident experienced an event that required CPR to be performed, she would check the EMR for their code status.
*She would also call for a "code" from her walkie talkie with the room number of the resident.
-This would notify the nurse that she was needed.
*She verified the code status for resident 35 on the first page of the EMR as DNR.

Interview on 3/8/22 at 9:11 a.m. with licensed practical nurse C regarding code status of residents revealed:
*If a resident experienced an event that required CPR to be performed, she would check the first page of the EMR for their code status.
*She verified the code status for resident 35 on the first page of the EMR was DNR.

Interview on 3/8/22 at 9:16 a.m. with MDS/Care plan coordinator L regarding the process for reviewing code status at care conferences revealed:

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*She had started working for the provider in November 2021.
*There had not been a care conference with resident 35 since she had started.
-Code status was
*Resident 35 had been recently hospitalized.
*She verified the first page of the EMR and the physician's order for code status for resident 35 was DNR.
*She verified the care plan and the signed resuscitation designation order for resident 35 was for FULL CODE.
*She would have notified the director of nursing (DON) if a change to the code status was to be made.
*Care conferences were completed quarterly.
-There was not a care conference when a resident returned from the hospital.
*The care plan would be updated with a significant change in the resident's status, but they would not do an actual care conference.
*The social service director oversaw scheduling care conferences.
*She ensured that the care conferences were held and documented what was discussed at them on a paper form.
-The paper form would then go to the resident's physician for their review and signature.
-When the form was signed by the physician and returned medical records personnel would scan and upload the signed document into the EMR and then file the document in the paper chart.
*A progress note would be made that documented the care plan had occurred, family comments, and specifically reviewed items.

Interview on 3/8/22 at 9:34 a.m. with social service director M regarding code status for resident 35 revealed:

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*Care conferences are held each quarter.
*There is a form that that everyone attending (staff and resident) indicating they have reviewed each section.
*Code status is obtained from the resident by the business office on admission.
*She would then make sure the code status in the EMR matches the signed resuscitation designation order in the resident's paper chart.
*If there was a change requested, she or a nurse would have the form signed by the resident and send it to the resident's primary healthcare provider for signature.
-After the healthcare provider signed and returned the form, it would be scanned and uploaded into the EMR.
--The actual EMR change would be made by the MDS nurse, medical records, or herself.
*She had been made aware on this day that resident 35 had her code status changed it to DNR when she returned from the hospital.
-She had not seen the signed form for this.
*She verified the code status for resident 35 was DNR on the first page of the EMR and that the care plan showed FULL CODE.
-She did not know who had entered the information into the EMR.

Interview on 3/8/22 at 10:52 a.m. with director of nursing B regarding resident 35's code status revealed:
*There had been a 1/27/22 healthcare provider note and a physician order for her to have a code status of DNR.
*The code status would not have been updated on the care plan until the primary care provider had signed and returned the code status form.
*Her expectation would have been for nurse to follow the signed resuscitation designation order

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that was a FULL CODE, as they are to verify that form which had been signed by the resident, staff representative and physician.

Review of provider's September 2019 advanced directives policy revealed:
*Policy: It is the policy of the facility for each resident to choose their Advanced Directives upon admission and such may be changed by the resident at any time during their stay."
-"2. An Advance Directive form (as provided by the healthcare facility) .....shall be completed with the resident and/or legal representative to verify treatment options as well as code status.
3. Appropriate information will be added to Physician Order Sheet (POS).
4. The resident's Advance Directive choices/options shall be reviewed with resident/resident representative during quarterly and significant change assessment and care planning.
5. Discussion of Advance Directives and treatment options/refusals will be addressed in appropriate chart documentation as well as care planned during the admission process, as indicated."

8. Interview on 3/7/22 at 3:50 p.m. with spouse of resident 21 revealed:
*He had an open area (wound) on his buttocks.
-This was the first open area he had since he was admitted.
*He had a skin tear (wound) on his arm due to a transfer from a lift.

Review of resident 21's care plan revealed:
*He had been admitted on 5/1/19.
*A care plan started on 3/25/21 for wound treatment to be applied as ordered by the

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physician.
*A 2/3/22 skin assessment that indicated he had shearing to his buttock.
*A 2/4/22 progress note that indicated he had an open area on his left buttock.
*A 2/9/22 interdisciplinary progress note that did not mention any open areas.
*A 2/11/22 nutrition note that said he did not have any current wounds or open areas.
*A 3/3/22 skin evaluation that indicated he had an open area on his buttocks and a skin tear on his left arm, with dressings as ordered by the physician in place.
-This evaluation did not include any measurements of his wounds.
*His care plan included:

Interview on 3/7/22 at 4:19 p.m. with MDS/Care plan coordinator L regarding process for measurement of wounds revealed:
*They currently did not have a wound nurse.
*She thought registered nurse (RN) G had been the interim wound nurse and had been helping the director of nursing (DON) with wound management.
-She knew the measurements should be documented by the wound nurse, who would typically do this on Tuesday's.
-She was not sure what the policy was for who should measure a wound when it was first observed.

Interview on 3/9/22 at 12:35 p.m. with DON B and RN G regarding wound nurse and training revealed:
*RN G was not the interim wound nurse.
-She was assisting the DON with wound management and documentation of it.
*DON B and RN G had not completed any wound

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F 658	Continued From page 17 training. *The provider had a couple of resources, including a wound supply company and a wound specialist provider that they utilized. *Had a training scheduled a couple of months ago, for DON B and RN G that had to be canceled due to COVID-19. *There was no documentation of resident 21's wounds. Interview on 3/9/22 at 12:58 p.m. with Administrator A regarding wound measurement documentation for resident 1 revealed there was no documentation.	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755	RN F was immediately educated at the time of discovery regarding singing off a controlled medication were immediately educated upon discovery to ensure a physical accounting of all controlled substances, to include controlled substances stored in the medication storage room refrigerator, is conducted between two nurses. All residents have been identified to be at risk of having inaccurate documentation of controlled substances. 2. The DON or designee will educate all nurses and medication aides on the Medication Administration policy to ensure accurate documentation is being completed when the medication is administered. Additionally, the DON will educate nurses and medication aides on the requirements of conducting a physical inventory of all scheduled II narcotics, to include the refrigerated items. Education will occur no later than April 7, 2022. Those not in attendance at education session due to vacaton, illness, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will audit five nurse end of shift reports to ensure all controlled substances were signed off at time of the administration and the nurses are conducting a physical inventory of all controlled substances, to include the refrigerated controlled substances. Results of the audits will be discussed by the DON. Audits will ly QAPI meeting with the Medical Director for analysis, recommendation continuation	04/18/2022

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the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, controlled substance book and policy review, the provider failed to ensure:
*One of one RN (F) had timely documentation in a controlled substance book of four of seventeen controlled substance medications he administered during one of one shift.
*A physical accounting of controlled substances stored in one of one medication storage room refrigerator had been conducted between two of two registered nurses (RN) (D and F) at one of one observed shift change.
Findings include:

1. Observation and interview on 3/6/22 at 6:00 p.m. with RN D and RN F during shift change on the West Hall revealed:
*RN D provided a verbal count of each controlled medication for each applicable resident inside that medication cart.
-At the same time RN F ensured that RN D's count for each medication matched the medication counts documented in the controlled substance book.
*Controlled medications were documented in the electronic medical record and accounted for in writing in the controlled substance book after

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administration.
*RN D counted 1 less medication than what was recorded in the controlled substance book for four medications.
-RN F had administered seventeen controlled medications during his shift.
*RN F stated he had given those four medications during his shift but must have forgotten to record those administrations in the controlled substance book.
-Reconciled the medication count in the controlled substance book at that time.
*RNs D and F knew it was expected that controlled substance medications were documented in the electronic medical record and the controlled substance book as soon as possible following their administration.
*The entire controlled substance reconciliation process occurred at that medication cart in the West Hall.

2. Observation and interview on 3/8/22 at 11:40 a.m. with RN E in the medication storage room revealed:
*Six vials of Ativan (controlled substance) in a plastic bag inside the medication refrigerator.
*RN E stated those vials were accounted for outside of that medication room at the medication cart during shift change.
-Confirmed during shift changes she had not visually inspected and accounted for the contents of that bag when controlled substance reconciliation was done.
-It would be difficult or impossible to account for any vials discovered missing using this process.

3. Interview on 3/9/22 at 10:30 a.m. with director of nursing B regarding the observations above revealed she:

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F 755	Continued From page 20 *Expected all medication administration documentation occurred as soon as possible following medication administration. *Expected controlled substance reconciliation occurred at the site where that controlled substance was stored. *Provided nursing education on 2/1/22 regarding controlled substance accountability after a potential drug diversion incident had occurred. Review of the September 2018 Medication Administration policy revealed: *Documentation: -"1. The individual who administers the medication dose, records the administration on the resident's MAR [medication administration record] immediately following the medication being given." Review of the November 2017 Controlled Medication Storage policy revealed "6. At each shift change or when keys are surrendered, a physical inventory of all Schedule II, including refrigerated items, is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substances count report."	F 755		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice	F 849	The facility obtained electronic documentation from the hospice agency on 03/30/2022 and placed the documentation into resident 34 medical chart. All hospice residents are at risk for being affected by the lack of collaborative communication between the provider and servicing hospice agency. All residents receiving Hospice services have Hospice services documentation in their medical record.	04/18/2022

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F 849	Continued From page 21 services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care.	F 849	2. The DON or designeed collaborated with the hospice agency to ensure documentation is provided to the facility on a weekly basis via a hand courier. The collorbation started 03/24/22. 3. The DON or designee will audit all charts of current hospice residents weekly for 4 weeks and monthly for two months to ensure the appropriate documentation has been received. The results of the audits will be discussed by the DON at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/discontinuation/revision of audits based on findings.	

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F 849	Continued From page 22 (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown	F 849		

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source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

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(iv) Obtaining the following information from the hospice:
(A) The most recent hospice plan of care specific to each patient.
(B) Hospice election form.
(C) Physician certification and recertification of the terminal illness specific to each patient.
(D) Names and contact information for hospice personnel involved in hospice care of each patient.
(E) Instructions on how to access the hospice's 24-hour on-call system.
(F) Hospice medication information specific to each patient.
(G) Hospice physician and attending physician (if any) orders specific to each patient.
(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

§483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and policy review, the provider failed to ensure collaborative communication was completed and documented between the provider and the hospice agency for one of two sampled residents.
Findings include:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING ______ B. WING ______	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR RAPID CITY, SD 57702

(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 849	Continued From page 25	F 849		

1. Review of resident 34's electronic medical record (EMR) revealed:
*He had been admitted on 4/10/20.
*On 2/16/22 he had started receiving hospice services for end-of-life care due to respiratory failure.

Interview on 3/8/22 at 9:40 a.m. with social service director M revealed and confirmed:
*He was on hospice.
*Resident updates were given in report from shift to shift.
*There was a hospice binder that included communication from the hospice provider.
*Interdisciplinary meetings between the facility and hospice provider were not conducted..

Interview and record review on 3/8/22 at 9:45 a.m. with registered nurse (RN) K revealed:
*Nurses would call the hospice provider if they had concerns regarding a hospice resident.
*Hospice did send staff to assist in caring for hospice residents.
-She was no sure which days they would come.
*There were binders for each resident on hospice.
-There was a section in these binders for hospice to make notes when they visited the resident.
-There were no hospice nurses notes located in the binder for resident 34.
-Hospice did not provide other notes of the care they provided.
*She would document in the EMR if she was aware of any changes in orders for the hospice residents.

Interview on 3/8/22 at 10:05 a.m. with hospice nurse O regarding documentation for hospice residents revealed:

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F 849	Continued From page 26 *She knew she should have documented in the hospice binders from past experience. -She did not know why she had not. Interview on 3/8/22 at 4:00 p.m. with director of nursing B regarding hospice communication revealed: *There had not been a staff member designated to coordinate communication. *The hospice provider's EMR had notes from the hospice nurse. -This EMR system was not available to facility certified nursing assistants or nurses to access.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880	1. Immediate corrective action was taken upon discovery for the lack of appropriate barrier placement on a recline chair when resident 19 chooses to sit with out clothing and underwear down for more independent toileting ease by the Infection Preventionist educating all nursing staff, including CNA J on duty, on placing a protective barrier between the resident and the recliner to mitigate resident's risk of infection on 03/07/2022. Immediate corrective action was taken for the identification of lack of appropriate hand hygiene and glove use during medication administration by the Infection Preventionist providing education to staff member C regarding appropriate hand hygiene and glove use policy during medication administration. The Infection Preventionist provided immediate education to staff member C on appropriate hand hygiene and glove uses during personal cares and procedural processes related to dressing changes. The administrator, DON, and/or designee in consultation with the Medical Director will review the Hand Hygiene and Infection Prevention Program policy to ensure appropriate barrier placement on a recliner chair, lack of appropriate hand hygiene and glove use during medication administration processes, and appropriate hand hygiene and glove use during personal cares and procedural processes related to dressing change. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by April 7, 2022, by the Infection Control Nurse and/or designee. Those not in attendance at education session due to vacation, illness, or casual work status will be educated prior to their first shift worked.	04/18/2022

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F 880 Continued From page 27

§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, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

F 880

2. All resident and staff have the potential to be affected by lack of appropriate barrier placement on a recliner and using appropriate hand hygiene and glove use during medication administration, personal care, and procedural processes related to dressing changes. All staff will be educated on the Infection Prevention Program policy and Hand Hygiene policy no later than April 7, 2022, by the Infection Control Nurse and/or designee. Those not in attendance at education session due to vacation, illness, or casual work status will be educated prior to their first shift worked.

3. The Root Cause Analysis (RCA) was conducted by the Infection Preventionist, Director of Nursing (DON), and Administrator of the facility's infection prevention and control in collaboration with the South Dakota Quality Improvement Organization (QIN) on 03/30/22. Results of the RCA included lack of auditing infection contol procedures and lack of an educated Infection Preventionist on staff. Administrator, DON, and Infection Preventionist contacedt the QIN on 03/29/22 and set up a call to discuss. The Administrator, DON, and Infection Preventionist had a conference call with a representative from the QIN on 03/30/2022 at 10:00 am and discussed additonal opportunities and resources for infection prevention and control. During the conference call they reviewed our RCA and stated it was one of the best RCA's they have seen. They discussed us utilizing "secret shopper" to audit staff with hand hygiene and glove use which we will implement for our audits . The QIN representatives walked us through the Great Plains website and showed us were to find covid resources, and a template that can be utilized when track resident vaccinations, CMS QSEP educations that can be used for staff training, and they walked us through the performacne tracker tool that can be utilized to analyze the data gathered from audits. The Infection Preventionist will educate the Administrator and DON on the Infection Prevention Plan and Hand Hygiene policy.

4. The Infection Preventionist or designee will audit five nurses over all shifts performing medication administration, personal cares, and procedural processes related to dressing changes to ensure identified and assigned tasks are being completed as educated and trained as well as ensure staff compliane. The DON or designee will audit five residents utilzing recliners to include resident 19 to ensyre a barrier is between residents skin and seat of recliner. After 4 weeks on monitoring demonstrating expectations have been determined to be met, monitoring may they be reduced to twice monthly for one month, then will continue monitoring at appropriate intervals upon analysis of ongoing

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F 880	Continued From page 28 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure infection prevention and control practices had been maintained for: *Placement of a barrier between the seat of a cloth recliner and the bare skin of one of one observed resident (19). *Correct glove use by one of one licensed practical nurse (LPN) (C) during medication administration for two of two observed residents (25 and 35). Findings include: 1. Observation and interview on 3/6/22 at 3:18 p.m. with resident 19 in her room revealed she: *Sat in her cloth recliner with her pants and underwear pulled down past her buttocks but well above her knees. -The armrest of the chair had concealed her bare skin from anyone passing by the room who may have looked in. *Was unable to verbally communicate why her pants had been positioned that way. Observation and interview on 3/7/22 at 10:15 a.m. with certified nurse aide (CNA)/medication aide N and CNA J regarding resident 19 in her room revealed: *The same observation of her in the recliner as referred to above. *They explained she preferred her pants and underwear positioned in that manner while in her chair. -One side of her body was weaker than the other	F 880	compliance by administrator, DON and/or designee to the QAPI committee which will include recommendations for continuation/discontinuation/ revision of audits until the facility demonstrates sustained compliance as determined by committee based on audit findings.	

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F 880	Continued From page 29	F 880		

and positioning her pants and underwear in that manner allowed her to use the toilet more independently.
*She was mostly continent of bowel and bladder.
*There was not a barrier between the cloth seat of her recliner and her bare bottom.

Observation and interview on 3/8/22 at 11:05 a.m. with director of nursing B regarding resident 19 revealed she:
*Was unaware of the observations referred to above then confirmed the same finding.
-A towel had now been placed on the recliner seat.
*Expected some type of water resistant barrier had been placed on the recliner seat to mitigate the resident's risk for infection.

2. Observation and interview on 3/7/22 between 9:20 a.m. and 9:30 a.m. with LPN C in resident 35's room revealed she:
*Appropriately performed hand hygiene, applied gloves, face mask, and a gown prior to entering that room posted for contact precautions.
*Set a medication cup with pills, a cup with pre-mixed laxative powder and water, and an insulin pen on top of the over-the-bed table in front of the resident.
*Set packaged intravenous (IV) medication and IV supplies on a wall shelf.
a. Lowered the bed covers, raised the resident's gown, cleaned an area on the left side of her abdomen with an alcohol pad, administered insulin, lowered the gown, and re-covered her with her bed covers.
b. Without removing her gloves, performing hand hygiene, and applying clean gloves she:
*Touched skin near the resident's eyes while instilling her eye drops.

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c. Without removing her gloves, performing hand hygiene, and applying clean gloves she then:
*Cleaned the resident's IV access site with an alcohol pad, flushed that IV port, reached into and removed from her front smock pocket a Sharpie marker then wrote an administration start time on the IV bag.
-Recapped and returned the Sharpie to her front smock pocket.
*Lifted the bedding that covered the resident's left foot after she complained of that foot hurting.
-Manipulated the foamed left foot boot into a more comfortable position.
d. Without removing her gloves, performing hand hygiene, and applying clean gloves she then:
*Connected the IV tubing between the port and the IV bag, hung the IV antibiotic medication, and programmed the IV pump to begin the IV antibiotic infusion.
*After removing her personal protective equipment, performing hand hygiene, and leaving the room she agreed opportunities for glove removal, hand hygiene, and the application of clean gloves had been missed during transitions in care after her gloves had touched unclean areas.

3. Observation and interview on 3/8/22 at 8:50 a.m. with LPN C in resident 25's room during medication administration revealed she:
*Appropriately performed hand hygiene, entered that room, coughed twice into her inner right wrist area, then applied gloves.
*Opened a bedside table drawer, rummaged through that drawer then handed the resident an unpackaged straw that he had requested.
*Picked up his used straw that had dropped on the floor and placed it into a garbage can.
*Without removing her gloves, performing hand

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F 880	Continued From page 31	F 880		

hygiene, and applying clean gloves she assisted the resident with his scheduled inhaler medications.
*Removed her gloves and performed hand hygiene after leaving the room.
*Agreed her gloves should have been removed, hand hygiene performed, and new gloves applied after touchiing unclean areas and before assisting the resident with his inhaler.

Review of the May 2021 Standard Precautions policy revealed: "Gloves should be removed, hand hygiene performed and a new pair of gloves applied before moving from a contaminated area to a clean area."
4. Observation on 3/7/22 at 10:15 AM with CNA I and RN E regarding resident 41's personal care and wound care revealed:
* Resident 41 was laying in her bed.
*CNA I applied gloves, positioned her to her left side, removed an incontinent product and was cleaning stool from her buttocks with wipes.
*RN E came into her room.
- Placed dressing supplies on the bedside table without a barrier.
-Applied gloves.
-Removed two old dressings from her right buttocks and disposed of them in the trash receptacle.
-Cleansed the two areas of her bottom with saline and gauze and disposed of it in the trash receptacle.
-Then without removing gloves went to pick up the clean dressing supplies.
-RN E was stopped and redirected to remove her soiled gloves, perform hand hygiene and apply clean gloves before opening or applying new dressings.
-RN E agreed she needed to remove her soiled

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F 880	Continued From page 32	F 880		

gloves, wash her hands and apply clean gloves before applying a clean dressings and stated she should have remembered to do this without a prompt from the surveyor.
-RN E thanked this surveyor she then proceeded to remove soiled gloves, washed her hands and then applied clean gloves.
-RN E then applied two clean dressings to her right buttocks.

*A dressing change policy was requested from the facility administrator and was not provided, but a competency -aseptic technique form was provided.

Interview on 3/9/22 at 11:50 a.m. with DON B regarding resident 41's dressing change revealed;
*She was not familiar with the dressing change competency for nursing staff.
*RN E started working at the facility in December 2021.
*The dressing change competency for nursing staff had not been completed with new nurse staff since she had started as the DON.
*Her expectation was that nursing would perform infection control during dressing changes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 03/23/2022
FORM APPROVED
OMB NO. 0938-0391

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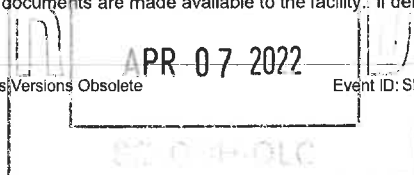
E 000	Initial Comments Surveyor: 40788 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 3/6/22 through 3/9/22. Avantara Arrowhead was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Malys	NHA	04/07/22

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
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	435051	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/08/2022**

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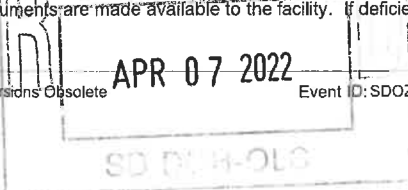
K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/8/22. Avantara Arrowhead was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Malys	NHA	04/07/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



South Dakota Department of Health

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	10668	A. BUILDING: ______ B. WING ______	03/09/2022

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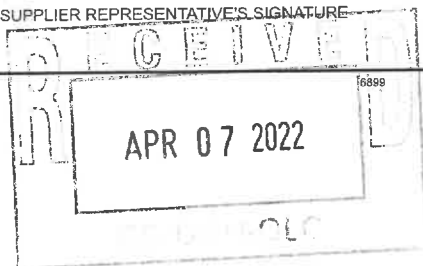
S 000	Compliance/Noncompliance Statement Surveyor: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/6/22 through 3/9/22. Avantara Arrowhead was found not in compliance with the following requirement: S326.	S 000		
S 326	44:73:08:07 Medication Administration Medication administration shall comply with §§44:73:08:02 to 44:73:08:05, inclusive, and with the requirements for training in §§20:48:04.01:14 and 20:48:04.01:15 and for supervision in §20:48:04.01:02. The supervising nurse shall provide an orientation to the unlicensed assistive personnel who will administer medications. The orientation shall be specific to the facility and relevant to the residents receiving administered medications. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 40788 Based on personnel file review, interview, and job description review, the provider failed to ensure: *Two of two medication aides (MA) (H and P) had received annual MA training. *There was a process to monitor the status of annual MA training. Findings include: 1. Interview and review of personnel files on 3/8/22 at 2:30 p.m. with human resource coordinator J revealed: *MA H's hire date was 10/13/20 and MA P's hire date was 7/1/19. -There was no documentation they had received specific training annually for medication	S 326	No immediate corrective action could be taken for staff members H and P missing annual Medication Aide training. All residents are at risk of being administered medication by a Medication Aide who has not been properly trained by a licensed nurse. Staff members H and P will have their annual training completed no later than April 15, 2022. Staff members H and P are the only two medication aides that have been employed with the facility in excess of one year. The Human Resources Director has implemented a tracking system to ensure medication aides annual training is completed within the required time frame. 2. All medication Aides currently employed at the facility will complete their annual training no later than April 15, 2022, and those not in attendance at the training session due to vacation, illness, or casual work status will be trained prior to their first shift worked. New medication aides that have been hired by the facility will complete a medication administration competency on day one of their	04/18/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ashley Malys

TITLE: Administrator

(X6) DATE: 04/02/2022



South Dakota Department of Health

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	10668	A. BUILDING: ____ B. WING ____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA ARROWHEAD	2500 ARROWHEAD DR RAPID CITY, SD 57702

(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 326	Continued From page 1 administration. Interviews on 3/8/22 at 4:30 p.m. and on 3/9/22 at 10:40 a.m. with director of nursing (DON) B revealed she: *Assumed the DON position in October 2021. *Stated there were four MAs. -Two MAs (H and P) had been employed for greater than one year. *Confirmed MAs H and P had not received specific training annually for medication administration. *Had not known who was responsible for ensuring annual MA training had occurred. -There was no system to track when MAs had received annual medication training to ensure it had been completed and in a timely manner. Review of the September 2019 Medication Aides job description revealed no expectation for annual training in all aspects of medication administration.	S 326	orientation. The Human Resources Director will track the date of competency to ensure training is completed annually. 3. The DON or designee will audit all new Medication Aides to ensure competencies are completed during orientation. The audit will be weekly for four weeks, and then monthly for two months. The results of the audit will be discussed by the DON at the monthly QAPI meeting with IDT and Medical Director for analysis and recommendation for continuation/ discontinuation/ revision of audit based on findings.	
S 000	Compliance/Noncompliance Statement Surveyor: 40788 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 3/6/22 through 3/9/22. Avantara Arrowhead was found in compliance.	S 000		