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
	435048	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

(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 000	INITIAL COMMENTS Surveyor: 41895 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 11/2/21 through 11/4/21. Avantara Groton was found not in compliance with the following requirements: F582, F657, F658, F686, F698, F760, F801, F812, F880, and F883. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from11/2/21 through 11/4/21. Areas surveyed included quality of care and resident rights. Avantara Groton was found not in compliance with the following requirements: F658, F686, F760, F801, and F880.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.	F 582	A skilled nursing facility Advance Beneficiary Notice (SNFABN) for resident 28 has been completed with the applicable dates and given to resident 28. All residents may be at risk. The administrator will complete a retrospective review of all residents still residing in the facility after a Medicare stay to ensure ABNs were issued timely by 12/3/2021.The Social Service Director, Administrator, and other applicable staff were educated on SNFABN requirements, including timely deliver, on 11/22/2021 by the VicePresident of Clinical Reimbursement andAssessment. The Administrator or designee will audit all residents who come to the end of their Medicare stay to ensure the ABN was issued timely. The audits will be weekly for 4 weeks, then monthly for 2 months. The administrator will report audit findings at the QAPI meeting monthly for review and recommendations.	12/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Shana Bedford, LNHA | Administrator | 12/7/2021

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 582	Continued From page 1 §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on record review and interview, the provider failed to ensure the proper Medicare notice was provided for one of three sampled	F 582		

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F 582	Continued From page 2 residents (28) who had remained in the facility following his discharge from skilled services. Findings include: 1. Review of resident 28's medical record revealed: *His last day of Medicare part A services was 10/12/21. *He had covered days remaining and continued to reside in the facility. *There was no record of a signed Skilled Nursing Facility Advance Beneficiary Notice (SNFABN). -This standardized notice allows Medicare beneficiaries to make informed decisions about whether to received certain Medicare services and accept financial responsibility for those services if Medicare does not pay. Interview on 11/3/21 at 11:10 a.m. with social services coordinator C regarding resident 28's SNFABN revealed: *She knew she should have completed the SNFABN. *She had not completed the SNFABN. A SNFABN policy had been requested on 11/3/21 at 11:30 a.m. from director of nursing B. *At 2:22 p.m. she indicated they did not have a policy.	F 582		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	Resident 16 and 25's care plans will be reviewed and updated to reflect their current needs and preferences by the Interdisciplinary team (IDT) by 12/3/2021. The IDT team will review and update all residents' care plans to reflect their current needs and preferences by 12/3/2021. Policy was reviewed with no revisions needed. The DON or designee will educate all care staff, no later than 12/3/2021 on the need to ensure care plans are up to date and reflect residents' current care needs. Education will include reporting any changes in care needs or preferences to the nurse to update care plans as changes occur. Those not in attendance will be educated prior to their next shift worked.	12/3/2021

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F 657	Continued From page 3 includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure two of eighteen sampled residents (16 and 25) had care plans revised to reflect the residents' current needs and preferences. Findings include: 1. Observation on 11/2/21 at 11:38 a.m. of resident 16 in the dining room seated in his high-back wheelchair with sheepskin padding behind his upper back. Interview on 11/2/21 at 2:35 p.m. with certified nursing assistant (CNA) M regarding resident 16 revealed:	F 657	The DON or designee will audit 3 random resdient's care plans each week to ensure they reflect their care needs and preferences. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for review and recommendations.	

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F 657	Continued From page 4 *He was dependent on staff and a total lift during cares. *He had been unable to communicate other than to mumble. *He was repositioned about every two hours and checked on often by staff. *The CNAs were not expected to chart or document when they repositioned residents. Review of resident 16's 9/8/21 quarterly minimum data set (MDS) assessment revealed: *He was at risk for pressure injury. *He had a pressure reducing device for his chair and bed. *Needed extensive physical assistance of two or more staff for bed mobility. *Was totally dependent on two or more staff for transfer. *Was not able to walk. *Interventions included a pressure reducing device for his chair and bed. *Repositioning/turning program had been marked as not used. Review of resident 16's medical record revealed: *He had been admitted on 6/11/17. *Diagnosis of dementia with Lewy bodies, anxiety disorder, right shoulder pain, atrial fibrillation, osteoarthritis, communication deficit. *He had an unstageable pressure ulcer to his right shoulder blade that had been identified on 10/5/21. Review of resident 16's 6/23/21 revised care plan revealed: *Resident had a history of pressure ulcer injury on his right heel and coccyx. *Interventions: -Apply barrier cream PRN (as needed) after	F 657		

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F 657	Continued From page 5	F 657		

incontinent episode, and dry peri area; initiated 12/23/20.
-Apply ointments/medications and change dressings per MD order, initiated 3/26/21.
-Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; initiated 12/12/18.
-Anticipate and meet needs, change resident when needed and be sure to dry perineum to prevent break down; no initiation date.
-Apply barrier cream as needed to prevent skin impairment; initiated 8/20/20.
-Has fluctuating air mattress on his bed; initiated 2/4/19 and revised on 7/6/19.
-Wear protective boots at all times; initiated 12/12/18.
*A handwritten entry initiated on 10/27/21:
-Actual skin impairment. Unstageable pressure ulcer to left scapula.
*There was no mention of:
-A cushion to be placed in his wheelchair.
-A repositioning schedule.
-His sheepskin protective padding.

Interview on 11/4/21 at 8:28 a.m. with director of nursing (DON) B regarding resident 16 revealed:
*They shared an MDS coordinator with another sister facility.
-She worked twice a week one week and three times a week the next week alternating between the two facilities.
-They worked together to complete the care plans but DON B had been responsible to make sure they were kept current.
*A physician referral had been made for occupational therapy (OT) to evaluate the resident's wheelchair and for pressure relief on 10/28/21.
*She stated the OT referral for evaluation should

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F 657	Continued From page 6	F 657		

have been requested earlier as his pressure ulcer had been discovered on 10/5/21.
*She was not aware his care plan had not been revised to include the sheepskin padding, repositioning, or a cushion for his wheelchair but would expect it to be included in his current interventions.

Interview on 11/4/21 at 11:38 a.m. with administrator A revealed:
*They had identified some gaps in documentation and were working to get those areas corrected.
*Her expectation would be that staff complete documentation and assessments to ensure resident information is kept current to meet their needs.
Surveyor: 41895
2. Interview on 11/2/21 at 2:17 p.m. with resident 25 regarding her interests revealed she:
*Would like to watch professional football games but did not know the schedule or the television channels.
*Had been a professional football fan for years.

Review of resident 25's 10/5/21 admission Activity Evaluation indicated she:
*Was able to make her needs known.
*Since admission she enjoyed collecting, family contact, music, news/current events, outside/fresh air, religious services, and watching television.
*Liked to watch professional football in her free time.

Review of resident 25's revised 11/3/21 care plan revealed:
*She was new to the facility.
*There had been no documentation of her interests on the care plan.

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F 657	Continued From page 7	F 657		

Interview on 11/3/21 at 3:25 p.m. with activity coordinator G regarding resident 25 revealed she had:
*Known resident 25 had wanted to watch professional football.
*Been trying to figure out what channels the facility had because all the televisions had different channels.
*Agreed that they had television channels which would have professional football on them.
*Staff had not been told she liked to watch football but she was going to write it in the communication book today.
*Agreed resident 25's care plan had not reflected her interests.

Interview on 11/3/21 at 4:06 p.m. with DON B regarding resident 25 revealed:
*They do have regular cable with local channels that would have had professional football games on them.
*Resident 25's family had told her last week she liked football and the game was put on for her on Thursday evening.
*She would help activity coordinator G figure out the television channels so resident 25 could watch football.
*Agreed the Care plan should have reflected resident 25's interests.

Review of the provider's September 2019 Care Planning policy revealed:
*"1. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personally facets must be addressed in addition to medical/diagnosis-based care considerations.
*2. Each resident has the right to be happy,

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F 657	Continued From page 8 continue their life-patterns as able, and feel comfortable in their surroundings. *3. Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death. *4. Each resident is included in the care planning process and encouraged to achieve or maintain their highest practicable physical and mental abilities through the nursing home stay. *5. The physician's orders (including medications, treatments, labs, and diagnostics) in conjunction with the resident's care plan constitute the total 'plan of care.' Physicians order's are referenced in the resident's care plan, but not rewritten into that care plan. *6. The DON will be responsible for holding the team accountable to initiating and completing the Admission care plan within 48 hours and the long-term care plan by day 21 and updated as necessary thereafter."	F 657		
F 658 SS=D	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: Surveyor: 41088 Based on observation, interview, record review, and policy review the provider failed to ensure family and physician had been notified, physician orders had been received, weekly skin assessments, and monthly pressure ulcer risk assessments had been completed, for one of one sampled resident (16) who had developed a	F 658	Resident 16's primary care provider (PCP) was notified, orders were obtained and reflected on his care plan, and family was notified by RN, DON on 11/2/2021. Residents 16's weekly skin assessments have been completed. All residents may potentially be at risk. the DON or designee will review all current residents' medical records to ensure monthly risk assessments have been completed on all residents by 12/3/2021. The PCP and families, if applicable, will be notified of any identified skin concerns/treatments and care plans will be updated to reflect those interventions by the DON or designee by 12/3/2021. Policies were reviewed with no revisions needed. The DON or designee will provide education by 12/3/2021 to all care staff on reporting skin changes to the nurse. Nurses' education will aslo include assessing reported skin changess, notifying the PCP and family if applicable, obtaining and following pressure ulcer risk assesments and updating care plans with current interventions. Those not in attendance will be educated prior to their next worked shift. The DON or designee will audit 3 random medical records weekly to ensure weekly skin/altered skin assessments, monthly pressure ulcer risk assessments are completed; concerns are communicated to the PCP	12/3/2021

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F 658	Continued From page 9 pressure ulcer while in the facility. Findings include: 1. Review of resident 16's medical record revealed: *He had admitted on 6/11/17. *His diagnoses included: -Dementia with Lewy bodies. -Anxiety disorder. -Atrial Fibrillation. -Osteoarthritis. -Right shoulder pain. -Cognitive communication deficit. *A pressure ulcer on his left shoulder blade had been identified on 10/5/21. *No note that his physician or family had been notified of the new pressure ulcer. *A 10/28/21 fax to his physician requesting: -"[Resident name] has an unstageable pressure ulcer to his left scapula. Measures 4 cm [centimeters] X 3 cm. Per wound care recommendations may we have orders to apply hydrogel to wound bed, cover with border dressing, change once daily? Will follow up with wound care next week." *No physician orders had been obtained regarding how to treat the pressure ulcer until a phone order had been obtained on 11/2/21, almost a month later. Review of resident 16's Braden scale assessment for predicting pressure ulcer risk revealed: *On 1/4/21, 3/21/21, and 9/7/21 he was identified as at high risk for developing pressure ulcers. *There had not been assessments completed for February, April, May, June, July, August, or October of 2021. Review of resident 16's weekly skin evaluations	F 658	and family if applicable, orders are obtained, if applicable and care plans are updated to reflect current interventions. Results of audits will be presented by the DON or designee at the monthly QAPI meeting for review and recommendations for not less than 3 months.	

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F 658	Continued From page 10 revealed: *His 9/26/21 evaluation had noted no skin alterations. *His 10/10/21 evaluation noted a wound to his left shoulder. *An evaluation had not been completed on 9/12/21 or 10/3/21. Review of resident 16's weekly skin alteration assessments revealed: *Assessments were completed on 10/13/21, 10/20/21, and 10/27/21. *An assessment had not been completed the week of 10/5/21 when the pressure ulcer had been discovered. *His 10/13/21 assessment indicated an area 4 cm X 3 cm that was unstageable. -50% granulated, 50% necrotic, regular/well defined margins, surrounding edges intact and no drainage present. -Note: Resident has an unstageable pressure ulcer to his left scapula. Area measures at 4 cm X 3 cm. Area covered with protective dressing and resident repositioned frequently *His 10/20/21 assessment had no changes. -Note: Area is showing improvement. *His 10/27/21 assessment indicated no changes. -Note: Will be seen by wound care on 10/28/21. Interview on 11/4/21 at 8:28 a.m. with director of nursing (DON) B regarding resident 16 revealed: *She agreed that there had not been a physician order for how to treat the pressure ulcer. *She could not remember if notification had been made to the physician or family when the pressure ulcer had been discovered but it should have been in charting if it was done. *Weekly skin assessments were to be completed by nursing staff.	F 658		

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F 658	Continued From page 11 *Certified Nursing Assistant (CNA)s were to check for any skin issues during resident bathing and report concerns to the nurses. *She stated she: -Had not been aware there were missing Braden scale assessments, weekly skin evaluations or weekly skin alteration assessments. -Agreed if those documents were not in the charting or on the MAR it had not happened. -Stated it was a professional standard for nursing staff to follow physician orders and document on the MAR. -Had been responsible for completing the weekly skin alteration assessments. -Confirmed there had been a delay in getting the resident assessed, added interventions in place and getting a physician order for treatment. *The care plan should have been updated when the interventions had been added for the resident.	F 658		
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:	F 686	Residents 16's primary care provider (PCP) was notified, orders were obtained, care plan was updated with current interventions, and family was notified by RN, DON on 11/2/2021. Residents 16's weekly skin assesssments have been completed weekly since end of survey. All residents at risk for impaired skin integrity have the potential to be affected. The DON or designee will review all resdients' medical records for completed montly skin risk assessments. If not completed, the DON or designee will complete no later than 12/3/2021. All residents will have a skin assessment performed by the DON or designee no later than 12/3/2021. Any identified areas of concerns will be immediately communicated to the PCP for review and treatment orders, care plans will be updated to reflect current interventions and families will be notified, if applicable by 12/3/2021. The DON or designee will educate the nursing staff regarding skin program policy, which includes completion of the user Defined Assessments (UDA) for routine weekly skin evaluations and weekly altered skin evaluations for identified areas, as well as monthly skin risk assessments by 12/3/2021. The education will also include notification to the PCP for review and treatment orders, notification of families of updated conditions/treatment and updated care plans to reflect current interventions. Those not in attendance at the	12/3/2021

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	435048	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 686	Continued From page 12 Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure one of one sampled resident (16) who had developed a pressure ulcer while in the facility had: *Family and physician notified of the new pressure ulcer. *Obtained physician orders for treatment of the pressure ulcer. *Interventions for prevention of the pressure ulcer updated in his care plan. *Weekly skin assessments and wound assessments completed. *Monthly pressure ulcer risk assessments completed. Findings include: 1. Observation on 11/2/21 at 11:38 a.m. of resident 16 seated in his wheelchair in the dining room getting assistance from certified nursing assistant (CNA) I to eat his meal. *Resident had a sheepskin padding between his high-back wheelchair and behind his upper back. Interview on 11/2/21 at 2:35 p.m. with CNA M regarding resident 16 revealed: *He was dependent on staff and a total lift during cares. *He had been unable to communicate except to mumble. *He was repositioned about every two hours and checked on often by staff. *The CNAs had not been required to chart or document when they repositioned residents. Observation and interview on 11/2/21 at 4:03 p.m. with CNA I assisting registered nurse (RN) J to complete a dressing change for resident 16	F 686	education session due to vacation, sick leave, or causal work status will be educated prior to their next shift worked. The DON or designee will audit all residents with wounds each week for wound documentation, notification of PCP/families, and reflection of current interventions on their care plans. Additionally, the DON or designee will audit 3 random residents' medical records for completeion of routine weekly skin assessments and monthly presure ulcer risk assessments, Audit findings will be providied by the DON or designee monthly to the QAPI meetings for review and recommendations for not less than 3 months.	

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F 686	Continued From page 13	F 686		

revealed:
*The resident had been seated in his recliner.
*RN J brought dressing supplies into the resident's room and completed the dressing change.
*CNA I had assisted him to lean forward and back against the back of his recliner when the dressing had been changed.
-She stated she had not been working when the wound was discovered and was not sure when that had been.
*RN J stated:
-The wound had recently been discovered.
-She was unsure what date that had been.
-There had been a physician order for how to treat the pressure ulcer.
*The pressure ulcer was unstageable due to the eschar covering the area.
*She placed a clean dressing dated 11/2/21 onto the wound and lowered his shirt.
*CNA I leaned the resident back into position in his recliner.

Review of resident 1's medical record revealed:
*He had admitted on 6/11/17.
*His diagnoses included:
-Dementia with Lewy bodies.
-Anxiety disorder.
-Atrial Fibrillation.
-Osteoarthritis.
-Right shoulder pain.
-Cognitive communication deficit.
*A 10/5/21 note in charting that identifies a pressure ulcer on his left shoulder blade on 10/5/21.
*No note that his physician or family had been notified of the new pressure ulcer.
*A 10/28/21 fax to his physician requesting:
-"[Resident name] has an unstageable pressure

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F 686	Continued From page 14	F 686		

ulcer to his left scapula. Measures 4 cm X 3 cm. Per wound care recommendations may we have orders to apply hydrogel to wound bed, cover with border dressing, change once daily? Will follow up with wound care next week."
*No physician orders had been obtained regarding how to treat the pressure ulcer until a phone order had been obtained on 11/2/21, almost a month after the pressure ulcer had been discovered.

Review of resident 16's 9/8/21 quarterly minimum data set (MDS) assessment revealed:
*He was at risk for pressure injury.
*Needed extensive physical assistance of two or more staff for bed mobility.
*Was totally dependent on two or more staff for transfer.
*Was not able to walk.
*Interventions included a pressure reducing device for his chair and bed.
*Repositioning/turning program had been marked as not used.

A review of resident 16's 1/4/21, 3/21/21, and 9/7/21 Braden Scale for predicting pressure sore risk assessments revealed he had been at high risk for developing pressure ulcers.
*There had not been assessments completed for February, April, May, June, July, August, or October of 2021.

Review of resident 16's weekly skin evaluations revealed:
*His 9/26/21 evaluation had noted no skin alterations.
*His 10/10/21 evaluation noted a wound to his left shoulder.
*An evaluation had not been completed on

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F 686	Continued From page 15 9/12/21 and 10/3/21. Review of resident 16's 10/13/21, 10/20/21, and 10/27/21 weekly skin alteration assessments revealed: *An assessment had not been completed the week of 10/5/21 when the pressure ulcer had been discovered. *His 10/13/21 assessment indicated an area 4 centimeters (cm) X 3 cm that was unstageable. -50% granulated, 50% necrotic, regular/well defined margins, surrounding edges intact and no drainage present. -Note: Resident has an unstageable pressure ulcer to his left scapula. Area measures at 4 cm X 3 cm. Area covered with protective dressing and resident respositioned frequently *His 10/20/21 assessment had no changes. -Note: Resident has an unstageable pressure ulcer to his left scapula. Area measure at 4 cm X 3 cm. Area covered with protective dressing and resident repositioned frequently. Area is showing improvement. *His 10/27/21 assessment indicated no changes. -Note: Will be seen by wound care on 10/28/21. Review of resident 16's 6/23/21 revised care plan revealed: *Resident had a history of pressure ulcer injury on his right heel and coccyx. *Interventions: -Apply barrier cream PRN (as needed) after incontinent episode, and dry peri area; initiated 12/23/20. -Apply ointments/medications and change dressings per MD order, initiated 3/26/21. -Avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short; initiated 12/12/18.	F 686		

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F 686	Continued From page 16 -Anticipate and meet needs, change resident when needed and be sure to dry perineum to prevent break down; no initiation date. -Apply barrier cream as needed to prevent skin impairment; initiated 8/20/20. -Has fluctuating air mattress on his bed; initiated 2/4/19 and revised on 7/6/19. -Wear protective boots at all times; initiated 12/12/18. *A handwritten entry initiated on 10/27/21: -Actual skin impairment. Unstageable pressure ulcer to left scapula. *There was no mention of: -A cushion to be placed in his wheelchair. -A repositioning schedule. Interview on 11/4/21 at 8:28 a.m. with director of nursing (DON) B regarding resident 16 revealed: *She agreed that there had not been a physician order for how to treat the pressure ulcer. *She could not remember if notification had been made to the physician or family when the pressure ulcer had been discovered but it should have been in charting if it was done. *Weekly skin assessments were to be completed by nursing staff. *CNAs were to check for any skin issues during resident bathing and report concerns to the nurses. *She stated she: -Had not been aware there were missing Braden assessments, weekly skin evaluations or weekly skin alteration assessments. -Agreed if those documents were not in the charting it had not happened. -Had been responsible for completing the weekly skin alteration assessments. -Confirmed there had been a delay in getting the resident assessed, added interventions in place	F 686		

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F 686	Continued From page 17 and getting a physician order for treatment. -When there had been no response from the physician there should have been follow-up. *The care plan should have been updated as soon as possible once the interventions had been added for the resident. Review of the provider's revised April 2021 Skin Program Policy revealed: *"Risk assessments [Braden or PUSH] will be completed with admission/readmission weekly for four weeks, and then monthly thereafter. *When a pressure injury, bruise, or skin tear is noted, a Skin Evaluation UDA [user defined assessment] should be completed, and the injury entered into Risk Management in [Name of computer program]. 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 competed weekly until resolved. *Nursing personnel will develop a plan of care with interventions consistent with resident and family preferences, goals and abilities, to create an environment to the resident's adherence to the pressure injury prevention/treatment plan. POC [plan of care] to include: Impaired mobility, pressure relief, nutritional status and interventions, incontinence, skin conditions, treatment, pain, infection, education of resident and family, possible causes for pressure injury and what interventions have been put into place to prevent. Skin checks to be completed at least weekly by a licensed nurse. *Routine skin checks will be completed weekly and recorded on the Skin Evaluation UDA."	F 686		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698	Resident 5's past omitted assessments of dialyisis access site and pre/post dialysis treatment cannot be corrected. Resident 5's is being assessed pre/post	12/3/2021

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F 698	Continued From page 18 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, record review, and policy review, the provider failed to ensure dialysis assessments had been completed before and after dialysis treatment, and the dialysis access site had been monitored as ordered for one of one sampled resident (5) receiving dialysis treatments. Findings include: 1. Observation and interview on 11/2/21 at 9:12 a.m. with resident 5 revealed she: *Recently started dialysis. *Went to dialysis treatments at an off-site location nearby on Mondays, Wednesdays, and Fridays. *Was scheduled to leave early in the morning at 6:00 a.m. and returned at 11:30 a.m. *Showed her dialysis catheter located on her right upper chest area. -It was covered with a dressing dated 11/1/21. *Reported nurses checked on her before and after she returned from dialysis treatments. Review of resident 5's medical record revealed: *She had admitted on 8/3/21. *She received dialysis three times a week on Mondays, Wednesdays and Fridays. *Her diagnosis of: -Amputation of lower right leg below the knee. -Stage 4 chronic kidney disease.	F 698	dialysis treatments and access site is being assessed as ordered. All residents who receive dialysis may potentially be at risk. The DON or designee will review medical recordsfor all residents who receive dialysis for documentation of completed assessments by 12/3/2021. The DON or designee will educae nursing staff on dialysis resident assessment pre/post treatment and assessment of access site by 12/3/2021. Those not in attendance will be educated prior to their next shift worked. The DON or designee will audit all residents who receive dialysis for documentation of pre/post assessments and access site assessment(s) weekly. Audit findings will be provided by the DON or designee to the monthly QAPI meetings for review and recommendations for not less than 3 months.	

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F 698	Continued From page 19	F 698		

-Type II diabetes.
-Hypertension.
-Anxiety disorder.
-Respiratory failure
-Major depressive disorder.
-Anemia
*A 9/8/21 physician's order for her dialysis site to be checked by nursing staff twice a day and documented on the MAR.

Review of resident 5's dialysis evaluations for pre and post dialysis treatments revealed:
*Missed evaluations for 8/16/21, 8/18/21, 8/20/21, 8/27/21, 10/4/21, 10/15/21, 10/22/21, and 10/25/21.
*Those evaluations were to monitor for complications such as bleeding, hypotension, or infection.

Review of resident 5's medication administration records (MAR) revealed:
*September 2021:
-There had been missed documentation on 9/16, 9/20, 9/23, 9/27, and 9/29.
October 2021:
-There had been missed documentation on 10/3, 10/6, 10/10, 10/15, 10/18, and 10/20.

Interview on 11/3/21 at 7:40 a.m. with registered nurse (RN) J regarding resident 5 revealed:
*The resident had left for dialysis early in the morning.
*Confirmation nursing were to do an assessment before and after she returned from her treatments.
*The dialysis site was to be checked for infection or leaks and documented on the MAR.

Interview on 11/4/21 at 8:40 a.m. with director of

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F 698	Continued From page 20 nursing (DON) B regarding resident 5 revealed: *They had identified there were gaps in documentation for the resident's dialysis care. *They had addressed these concerns with nursing staff to correct things. *She agreed the physician order for the dialysis site to be checked twice daily had been missed at times. *Confirmed the above missing documentation. Review of the provider's November 2019 Dialysis Management policy revealed: *Ensure facility completed dialysis communication form accompanies resident to dialysis on treatment days to facilitate communication of resident information and coordinate care between dialysis center and facility. *Dialysis center personnel to complete dialysis communication form and return to facility. *Upon return from dialysis center, review information provided on dialysis communication form. Communicate and address as appropriate. Complete post-dialysis information and place in resident's medical record/record on UDA in electronic medical record. *Assess and manage post dialysis complications.	F 698		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, record review, and policy review the provider failed to ensure: *Physician orders had been followed for one of	F 760	Resident 5, 25 and 186's past omitted documentation cannot be corrected. All residents may potentially be at risk. The DON or designee will educate nursing staff on timely documentation in the medication administration record (eMAR) for administration of medications, blood sugars, ordered weights, dialysis access sites assessed, and the process for medication errors, which includes notifying physician/resident representative by 12/3/2021. Those not in attendance will be educated prior to their next shift worked. The DON or designee will review eMAR documentation reports each week-day to ensure medications were administered as ordered,	12/3/2021

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F 760	Continued From page 21 one sampled resident (25) related to blood sugar levels. *Physician orders had been followed and documented on the medication administration record (MAR) for three of three sampled residents (5, 25, and 186) Findings include: 1. Interview on 11/2/21 at 9:42 a.m. with resident 25 revealed she had diabetes and received insulin. Review of resident 25's October 2021 MAR revealed: *A physicians order for sliding scale insulin three times a day, meaning the dose of insulin was based on blood sugar level. -The doctor was to be notified when her blood sugar was less than 60 or greater than 400. -On 10/9/21, 10/10/21, and 10/28/21 at 7:00 a.m. her blood sugar was less than 60. -On 10/29/21 at 11:00 a.m. her blood sugar was 485. -On 10/6/21 at 7:00 a.m. her blood sugar had been documented as not applicable. -On 10/3/21 at 5:00 p.m., on 10/4/21 at 11:00 a.m., and on 10/18/21 at 7:00 a.m. and 11:00 a.m. there had been no documentation of what her blood sugar was or if she had required insulin. *A physicians order for two units of insulin Aspart solution to be administered prior to noon and evening meals. -There had been no documentation she had received the prescribed dose for five out of sixty opportunities. *A physicians order for Metformin 500 milligram (mg) tablet twice a day. -There had been no documentation she had	F 760	the medication error process is followed, the documenation of dialysis access site assessments, ordered weights, blood sugar results, and notifications to the physician and family of any med errors, if applicable. Audit findings will be provided by the DON or designee to monthly QAPI meetings for review and recommendations for not less than 3 months.	

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F 760	Continued From page 22 received the prescribed dose for one out of sixty-two opportunities. Review of resident 25's medical record revealed: *Documentation on 10/28/21 revealed a fax had been sent to resident 25's physician on 10/28/21 which had included: -Resident's low blood sugar of 54 that morning. -Notification of the on-call doctor. -Resident had been given a glass of orange juice, as breakfast was only half-an-hour away. *There had been no documentation the doctor had been notified of the abnormal blood sugars on 10/9/21, 10/10/21, or 10/29/21. *There had been no documentation what was done about the abnormal blood sugars. *There had been no documentation the doctor, resident, or resident's representative had been notified when blood sugars had not been taken or medications had not been administered. Review of the provider's signed September 2021 standing orders revealed "Hypoglycemia [low blood sugar]: administer glucose gel 1 tube by mouth or 15 grams of carbohydrate snack by mouth for accucheck [blood sugar meter] [less than]80; recheck in 15 minutes. Repeat until accucheck is [greater than]100. Surveyor 41088 2. Interview on 11/2/21 9:12 a.m. interview with resident 5 revealed she was receiving dialysis treatments. Review of resident 5's August 2021 MAR revealed: *An order for Advair Diskus Aerosol Powder 100-50 microgram (mcg) for one puff inhaled orally twice daily.	F 760		

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F 760	Continued From page 23 -No documentation had been completed for two of 62 opportunities. *An order for Carvedilol 12.5 mg daily. -No documentation had been completed for two of 31 opportunities. *An order for Furosemide 80 mg twice a day. -No documentation had been completed for two of 62 opportunities. *An order for Senna Plus 8.6-50 mg one tablet twice daily. -No documentation had been competed for two of 62 opportunities. *An order for Gabapentin 100 mg three times a day. -No documentation had been completed for four of 93 opportunities. Review of resident 5's September 2021 MAR revealed: *An order for Dialyvite 1 mg at bedtime. -No documentation had been completed for one of 30 opportunities. *An order for melatonin 6 mg at bedtime. -No documentation had been completed for one of 30 opportunities. *An order for Advair Diskus Aerosol Powder 100-50 mcg for one puff inhaled orally twice daily. -No documentation had been completed for one of 60 opportunities. *An order for Carvedilol 12.5 mg daily. -No documentation had been completed for one of 30 opportunities. *An order for Furosemide 80 mg twice a day. -No documentation had been completed for two of 60 opportunities. *An order for dialysis site to be checked twice a day. -No documentation had been completed for five of 60 opportunities in September.	F 760		

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	435048	A. BUILDING _____ B. WING _____	C 11/04/2021

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F 760	Continued From page 24 *An order for Gabapentin 100 mg three times a day. -No documentation had been completed for two of 90 opportunities. Review of resident 5's October 2021 MAR revealed: *Duloxetine HCl 30 mg sprinkles daily. -No documentation had been completed for one of 31 opportunities. *An order for Felodipine ER 7.5 mg daily. -No documentation had been completed for one of 31 opportunities. *An order for Lansoprazole capsule delayed release 30 mg daily. -No documentation had been completed for one of 31 opportunities. *An order for Polyethylene Glycol 3350 Powder 17 gram scoop give 34 gram one time daily. -No documentation had been completed for one of 31 opportunities. *An order for Spiriva Respimat Aerosol Solution 2.5 mcg 2 puffs inhaled daily. -No documentation had been completed for one of 31 opportunities. *An order for Advair Diskus Aerosol Powder 100-50 mcg for one puff inhaled twice daily. -No documentation had been completed for one of 62 opportunities. *An order for Carvedilol 12.5 mg twice daily. -No documentation had been completed for one of 62 opportunities. *An order for Furosemide 80 mg twice a day. -No documentation had been completed for two of 62 opportunities. *An order to check dialysis site twice a day. -No documentation had been competed for six of 62 opportunities.	F 760		

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F 760	Continued From page 25 Surveyor 41895 3. Review of resident 186's August 2021 MAR revealed: *An order for daily blood pressure checks. -No documentation this had been completed for one of thirty-one opportunities. *An order for Sertraline 100 mg daily. -No documentation this had been administered for six of thirty-one opportunities. *An order for weekly skin assessment on Saturday. -No documentation this had been completed for one of four opportunities. *An order for monthly weight. -No documentation this had been completed for one of one opportunity. *An order for Advair Diskus one puff two times a day. -No documentation it had been administered for six of sixty-two opportunities. *An order for Clonazepam 0.5 mg two times a day. -No documentation it had been administered for two out of sixty-two opportunities. *An order for Eliquis 5 mg twice a day. -No documentation this had been administered for six out of sixty-two opportunities. *An order for Fluticasone Propionate suspension 1 spray in each nostril twice a day. -No documentation this had been administered for six out of sixty-two opportunities. *An order for Metformin 1000 mg twice a day. -No documentation this had been administered for six out of sixty-two opportunities. *An order for Metoprolol Tartrate 75 mg twice a day. -No documentation this had been administered for six out of sixty-two opportunities. *An order for Topamax 25 mg twice a day.	F 760		

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F 760	Continued From page 26 --No documentation this had been administered for six out of sixty-two opportunities. *An order for Pramipexole Dihydrochloride 0.25 mg twice a day. -No documentation this had been administered for six out of sixty-two opportunities. 4. Interview on 11/4/21 at 10:05 a.m. with director of nursing B revealed: *Resident 25's doctor had not been notified of the 10/9/21, 10/10/21, or 10/29/21 blood sugars. *If a resident had a low blood sugar she would expect the nurses to administer glucose or give them a high protein snack. *She had agreed orange juice was not a high protein snack. *She would have expected all residents to have their blood sugar re-checked if it was abnormal. *She expected physician orders to be followed and all medications given as prescribed. *Agreed if a medication had not been given it would be a medication error. *There had been no medication error reports completed for resident 25 or resident 186. 5. Review of the provider's September 2018 Medication Administration policy revealed: *When a medication was administered it was to be documented on the MAR immediately by the person who administered the medication. *If a regularly scheduled medication had not been given then a reason should have been documented. Review of the provider's June 2020 Medication Errors policy revealed: *"To assure all medication errors are identified in order to prevent adverse resident effects. Errors will be documented, investigated, reported and	F 760		

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F 760	Continued From page 27 reviewed for need of interventions and to prevent recurrence." *Each medication error would be documented on a medication error report form, and reported to resident's physician.	F 760		
F 801 SS=D	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not	F 801	The dietary manager position is open and currently being covered under the 1135 waiver. Recruitment efforts remain in place to fill this position. Educational and certification requirements for dietary manager have been reviewed by the Regional Dietary Specialist (RDS) and discussedwith the Administrator and recommendations. If the newly hired dietary manger (DM) is not a current certified dietary manager (CDM), they will be enrolled in the CDM course upon hire, will complete the course within 1 year. The RD and RDS will participate in training and education of the new hire and will meet with the new hire at least monthly for review of completed lessons and ongoing support and dietary operations. The RD or RDS will provide facility oversight and support, including visiting the facility at least weekly to review/audt dietary operations and assess the nutritional needs of residents, evaluate diets, educate staff and residents as needed, review purchasing of food supplies, food preparation, food storage, and kitchen sanitization until the dietary manager position is filled. Audit findings and food/nutrition services concerns will be discussed by the RD or the RDS at monthly QAPI meetings for review and recommendations.	12/3/2021

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F 801	Continued From page 28	F 801		

provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section.
(iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.

§483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who-
(i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is:
(A) A certified dietary manager; or
(B) A certified food service manager; or
(C) Has similar national certification for food service management and safety from a national certifying body; or
D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and
(ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and
(iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically

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F 801	Continued From page 29 qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation and interview, the provider failed to employ a full-time qualified registered dietician or dietary manager who met the requirements to serve as the director of food and nutrition services. Findings include: 1. Observation on 11/2/21 at 8:16 a.m. of the provider's kitchen revealed: *Housekeeping supervisor K was at the steam table and was working as dietary cook. *Social services coordinator C was working as dietary aide. Interview with housekeeping supervisor K revealed: *There was no dietary manager (DM). *The provider used to contract dietary services. -This arrangement did not work out. -The contract for dietary services ended on 10/1/21. *She -was the housekeeping supervisor. -used to be a dietary cook. -was helping in the kitchen on a regular basis. -was not a certified dietary manager (CDM). Interview on 11/2/21 at 11:55 a.m. with consultant registered dietitian (RD) L revealed: *She started as consultant RD in April 2021. *The was not current DM or CDM. *She had been coming to the facility 3-4 times a month. Interview on 11/4/21 at 12:45 p.m. with administrator A revealed:	F 801		

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F 801	Continued From page 30 *In the absence of a DM, she oversaw the dietary department. *She was not a CDM. *Consultant RD was not full-time.	F 801		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one mechanical dishwasher with heat sanitization had been monitored for appropriate temperature to ensure dishes were sanitized properly. *Three of three refrigerators and freezers were appropriately maintained for best temperature control.	F 812	Thermometers and applicable temperature logs are in place for the above refrigerators, freezers, and dishwasher. All residents may potentially be at risk. The administrator or designee will educate staff on monitoring and documenting temperatures for the dishwasher, refrigerators and freezers by 12/3/2021. Those not in attendance will be educated prior to their next shift worked. Nursing staff will monitor fridge temps for the activity and snack/nourishment fridge. kitchen staff will monitor walk in freezer, walk in cooler, and dishwasher temps. The administrator or designee will audit refrigerators, freezers and dishwasher temperature logs for completion as well as presence of applicable thermometers each week-day. Audit findings will be provided by the administrator or designee to monthly QAPI meeting for review and recommendations for not less than 3 months.	12/3/2021

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F 812	Continued From page 31 Findings include: 1. Observation and interview on 11/2/21 at 8:16 a.m. in the kitchen revealed housekeeping supervisor K working as dietary cook, upon entering the kitchen's dish machine room and asking regarding the sanitization method used, housekeeping supervisor K replied the mechanical dishwasher used "heat sanitizing with temperature at 180 [degrees]." Interview on 11/2/21 at 11:55 a.m. with consultant RD L confirmed that the mechanical dishwasher used heat sanitization with final rinse temperature at 180 degrees Fahrenheit. Observation and interview on 11/4/21 at 9:07 a.m. of the kitchen's dish machine room with medical records coordinator N revealed: *She was working as the dietary dishwasher. *She recently helped by working one day a week in dietary. *She demonstrated how to test for appropriate sanitization by placing an indicator strip on a dishwashing rack, running it through the dishwasher wash and rinse cycles and after the cycles had completed, the indicator strip turned orange as stated on the indicator strip. *She stated the wash cycle should run at 150 degrees and the rinse cycle at 180 degrees. Observation on 11/4/21 at 9:17 a.m. of the posted dish machine temperature log for November 2021 revealed: *For November 1, the breakfast, lunch, and dinner "Wash Temp" and "Rinse Temp" were recorded. -These temperatures complied with the federal regulations for a high temperature dishwasher	F 812		

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F 812	Continued From page 32 using heat sanitization with wash temperatures ranging between 150-165 degrees Fahrenheit (F) and final rinse temperature of 180 degrees F. *For November 2, only the breakfast wash temp of 160 and rinse temp of 186 was recorded. *For November 3, no wash temp or rinse temp for breakfast, lunch, or dinner was recorded. At this time, this surveyor requested the dish machine temperature log for October 2021. 2. Observation and interview on 11/4/21 at 9:49 a.m. of the snack/nourishment refridgerator and freezer in the clean utility room revealed: *In the freezer were various boxes of ice cream products identified with handwritten resident names. *No thermometer was found in the freezer. *In the refrigerator were two sealed containers of luncheon meats and various cans/bottles of drinks. *No thermometer was found in the refrigerator. *An unidentified nursing staff member present in the clean utility room during the above observation was asked who monitors the temperatures of the snack/nourishment refrigerator and freezer replied that dietary staff monitor the temperatures. Interview on 11/4/21 following the observation of the snack/nourishment refrigerator and freezer with consultant RD L and housekeeping supervisor K in the kitchen, when asked who monitors the temperatures of the snack/nourishment refrigerator and freezer revealed: *Consultant RD L stated "That's a good question." *Housekeeping supervisor K replied that dietary staff record the temperatures of the snack/nourishment refrigerator and freezer and	F 812		

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F 812	Continued From page 33 she will provide a log of the temperatures recorded last month. On 11/4/21 at 10:23 a.m. Consultant RD L provided the following records for October 2021 to review: *"Record of Refrigeration Temperatures" -The walk-in refrigerator daily temperatures were recorded for 26 of the 31 days. -The walk-in freezer daily temperatures were recorded for 26 of the 31 days as noted: --Days 1 through 19 were either above the form's stated "not greater that 0 degrees F" or were not recorded and nothing was filled out in the column noted "Comments/Action Taken." --Days 20 through 25 were lined out. --Days 26, 27, and 29 were not recorded. --Day 28 was at -6 degrees F, with "truck freezer" noted. --Day 30 and 31 were within the form's stated temperature range noted above. -The clean utility room's snack/nourishment refrigerator temperatures were recorded for 3 of the 31 days. -The clean utility room's snack/nourishment freezer temperatures were not recorded. -The dining room's activity department refrigerator temperatures were recorded for 2 of the 31 days. -The dining room's activity department freezer temperatures were not recorded. *"Dish machine Temperature Log" -This form contained the following statements: --Stated high temperature machines equal or greater than 180 degrees F. --Notify supervisor when temps are not adequate. -25 rinse temperatures were less than the minimum 180 degrees F. -32 meal time temperatures were not recorded	F 812		

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F 812	Continued From page 34 out of 93 opportunities, a 34% error rate. Interview on 11/4/21 at 12:45 p.m. with administrator A revealed and confirmed: *In the absence of a dietary manager, she was in charge of the dietary department. *Her expectations for the dietary department included: -Daily temperature checks on dishwasher for to be performed at breakfast, lunch, and dinner meals; recording the temperatures on the dish machine temperature log. -Daily temperature checks of the provider's refrigerators and freezers to be completed and noted on the record of refrigeration temperatures form. *In discussing the walk-in freezer's October 20-25 lined out spaces, she stated the provider's freezer had been moved away from the facility to place a cement pad and they had used a refrigerated truck from 10/20/21 to this Monday, 11/1/21. 3. Review of 8/1/19 kitchen policy revealed: *The facility will comply with state and federal regulations in operating facility's kitchen. *Refrigerator temperatures should be 41 degrees and below. *The facility will ensure that the daily temperature is checked to ensure proper temperature.	F 812		
F 880 SS=D	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	F 880	For the identification of lack of: *Appropriate hand hygiene and or use of gloves during performance of assigned tasks.*Appropriate use of barrier during wound care.*Appropriate disinfection of mechanical lift between residents use. The administrator, DON/ infection control nurse and/or designee reviewed the policies and procedures for the above identified areas. The medical director was not available for review at the time of plan of correction, but had reviewed and approved infection prevention and control policies prior to survey. No revisions were necessary as they are in line with CDC and CMS recommendations for the above identified areas.	12/3/2021

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F 880	Continued From page 35 diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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	F 880	All facility staff who provide or are responsible for the above cares and services, including social service worker C, CNA I, CNA M and RN J. will be educated/ re-educated by the DON or designee by 12/3/2021. Those not in attendance will be educated prior to their next shift worked. ALL residents and staff have the potential to be affected if staff do not adhere to identified areas. Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by the administrator, DON or designee by 12/3/21. Root cause analysis conducted using the 5 Whys method. Staff being nervous during surveyor observations was the identified Root Cause for the observed lapses in infection control practices at time of survey. Administrator, DON/infection control nurse, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation.The Regional Nurse Consultant contacted the South Dakota Quality Improvement Organization (QIN) on 11/24/21. The root cause analysis and this plan of correction were discussed. The QIN agreed with this plan of correction and provided links for tools that may be used in continued staff education. Administrator, DON/infection control nurse, and/or designee will conduct auditing and monitoring for areas identified above. Monitoring of determined approaches to ensure effective Implementation and ongoing sustainment include at a minimum 2-3 times weekly for 4 weeks, administrator, DON, infection control nurse, and/or a designee making observations across all shifts to ensure staff compliance with: *Appropriate hand hygiene and/or glove use. *Appropriate use of barrier for supplies during wound care.*Appropriate disinfection of mechanical lift between uses.After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. . Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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	435048	A. BUILDING _____ B. WING _____	C 11/04/2021

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F 880	Continued From page 36 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 41088 Based on observation, interview, and policy review, the provider failed to ensure: *Appropriate glove use and hand hygiene had been performed during two of two observations of residents (4 and 27) personal care by two of two observed certified nursing assistants (CNA) (I and M). *A clean barrier had been placed under wound dressing supplies during wound care by one of one registered nurse (RN) J for one of two sampled residents (16). *One of one mechanical lift had been disinfected after use by one of two CNAs (M). *One of one social services coordinator C had used appropriate hand hygiene while delivering meal trays to residents in their rooms. Findings include:	F 880		

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F 880	Continued From page 37	F 880		

1. Observation and interview on 11/2/21 at 1:43 p.m. with director of nursing (DON) B and CNA I assisting resident 4 with personal care revealed:
*Resident 4 was in her room seated in her wheelchair.
*DON B and CNA I entered the room to assist her to use the restroom.
*DON B washed her hands with soap and water, dried her hands with paper towels, and put on gloves.
*A mechanical lift was brought in the room.
*CNA I entered the room, put on gloves without washing her hands or performing hand hygiene.
*CNA I moved the mechanical lift into position next her wheelchair.
*DON B and CNA I both assisted to attach the mechanical lift back support around the resident and hooked it to the mechanical lift.
*The resident's legs were placed on the foot platform and the leg strap was attached around her lower legs.
*Using the mechanical lift CNA I raised the resident out of the wheelchair and moved her into the restroom.
*She pulled down her pants, removed her brief, and lowered her onto the toilet.
*With the same gloved hands CNA I then closed the bathroom door for privacy.
*When the resident indicated she had finished, CNA I opened the bathroom door.
*She raised the resident off the toilet with the mechanical lift, placed a clean brief on her, pulled up her pants and moved her out of the bathroom and beside her wheelchair.
*CNA I lowered her into her wheelchair, flushed the toilet, took the garbage bag out of the garbage can, removed her gloves, placed them into the garbage bag and tied it shut with bare

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F 880	Continued From page 38	F 880		

hands.
*She opened the door, removed the mechanical lift and parked it in the hallway.
*CNA I had not washed her hands or performed hand hygiene after exiting resident 4's room.
*DON B confirmed CNA I had missed opportunities for washing hands, hand hygiene and glove changes.
-She would expect all staff to follow good infection control procedures.
*CNA I agreed that she had missed opportunities to perform hand hygiene and change gloves.

2. Observation and interview on 11/2/21 at 4:03 p.m. with CNA I assisting RN J to complete a dressing change for resident 16 who had a pressure ulcer on his left shoulder blade revealed:
*RN J brought dressing supplies into the resident's room and placed them onto a bedside stand she had not disinfected.
*She had not placed a clean barrier between the dressing supplies and the bedside stand.
*She washed her hands, dried them, and put on gloves.
*CNA I had placed gloves on and assisted to pull up his shirt and lean resident 16 forward in his recliner where he was seated.
*RN J stated he had an unstageable pressure ulcer that was recently discovered.
*She removed the old dressing that was dated 11/1/21 and stated the wound dressing was changed daily.
*A wound cleanser was sprayed on the area with a spray bottle and she dabbed the area dry with a piece of gauze.
*Surveyor asked if the wound cleanser was designated as the residents and used only for him, she stated it was a stock bottle and not his

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 39 personal bottle of cleanser. *She stated it was unstageable due to the eschar covering the area. *She was not sure what day it had been discovered. *She placed a clean dressing dated 11/2/21 onto the wound and lowered his shirt. *CNA I leaned the resident back into position in his recliner. Interview on 11/4/21 at 11:20 a.m. with DON B regarding the above dressing change revealed: *RN I should have disinfected the bedstand and placed a clean barrier between the stand and the dressing supplies. *She stated he should have his own bottle of wound cleanser that is only used for him alone. *She was unable to find a wound spray bottle that had been designated to resident 16 in the medication room or in the medication carts to confirm he had his own. Surveyor: 41895 3. Observation on 11/2/21 at 10:28 a.m. of certified nursing assistant (CNA) M after she had assisted resident 27 into a chair with a mechanical lift revealed: *She had removed the mechanical lift from resident 27's room and put it in room 104, which was used for storage of the lifts. -She had not disinfected the mechanical lift. *Went back into resident 27's room: -Assisted her to position more comfortably in the chair. -Used a marker on a white board to communicate with her. -Gave her a drink of water. *Left the room with the water cup in her hand,	F 880		

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F 880	Continued From page 40 walked down the hall to the clean utility room, entered the room, filled the water cup, and then went back into the residents room. *During the above observations she had not performed hand hygiene. Interview on 11/2/21 at 10:46 a.m. with CNA M regarding the above observation revealed she had: *Agreed she should have washed her hands before and after entering the room, and when touching contaminated surfaces. *Stated the mechanical lifts were supposed to be cleaned after each use. *Went back to room 104 and disinfected the mechanical lift. 4. Observation on 11/2/21 at 12:14 p.m. of social services coordinator (SSC) C passing meal trays to residents in their rooms revealed: *She had entered and exited rooms 101, 102, 106, and 108. *She had delivered the meal trays and assisted residents with setting up the meal so they could eat. *She had missed eight opportunities to perform hand hygiene during the observations. Interview on 11/2/21 at 12:18 p.m. with SSC C regarding the above observations revealed: *When she was asked when she should wash her hands and she stated, "when I leave a room". *Agreed she should perform hand hygiene when touching a potentially contaminated surface also. 5. Interview on 11/4/21 at 12:32 p.m. with director of nursing B regarding the above observations revealed she: *Agreed staff should have performed hand	F 880		

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F 880	Continued From page 41 hygiene when entering and exiting a resident room and after touching surfaces that could be contaminated. *Expected all mechanical lifts to be disinfected after use with a resident. 6. Review of the provider's October 2019 Hand Hygiene policy revealed: *"This facility considers hand hygiene the primary means to prevent the spread of infections." *Hand hygiene should have been completed: -Before and after handling food. -Before and after direct contact with residents. -When leaving a resident room. -Before handling clean or soiled dressings. -After contact with objects near residents. -After removal of personal protective equipment. Review of the provider's revised 4/10/20 Cleaning and Disinfection - COVID-19 policy revealed: "Supplies and equipment will be cleaned immediately after use."	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;	F 883	Resident 9,11, 23, 32 will either receive their vaccination or will sign a declination form by 12/3/2021. All residents may potentially be at risk. The DON or designee will educate nursing staff on educating and offering the pneumonia vaccination to all newly admitted resdients, and documentation of administration of vaccine or resdient refusal by 12/3/2021. Those not in attendance will be educated prior to their next shift worked. The DON or designee will review all newly admitted resident's medical records to ensure residents were educated and offered pneumonia vaccinations and documentation of administration of vaccine or resident's refusal is in the medical record. Auditing findings will be provided by the DON or designee to monthly QAPI meeting for review and recommendations for not less than 3 months.	12/3/2021

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F 883	Continued From page 42 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical	F 883		

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F 883	Continued From page 43 contraindication or refusal. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on record review, interview, and policy review, and Centers for Disease Control and Prevention (CDC) recommendations, the provider failed to ensure four of five randomly sampled residents (9, 11, 23, and 32) had documented pneumonia vaccination administration or refusal in their care records. Findings include: Review of resident 9's medical record revealed: *He had been admitted on 3/25/21. *He had received pneumococcal conjugate vaccine (PCV13) on 3/2/20. *There was no record or refusal documentation of the pneumococcal polysaccharide vaccine (PPSV23). Review of resident 11's medical record revealed: *She had been admitted on 4/21/16. *She had PPSV23 on 9/20/13. *There was no record or refusal documentation of the PVC 13. Review of resident 23's medical record revealed: *He had been admitted on 7/20/20. *There was no record or refusal documentation of the PPSV23 or PVC 13. Review of resident 32's medical record revealed: *He had been admitted on 10/11/21. *There was no record or refusal documentation of the PPSV23 or PVC 13. Interview on 11/4/21 at 12:05 p.m. with director of nursing B regarding pneumococcal vaccines revealed:	F 883		

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

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F 883	Continued From page 44 *She was aware of the recommendations for pneumonia vaccines. *The above residents were not up to date on pneumonia vaccines. *They had not been educated or offered a pneumonia vaccine. Review of the provider's 9/21/16 Pneumococcal Vaccination policy revealed: *"1. Upon admission, resident will be assessed for eligibility to receive the pneumococcal vaccine and when indicated, will be offered the vaccination, unless medically contraindicated or the resident has already been vaccinated." *"8. Administration of the pneumococcal vaccination or revaccination will be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination." Per the CDC recommendations, found at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/recommendations.html, "CDC recommends routine administration of pneumococcal polysaccharide vaccine (PPSV23) for all adults 65 years or older. In addition, CDC recommends PCV13 based on shared clinical decision-making for adults 65 years or older who do not have an immunocompromising condition, cerebrospinal fluid leak, or cochlear implant and have never received a dose of PCV13. Clinicians should consider discussing PCV13 vaccination with these patients to decide if vaccination might be appropriate."	F 883		

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

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E 000	Initial Comments Surveyor: 41895 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 11/2/21 through 11/4/21. Avantara Groton was found not in compliance with the following requirement: E0001.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and	E 001	Administrator or designee will complete a facility based and community based risk assessment utilizing an all hazards approach, including missing residents, by 12/3/2021. Utilizing risk assessment findings, the Administrator or designee will review facility emergency program documentation and make necessary changes by 12/3/2021. Administrator reviewed and identified current policies and procedures of the emergency preparedness plan including: delegations of authority and succession plans, evacuation plan and location, alternate means for communication and contact information and updated as necessary. Administrator added tab dividers to clearly mark identified policies and procedures listed above in the EP plan. The administrator or designee will educate staff on the changes made to the emergency program by 12/3/21. Those not in attendance will be educated prior to their next shift worked. Findings will be provided to the QAPI committee for review and recommendations. The administrator or designee will complete a risk assessment and emergency program review annually. Findings will be provided to the QAPI committee for review and recommendations.	12/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Shana Bedford, LNHA | Administrator | 12/7/2021

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.

DEC 09 2021

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	435048	A. BUILDING _____ B. WING _____	11/04/2021

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E 001	Continued From page 1 local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Surveyor: 43021 Based on interview and record review, the provider failed to establish a comprehensive emergency preparedness (EP) program that included policies, procedures, communication plan, and contact information. Findings include: 1. Interview on 11/4/21 at 12:25 p.m. and review of the provider's EP program documentation with administrator A revealed: *She had been the provider's administrator since 6/29/2020 but had not reviewed or made changes to their EP program. *They did not have a complete EP program. *They had not: -Maintained an EP plan that must be reviewed and updated at least annually. --The last revision of provider's EP program was 10/11/19. -Based their EP plan on and included a documented, facility-based and community-based	E 001		

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
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E 001	Continued From page 2 risk assessment, utilizing an all-hazards approach, including missing residents. --She confirmed the presence of cognitively impaired residents who had wander alert devices due to wandering/exit-seeking behavior. -Addressed patient/client population, including, but not limited to persons at risk; type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. -Addressed policies and procedures for: --Safe evacuation from the long term care facility, including evacuation location. --Alternate means for communicating with the facility's staff.	E 001		

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
	435048	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 NORTH SECOND STREET GROTON, SD 57445

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 11/2/21. Avantara Groton was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K351 and K361 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced	K 351	Maintenance Director or designee will coordinate with contractor to install sprinkler head to cover the walk in cooler and freezer by 12/3/2021. Maintenance Director or designee will complete facility wide audit of facility fire sprinkler system to ensure that all sprinkler heads are installed. Facility will correct any found concerns as needed by 12/3/2021 Facility will implement weekly audits to ensure proper operations.Administrator will conduct a documentation review monthly for three months to ensure inspections and completed and documented. The QA Committee will review findings submitted by the Maintenance Director or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Shana Bedford, LNHA | Administrator | 11/26/2021

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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K 351	Continued From page 1 by: Surveyor: 27198 Based on observation and interview, the provider failed to provide sprinkler protection throughout the facility as required. An area within the kitchen (walk-in cooler and freezer) was not covered by the automatic fire sprinkler system. Findings include: 1.) Observation on 11/2/21 at 10:15 a.m. revealed the walk-in cooler and freezer in the kitchen was not covered by the sprinkler head installed in those spaces. Interview with the maintenance representative at that same time revealed they had recently repositioned the cooler-freezer unit by putting a new concrete pad under it. He further stated they had not yet reinstalled the sprinkler system in that area. The deficiency could affect 100% of the smoke compartment occupants.	K 351		
K 361 SS=E	Corridors - Areas Open to Corridor CFR(s): NFPA 101 Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain a corridor separation from	K 361	Maintenance Director or designee will coordinate with contractor to install smoke detectors that are connected to the facility fire alarm system in the dining and activity rooms by 12/3/2021. Maintenance Director or designee will complete facility wide audit of facility fire smoke detectors to ensure appropriate coverage and connection are in place. Facility will correct any found concerns as needed by 12/3/2021. The QA Committee will review findings submitted by the Maintenance Director or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

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K 361	Continued From page 2 areas not protected by an approved electrically supervised automatic smoke detection system (fire alarm) in two randomly observed areas (dining room and television room). Finding include: 1.) Observation and interview on 11/2/21 at 11:26 a.m. revealed the dining room area had double set of doors that opened into the corridor system. Those doors did not automatically latch into the door fame when the fire alarm was activated and therefore left that area open to the corridor. That area did not have smoke detectors connected to the buildings fire alarm system. Interview with the maintenance representative at that same time confirmed those findings. 2.) Observation and interview on 11/2/21 at 12:55 p.m. revealed the television room area had double set of doors that opened into the corridor system. Those doors did not automatically latch into the door fame when the fire alarm was activated and therefore left that area open to the corridor. That area was not provided with smoke detectors in accordance with NFPA 72 spacing requirements. The only smoke detector in that large room was in the very south west corner over the alter area. Interview with the maintenance representative at that same time confirmed those findings. The deficiency could affect 100% of the smoke compartment occupants. Ref: LSC 19.3.6.1(1)(c), NFPA 72 chapter 17.	K 361		

South Dakota Department of Health

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	10626	A. BUILDING: _____ B. WING _____	11/04/2021

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 11/2/21 through 11/4/21. Avantara Groton was found not in compliance with the following requirements: S157, S210, and S236.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in five randomly observed rooms (Rooms 110, 114, 204, 311 and 314). Findings include: 1.) Observation and testing beginning on 11/2/21 at 12:04 p.m. revealed the toilet room in resident room 311 did not have functioning exhaust ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working. Further testing of the exhaust in the toilet room of resident room 314 at that same time confirmed that statement. 2.) Observation and testing beginning on 11/2/21 at 1:28 p.m. revealed the toilet room in resident room 114 did not have functioning exhaust	S 157	Maintenance Director or designee will complete facility wide audit of bathroom exhaust systems to ensure system is operating properly. Facility will correct any found concerns in house or by HVAC contractor as needed by 12/3/2021. Facility will implement monthly audits to ensure proper operations.Administrator will conduct a documentation review monthly for three months to ensure inspections completed and documented. . The QA Committee will review findings submitted by the Maintenance Director or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shana Bedford, LNHA

TITLE: Administrator

(X6) DATE: 12/3/2021

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S 157	Continued From page 1 ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working. Further testing of the exhaust in the toilet room of resident room 110 at that same time confirmed that statement. 3.) Observation and testing beginning on 11/2/21 at 1:37 p.m. revealed the toilet room in resident room 204 did not have functioning exhaust ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working.	S 157		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse	S 210	Human Resource Director or Designee will obtain and ensure completion of an appropriately signed health evaluation to demonstration that employees D, F,G and H are free from communicable diseases by 12/3/21. Employees E is no longer employed at the facility. Human Resource Director or Designee will complete an audit of all current employees to ensure health evaluations are completed accurately and completely by 12/3/2021. Human Resource Director or Designee will add the verification of licensed healthcare profess -ional signature and date to the new hire checklist form by 12/3/2021. Administrator or designee will audit new hire files weekly for 4 weeks and then monthly for three months to ensure completion of health evaluations. The QA Committee will review findings submitted by the Administrator or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

South Dakota Department of Health

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S 210	Continued From page 2 specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on record review and interview the provider failed to ensure five of five sampled employees (D, E, F, G, and H) had a health evaluation that included a review for communicable diseases by a licensed health professional completed within fourteen days of being hired. Findings include: 1. Review of the following sampled employees D, E, F, G, and H 's personnel files revealed: *The employees had been hired on the following dates: -10/20/21: Licensed Practical Nurse D. -9/13/21: Cook E. -10/01/21: Housekeeper/Laundry Aide F. -4/5/21: Activity Coordinator G. -8/5/21: Certified nursing assistant H. *The above employees' personnel files had no evidence of a signed health evaluation by a health care professional to determine they were free of communicable diseases. Interview on 11/4/21 at 11:45 a.m. with human resource director O regarding the above personnel files revealed and confirmed: *She was responsible for training new employees during their orientation. *Provided a form to the new employees on orientation day which included a statement that the new employee was free from communicable disease with a signature line for a licensed health professional and date. *Had the employee's fill-in the form with their name where indicated.	S 210		

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S 210	Continued From page 3 *The form was not completed with a licensed health professional's signature and date. *She agreed that the form confirming the new employee was free from communicable diseases was not completed.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by:	S 236	Human Resource Director or Designee will obtain and ensure completion of a 2-step method tuberculin skin test for employees D, E,F, and H by 12/3/21. Employees E is no longer employed at the facility. Human Resource Director or Designee will complete an audit of all current employees to ensure completion of a 2-step method tuberculin skin test by 12/3/2021. Human Resource Director or Designee will implement a tracking sheet to ensure that skin tests are completed timely by 12/3/2021. Administrator or designee will audit new hire files weekly for 4 weeks and then monthly for three months to ensure appropriate completion of the tuberculin screening. The QA Committee will review findings submitted by the Administrator or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

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S 236	Continued From page 4 Surveyor: 43021 Based on record review and interview, the provider failed to ensure four of five sampled employees (D, E, F, and H) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Five employees who had been hired within the last seven months were randomly selected for review and a request for their employee files was made on 11/3/21. Review of these employee files on 11/4/21 revealed: *Employee D had been hired on 10/20/21. -There was a note "waiting on TB from previous employer." *Employee E had been hired on 9/13/21. -Her initial TB skin test had been completed on 11/3/21. -Her second TB skin test had not been completed. *Employee F had a hire date of 8/4/21 with the provider's previously contracted company. -She had been hired on 10/01/21 with the provider, the date the previous company's contract ended. -Her initial TB skin test was identified with the initials "LFA" but was not dated. -Her second TB skin test had not been completed. *Employee H had been hired on 8/5/21. -Her initial TB skin test had been completed on 11/3/21. -Her second TB skin test had not been completed. Interview on 11/4/21 at 11:45 a.m. with human resources director (HRD) O regarding TB screening for employee D confirmed and revealed:	S 236		

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S 236	Continued From page 5 *She was waiting on the TB records from the employee's previous employer. *She had contacted the previous employer that morning and was informed that due to confidentiality of medical information, the previous employer would not release medical information directly to the provider. *Employee D's previous employer would mail the employee's TB record to her home address. *HRD O would then be able to access employee D's TB record directly from the employee. *The provider had not received documentation of employee D's previous tuberculin skin test completed within the prior 12 months. Continuing interview on 11/4/21 at 11:49 a.m. with HRD O regarding employee F's undated initial TB skin test revealed and confirmed: *The initials "LFA" stood for left forearm. *The date had been filled in with 11/3/21. -Employee F's initial TB test had just been administered yesterday, 11/3/21. *Employee E and H's initial TB test had also been administered yesterday, 11/3/21. *The second TB skin test had not been completed on employee E, F, and H. *New employees' E, F, and H had not received the two-step method of tuberculin skin test to establish a baseline within 14 days of their employment with the provider.	S 236		

South Dakota Department of Health

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S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in five randomly observed rooms (Rooms 110, 114, 204, 311 and 314). Findings include: 1.) Observation and testing beginning on 11/2/21 at 12:04 p.m. revealed the toilet room in resident room 311 did not have functioning exhaust ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working. Further testing of the exhaust in the toilet room of resident room 314 at that same time confirmed that statement. 2.) Observation and testing beginning on 11/2/21 at 1:28 p.m. revealed the toilet room in resident room 114 did not have functioning exhaust	S 157	Maintenance Director or designee will complete facility wide audit of bathroom exhaust systems to ensure system is operating properly. Facility will correct any found concerns in house or by HVAC contractor as needed by 12/3/2021. Facility will implement monthly audits to ensure proper operations.Administrator will conduct a documentation review monthly for three months to ensure inspections completed and documented. . The QA Committee will review findings submitted by the Maintenance Director or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shana Bedford, LNHA | TITLE: Administrator | (X6) DATE: 12/7/2021

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S 157	Continued From page 1 ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working. Further testing of the exhaust in the toilet room of resident room 110 at that same time confirmed that statement. 3.) Observation and testing beginning on 11/2/21 at 1:37 p.m. revealed the toilet room in resident room 204 did not have functioning exhaust ventilation. Interview with the maintenance representative at the time of the observation confirmed those findings. He further stated he believed the entire wing was not working.	S 157		
S 210	44:73:04:06 Employee Health Program The facility shall have an employee health program for the protection of the residents. All personnel shall be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Any personnel absent from duty because of a reportable communicable disease which may endanger the health of residents and fellow employees may not return to duty until they are determined by a physician or physician's designee, physician assistant, nurse practitioner, or clinical nurse	S 210	Human Resource Director or Designee will obtain and ensure completion of an appropriately signed health evaluation to demonstration that employees D, F,G and H are free from communicable diseases by 12/3/21. Employees E is no longer employed at the facility. Education was provided to the Human Resource director on 12/3/2021. Human Resource Director or Designee will complete an audit of all current employees to ensure health evaluations are completed accurately and completely by 12/3/2021. Human Resource Director or Designee will add the verification of licensed healthcare profess -ional signature and date to the new hire checklist form by 12/3/2021. Administrator or designee will audit new hire files weekly for 4 weeks and then monthly for three months to ensure completion of health evaluations. The QA Committee will review findings submitted by the Administrator or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

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S 210	Continued From page 2 specialist to no longer have the disease in a communicable stage. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on record review and interview the provider failed to ensure five of five sampled employees (D, E, F, G, and H) had a health evaluation that included a review for communicable diseases by a licensed health professional completed within fourteen days of being hired. Findings include: 1. Review of the following sampled employees D, E, F, G, and H 's personnel files revealed: *The employees had been hired on the following dates: -10/20/21: Licensed Practical Nurse D. -9/13/21: Cook E. -10/01/21: Housekeeper/Laundry Aide F. -4/5/21: Activity Coordinator G. -8/5/21: Certified nursing assistant H. *The above employees' personnel files had no evidence of a signed health evaluation by a health care professional to determine they were free of communicable diseases. Interview on 11/4/21 at 11:45 a.m. with human resource director O regarding the above personnel files revealed and confirmed: *She was responsible for training new employees during their orientation. *Provided a form to the new employees on orientation day which included a statement that the new employee was free from communicable disease with a signature line for a licensed health professional and date. *Had the employee's fill-in the form with their name where indicated.	S 210		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10626	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA GROTON	1106 N 2ND ST GROTON, SD 57445

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S 210	Continued From page 3 *The form was not completed with a licensed health professional's signature and date. *She agreed that the form confirming the new employee was free from communicable diseases was not completed.	S 210		
S 236	44:73:04:12(1) Tuberculin Screening Requirements Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of tuberculin skin test or a TB blood assay test to establish a baseline within 14 days of employment or admission to a facility. Any two documented tuberculin skin tests completed within a 12 month period prior to the date of admission or employment can be considered a two-step or one blood assay TB test completed within a 12 month period prior to the date of admission or employment can be considered an adequate baseline test. Skin testing or TB blood assay tests are not necessary if a new employee or resident transfers from one licensed healthcare facility to another licensed healthcare facility within the state if the facility received documentation of the last skin testing completed within the prior 12 months. Skin testing or TB blood assay test are not necessary if documentation is provided of a previous positive reaction to either test. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test or TB blood assay test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by:	S 236	Human Resource Director or Designee will obtain and ensure completion of a 2-step method tuberculin skin test for employees D, F, and H by 12/3/21. Employees E is no longer employed at the facility. Education was provided to the Human Resource director on 12/1/2021. Human Resource Director or Designee will complete an audit of all current employees to ensure completion of a 2-step method tuberculin skin test by 12/3/2021. Human Resource Director or Designee will implement a tracking sheet to ensure that skin tests are completed timely by 12/3/2021. Administrator or designee will audit new hire files weekly for 4 weeks and then monthly for three months to ensure appropriate completion of the tuberculin screening. The QA Committee will review findings submitted by the Administrator or designee to monitor continued compliance and opportunities for improvement.	12/3/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 236	Continued From page 4 Surveyor: 43021 Based on record review and interview, the provider failed to ensure four of five sampled employees (D, E, F, and H) had completed the two-step method for the Mantoux tuberculin (TB) skin test or TB screenings within fourteen days of being hired. Findings include: 1. Five employees who had been hired within the last seven months were randomly selected for review and a request for their employee files was made on 11/3/21. Review of these employee files on 11/4/21 revealed: *Employee D had been hired on 10/20/21. -There was a note "waiting on TB from previous employer." *Employee E had been hired on 9/13/21. -Her initial TB skin test had been completed on 11/3/21. -Her second TB skin test had not been completed. *Employee F had a hire date of 8/4/21 with the provider's previously contracted company. -She had been hired on 10/01/21 with the provider, the date the previous company's contract ended. -Her initial TB skin test was identified with the initials "LFA" but was not dated. -Her second TB skin test had not been completed. *Employee H had been hired on 8/5/21. -Her initial TB skin test had been completed on 11/3/21. -Her second TB skin test had not been completed. Interview on 11/4/21 at 11:45 a.m. with human resources director (HRD) O regarding TB screening for employee D confirmed and revealed:	S 236		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 236	Continued From page 5 *She was waiting on the TB records from the employee's previous employer. *She had contacted the previous employer that morning and was informed that due to confidentiality of medical information, the previous employer would not release medical information directly to the provider. *Employee D's previous employer would mail the employee's TB record to her home address. *HRD O would then be able to access employee D's TB record directly from the employee. *The provider had not received documentation of employee D's previous tuberculin skin test completed within the prior 12 months. Continuing interview on 11/4/21 at 11:49 a.m. with HRD O regarding employee F's undated initial TB skin test revealed and confirmed: *The initials "LFA" stood for left forearm. *The date had been filled in with 11/3/21. -Employee F's initial TB test had just been administered yesterday, 11/3/21. *Employee E and H's initial TB test had also been administered yesterday, 11/3/21. *The second TB skin test had not been completed on employee E, F, and H. *New employees' E, F, and H had not received the two-step method of tuberculin skin test to establish a baseline within 14 days of their employment with the provider.	S 236		