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

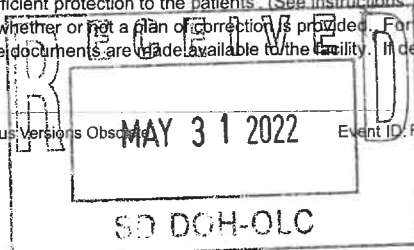
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING _______ B. WING _______	C 05/04/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/3/22 through 5/4/22. The area surveyed included a facility reported death. Avantara Arrowhead was found not in compliance with the following requirement: F842.	F 000		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842	1. No immediate corrective action could be taken for the facility failing to routinely monitor, document, and assess resident 1's ability to urinate following his Foley catheter removal. 2. All residents with an indwelling catheter are at risk of not being monitored, having documentation, and as assessment to determine their ability to urinate following the removal of an indwelling catheter. 3. The DON or designee will educate all nurses,, medication aides, and CNAs on the Patricia A. Potter, Fundamentals of Nursing, professional standards of nursing practice on the procedure following removal of an indwelling catheter. This education will include the requirements of monitoring urine output for 48 hours following removal of an indwelling catheter, with documentation of the time and amount of each voiding, including any incontinence, and if the resident has no output within six hours after removal of the indwelling catheter, the physician will need to be notified, unless otherwise specified by the physician. The CNA will utilize a specimen graduated pan that will be placed in the toiled to measure output. A task will be created in Point of Care for CNAs to document output and continence status following a removal	06/20/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ashley Malys	Administrator	05/31/2022

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



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F 842	Continued From page 1 (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of	F 842	of an indwelling catheter. An order will be placed on the treatment administration record for nurses to conduct a bladder assessment every 6 hours for 48 hours following the removal of an indwelling catheter. Education will occur on June 14, 2022, and those not in attendance at education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 4. The DON or designee will audit all residents who have had their indwelling catheter removed weekly for four weeks, then monthly for five months to ensure residents voiding is being monitored and recorded for at least 48 hours to include documentation of the time and amount of each voiding, including any incontinence, and that the physician is notified if resident has no urine output within 6 hours after removal of the catheter or per physician's order. Results of the audits will be discussed by the DON or designee at the monthly QAPI meeting with IDT and Medical Director for analysis, recommendation for continuation/ discontinuation/revision of audits based on findings.	

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F 842	Continued From page 2 identified professional standards of practice, the provider failed to routinely monitor, document, and assess one of one discharged resident's (1) ability to urinate following his Foley catheter removal. Findings include: Review of resident 1's care record revealed his: *Admission date was 2/14/22. *Diagnoses included chronic kidney disease, acute kidney failure, benign prostatic hyperplasia, and urinary retention. Review of the 4/26/22 Consultation/Clinic Referral form from resident 1's urology appointment revealed: *His Foley catheter had been removed at that appointment. -He urinated after the Foley removal and while in the clinic. *New order: "Please place Foley catheter if patient develops inability to urinate and notify Urology Clinic." Review of resident 1's interdisciplinary progress notes from 4/26/22 through 4/27/22 revealed: *No nurse progress notes related to his urology appointment or the status of monitoring and assessing the resident's ability to urinate after his Foley catheter removal. *He had fallen on 4/27/22 at 3:15 a.m. -Was found on the floor on his back in the bathroom wearing only his incontinence brief. -Was trying to use the bathroom. Review of resident 1's urinary continence data from 4/26/22 through 4/27/22 revealed: *Occurrences when he would have been continent, incontinent, or had not voided. *The only data on 4/27/22 at 5:59 a.m. was:	F 842		

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F 842	Continued From page 3 -He was incontinent at that time. *There was no other documentation in the resident's care record after the 4/26/22 urology appointment that demonstrated his urinary output had been monitored after the removal of his Foley catheter. Interview on 5/4/22 at 10:10 a.m. with administrator A and director of nursing (DON) B revealed: *They confirmed the information referred to above. *Resident 1's urology appointment was at 11:00 a.m. on 4/26/22 and he returned to the facility about 1:00 p.m. that same day. *DON B reported: -She had completed staff interviews that revealed: --He had not voided or had a bowel movement on 4/26/22 at 2:00 p.m. --Had been incontinent of urine at 2:00 a.m. on 4/27/22 when his brief was changed. --His brief was also changed between 7:00 a.m. and 7:20 a.m. on 4/27/22. --No urinary output documentation could be accounted for between 4/26/22 at 2:00 p.m. and 2:00 a.m. on 4/27/22. Continued interview on that same date at 11:00 a.m. with DON B revealed she had expected: *Nursing staff had monitored his urinary output at regular intervals after that appointment. *To document in the resident's care record that voiding information. Continued interview on that same date at 11:20 a.m. with administrator A and DON B revealed: the facility had no policy related to post-Foley catheter removal.	F 842		

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F 842	Continued From page 4 Review of Patricia A. Potter et al., Fundamentals of Nursing, Elsevier, chapter 46 Urinary Elimination, page 1171 provided by DON B as the facility's resource for professional standards of nursing practice for post-Foley catheter removal care revealed: "Monitor patient's voiding after catheter remove for at least 24 to 48 hours by using a voiding record or bladder diary. The bladder diary should record the time and amount of each voiding, including any incontinence." Continued interview on that same date at 11:30 a.m. with DON B regarding the standard of practice referred to above confirmed: *No voiding record or diary was kept for resident 1 after his Foley catheter had been removed. -That would have made it difficult to determine if he had developed an inability to urinate after his catheter had been removed. *The post-Foley catheter removal expected standard of practice had not been followed by nursing staff but should have been.	F 842		