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

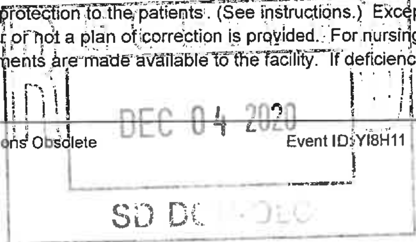
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. BUILDING ____ B. WING ____	C 11/13/2020

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: 26632 A COVID-19 Focused Infection Control Survey was conducted by the South Dakota Department of Health Licensure and Certification Office on 11/13/20. Avantara Groton was found in compliance with 42 CFR Part 483.10 resident rights and 42 CFR Part 483.80 infection control regulations: F550, F562, F563, F583, F880, F882, F885, and F886. An complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted on 11/13/20. Areas surveyed included assessments, monitoring, neglect, and nursing services. Avantara Groton was found not in compliance with the following requirements: F600, F656, and F658. Avantara Groton was found in compliance with 42 CFR Part 483.73 related to E-0024(b)(6). Total residents: 28	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-	F 600	Resident 1, the allegation of neglect was reported to the state survey Agency on 11/28/2020. All residents have the potential to be affected. A retrospective review of all resident's electronic records going back to 11/01/2020 will be conducted by the DON/ designee to ensure there were no documentation of resident incidents or injuries that may be a sign of neglect and were not reported by 12/9/2020 . Any potential neglect will be reported to the State Survey Agency and appropriately investigated. The Regional Director of Operations(RDO) provided education to the Administrator, DON and IDT team on the Abuse and neglect Policy and reporting and invest-	12/09/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shana Bedford	Administrator	12/03/2020

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 600	Continued From page 1 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to appropriately assess, document, treat, and provide notification to the physicians for one of one sampled resident (1) who had a surgical incision and falls. Findings include: 1. Review of resident 1's medical record revealed: *No comprehensive or ongoing assessments had been conducted for her lumbar surgical incision. *There was no documentation when her surgical incision had shown signs of infection. *There had been no communication with her physician or the surgeon regarding the surgical incision. *Her surgeon had not been informed when she had sustained two falls. Review of the provider's revised 5/15/19 Abuse and Neglect policy revealed: *Neglect was the failure to provide necessary and adequate care. *Neglect was the failure to care for a person in a manner, that would avoid harm and pain or the failure to react to a situation that might be harmful. *Staff should have been aware of the service the resident required but failed to provide that service. Refer to F656, finding 1, and F658.	F 600	igating alleged abuse and neglect on 12/03/2020. The Administrator/Designee will educate all staff on the Abuse and Neglect policy and reporting requirements as provided by the RDO by 12/09/2020. Education will include new hires, contract and agency staff. 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. The DON/Designee,will check each unit, every day of the week, for one month, and visit with staff and residents to determine if any unreported allegations of abuse or neglect occurred. Any allegation will be addressed immediately and will be documented for the identification of trends or patterns, and discussed by the nursing management team, then provided to the QAPI Committee by the DON for review and further discussion. The Quality Assessment and Assurance Committee will review findings submitted by the different subcommittees to monitor continued compliance and opportunities for improvement. Administrator or designee will monitor the QA process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. The Quality Assurance Committee will review facility progress on the identified concerns monthly.	

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F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656	Resident 1 comprehensive care plan was updated by the CCC on 11/25/2020 to include focus areas, goals and interventions for surgical incision and risk for impaired skin integrity based on assessments completed for this residents readmission. Resident 9 comprehensive care plan was updated by the CCC on 11/25/2020 to include focus areas, goals and interventions for renal failure with Dialysis including type of dialysis access and related medication. Residents 4, 8,9,10 and 11 have recovered from COVID-19. Their Comprehensive care plan were reviewed and updated to reflect that by DON on 12/01/2020. All residents have the potential to be affected. An audit of all residents care plans will be completed to ensure that appropriate comprehensive care plans are updated as required by the IDT team by 12/09/2020. The services provided or arranged by the facility as outlined by the comprehensive care plan, will be provided by qualified persons in accordance with each resident's written plan of care. Under the direction of the DON the facility Nursing Staff will receive in-service training regarding care plan implementation by 12/09/2020. 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. DON/Designee will review all current resident charts to ensure care plan accuracy and interventions are implemented by 12/09/2020 and then will audit 10 random charts weekly for four weeks.	12/09/2020

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F 656	Continued From page 3 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to review and revise comprehensive care plans for: *One of one sampled resident (1) who had a surgical wound. *One of one sample resident (9) who received dialysis and had been diagnosed with COVID-19 virus. *Four of four sampled residents (4, 8, 10, and 11) who had been diagnosed with COVID-19 and had been placed in isolation. Findings include: 1.. Review of resident 1's medical record revealed: *She had been admitted on 10/4/20 from the hospital after a spinal fusion surgery. *She had diagnoses that included: -Fusion of spine, lumbar region. -Diabetes mellitus type 2. -Other signs and symptoms involving cognitive functions and awareness. -Difficulty in walking. Review of resident 1's 10/4/20 hospital discharge orders regarding the spinal fusion surgery included: *"Special Instructions and Treatments:" -"TLSO [thoracic, lumbar, sacral orthosis] brace needs to fit with the brace crease in lower brace [sic] is between hip and ribs-must wear at all times for 6 wks [weeks] then must wear only when up."	F 656	Weekly interdisciplinary meetings and sub-committee meetings (i.e., skin, weight, safety, infection control, pharmacy, res-traints, etc) will continue to be conducted on a scheduled basis. The Quality Assessment and Assurance Committee will review findings submitted by the different sub committees to monitor continued compliance and opportunities for improvement. Administrator or designee will monitor the QA process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. The Quality Assurance Committee will review facility progress on the identified concerns monthly.	

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F 656	Continued From page 4 -"Ankle pumps every 30 minutes while awake." -"NO NSAIDS [non-steroidal, anti-inflammatory drugs] for cervical fusions and lumbar fusions. This includes Toradol." -"CMS [circulation, motion, and sensation] CHECKS Q2H [every two hours] X [times] 24H THEN Q4H & PRN [as needed]." -"ICE TO OP [operation] SITE." -"PORT. [portable] I.S. [incentive spirometer] Q1H W/A [while awake]" *"Additional Instructions:" -"Activity: Ambulation encouraged." -"Add'l [additional] Activity Info:" --"1. The patient [resident] will wear a TLSO brace full-time for 6 weeks and then a second 6 weeks when out of bed." --"2. The patient [resident] will avoid all tobacco and anti-inflammatory products for a full 6 months postoperatively." --"3. Routine core strengthening exercise to begin at approximately 8 weeks postop [post operatively]." --"4. No lifting greater than 10 pounds." --"5. No work below waist level." -"Diet: Cardiac/Heart Healthy." -"Discharge Wound Care: Keep clean/dry. Change dressing (change dressing on post op day number 7 to dry gauze.) Change daily thereafter. Do not allow incision to get wet with bathing. Monitor incision for signs and symptoms of infection daily and if these occur, promptly contact [surgeon's name] clinic." Review of resident 1's 10/4/20 hospital discharge documentation revealed: *Surgical incision: -Was located on her back. -Was not observable due to a dressing. -Dressing had a small amount of yellow drainage	F 656		

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F 656	Continued From page 5	F 656		

with no odor present.
*Left flank blister:
-"Blister noted to left flank with surrounding redness/irritation. Barrier cream applied, cloth barrier applied between brace and skin, brace lowered."
-Was intact, red, and dry.
-Had no drainage.

Review of resident 1's following Braden scale skin evaluations completed after her admission revealed:
*On 10/12/20 her score was thirteen that indicated high risk for impaired skin integrity.
*On 10/19/20 her score was thirteen.
*On 10/26/20 her score was sixteen that still indicated high risk for impaired skin integrity.

Review of resident 1's initiated 10/7/20 care plan revealed:
*Focus areas for: diabetes, mood due to COVID-19 restrictions, non-compliance to wear a surgical mask related to COVID-19, advance directives, confusion, activities of daily living (ADL), bowel and bladder, fall risk, nutritional status, and acute pain related to back surgery.
*There were no focus areas, goals, or interventions for: surgical incision, left flank blister, or risk for impaired skin integrity.
*The only mention of her TLSO brace was noted in the interventions for acute pain.
-"[Resident name] wears a TLSO brace when up."
-The order was to wear the TLSO brace at all times for six weeks.
*There were no focus areas related to the discharge orders for:
-"NO NSAIDS for cervical fusions and lumbar fusions. This includes Toradol."

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F 656	Continued From page 6 -"CMS CHECKS Q2H X 24H THEN Q4H & PRN." -"ICE TO OP SITE." -"PORT. I.S. Q1H W/A." 2. Review of resident 9's medical record revealed: *She had tested positive for COVID-19 on 10/29/20. *She had been placed in isolation at that time. *She also had a diagnosis of renal failure and received dialysis out of the facility three times a week. *Documentation in her initiated 10/26/20 care plan revealed: -A focus area related to her potential risk for alteration in her mood state due to COVID-19 restrictions had not been updated to her having been diagnosed with COVID-19 or having been placed in isolation. -One of the interventions stated, "Dialysis runs are T [Tuesday], TH [Thursday], and Sat. [Saturday] in the afternoons during her covid positive" status. The focus area had been initiated on 11/3/20. -A focus area related to her risk for alteration in nutritional status. -One of the interventions stated, "Dialysis runs on T, TH, Sat. Dietary provides 960 cc [cubic centimeters] fluid with meals and nursing allowed 540 cc per day." *There was no focus area, goals, or interventions related directly to her renal failure with dialysis. It was unknown what type of dialysis access she had or medications related to her renal failure. 3. Review of resident 4's medical record revealed: *She had tested positive for COVID-19 on 11/9/20.	F 656		

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F 656 Continued From page 7 F 656

*Her last revised 8/25/20 care plan had a focus area related to her potential risk of alteration in her mood state related to visitation restrictions because of COVID-19; initiated on 4/13/20.
*There were no focus areas related to her current positive COVID-19 status.

4. Review of resident 8's medical record revealed:
*He had tested positive for COVID-19 on 11/5/20.
*His last revised 8/25/20 care plan had a focus area related to his potential risk of alteration in his mood state related to visitation restrictions because of COVID-19; initiated on 4/13/20.
*There were no focus areas related to his current positive COVID-19 status.

5. Review of resident 10's medical record revealed:
*She had tested positive for COVID-19 on 11/6/20.
*Her last revised 8/25/20 care plan had a focus area related to her potential risk of alteration in her mood state related to visitation restrictions because of COVID-19; initiated on 4/2/20.
*There were no focus areas related to her current positive COVID-19 status.

6. Review of resident 11's medical record revealed:
*She had tested positive for COVID-19 on 10/29/20.
*Her last revised 6/15/20 care plan had a focus area related to her potential risk of alteration in her mood state related to visitation restrictions because of COVID-19; initiated on 4/13/20.
*There were no focus areas related to her current positive COVID-19 status.

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F 656	Continued From page 8 7. Interview on 11/13/20 at 3:30 p.m. with director of nursing (DON) C and registered nurse/Minimum Data Set (RN/MDS) coordinator B revealed: *RN/MDS coordinator B had only been in that position for approximately four months. *They stated it had been very busy due to COVID-19. *They agreed residents 1, 4, 8, 9, 10, and 11's care plans were not comprehensive. Review of the provider's September 2019 Care Planning policy revealed: *"Individual, resident-centered care planning will be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"The Resident-Centered Care Plan Format: -"Data/Problems/Needs/Concerns are the culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan. The care plan is broken down into separate focus areas: Psycho-social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Functions, Hygiene ADL's/Skin, Safety/Vulnerability, Mobility/Fall Prevention, Medications and Special Attention for Other Physical Conditions."	F 656		
F 658 SS=G	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,	F 658	Resident 1's wound was assessed and care is being provided and documented as prescribed by physician and reflected in the care plan by DON on 11/24/2020. All residents at risk for impaired skin integrity have the potential to be affected. All residents had a skin assessment performed by DON and CCC on 12/04/2020 with no new identified skin concerns. The DON/Designee will review all treatment orders to ensure appropriateness for wound(s) and physician orders were obtained by 12/09/2020.	12/09/2020

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F 658	Continued From page 9 must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 26632 Based on interview, record review, and policy review, the provider failed to ensure professional standards had been followed for documentation of assessments and appropriate care and treatment for one of one sampled resident (1) who had a surgical wound. Findings include: 1. Review of resident 1's medical record revealed: *She had been admitted on 10/4/20 from the hospital after a spinal fusion surgery on 9/29/20. *She had diagnoses that included: -Fusion of spine, lumbar region. -Diabetes mellitus type 2. -Other signs and symptoms involving cognitive functions and awareness. -Difficulty in walking. Review of resident 1's 10/4/20 discharge orders from the hospital regarding her spinal fusion surgery included: *"Special Instructions and Treatments:" -"TLSO [thoracic, lumbar, sacral orthosis] brace needs to fit with the brace crease in lower brace is between hip and ribs-must wear at all times for 6 wks [weeks] then must wear only when up." -"Ankle pumps every 30 minutes while awake." -"NO NSAIDS [non-steroidal, anti-inflammatory drugs] for cervical fusions and lumbar fusions. This includes Toradol." -"CMS [circulation, motion, and sensation] CHECKS Q2H [every two hours] X [times] 24H THEN Q4H & PRN [as needed]."	F 658	The DON/Designee will educate the facility nursing staff regarding skin program policy, which includes the User Defined Assessment (UDA) completion for routine skin evaluations and weekly wound documentation and ensuring treatments are performed as ordered by 12/09/2020. Those not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. The DON/Designee will audit all residents with wounds each week to ensure resident have weekly documentation of wound, treatments are performed as ordered, and care plan interventions are in place. Additionally,the DON/Designee will audit 5 random resident skin evaluation UDAs to ensure they are complete and accurate each week. The audits will be reviewed for the identification of trends or patterns, and discussed by the nursing management team, then provided to the QAPI Committee by the DON for review and further discussion for plan changes, continuation/discontinuation of the audit. The facility IDT will meet each weekday to discuss residents with wounds to ensure UDAs are being completed, treatments are performed and interventions are in place. IDT daily notes will be maintained for review at weekly IDT meetings. Concerns identified will be addressed timely. Weekly interdisciplinary meetings and sub-committee meetings(i.e., skin, weight, safety, infection control, pharmacy, restraints, etc) will continue to be conducted on a scheduled basis. The Quality Assessment and Assurance Committee will review findings submitted by the different sub-committees to monitored	

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F 658	Continued From page 10 -"ICE TO OP [operation] SITE." -"PORT. [portable] I.S. [incentive spirometer] Q1H W/A [while awake]" *"Additional Instructions:" -"Activity: Ambulation encouraged." -"Add'l [additional] Activity Info:" --"1. The patient [resident] will wear a TLSO brace full-time for 6 weeks and then a second 6 weeks when out of bed." --"2. The patient [resident] will avoid all tobacco and anti-inflammatory products for a full 6 months postoperatively." --"3. Routine core strengthening exercise to begin at approximately 8 weeks postop [post operatively]." --"4. No lifting greater than 10 pounds." --"5. No work below waist level." -"Diet: Cardiac/Heart Healthy." -"Discharge Wound Care: Keep clean/dry. Change dressing (change dressing on post op day number 7 to dry gauze.) Change daily thereafter. Do not allow incision to get wet with bathing. Monitor incision for signs and symptoms of infection daily and if these occur, promptly contact [surgeons name]." Review of resident 1's 10/4/20 hospital discharge documentation revealed: *Surgical incision: -Was located on her back. -Was not observable due to a dressing. -Dressing had a small amount of yellow drainage with no odor present. *Left flank blister: -"Blister noted to left flank with surrounding redness/irritation. Barrier cream applied, cloth barrier applied between brace and skin, brace lowered." -Was intact, red, and dry.	F 658	continued compliance and opportunities for improvement. Administrator or designee will monitor the QA process weekly to ensure identified issues are monitored and revised to correct quality deficiencies. The Quality Assurance Committee will review facility progress on the identified concerns monthly.	

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F 658	Continued From page 11 -Had no drainage. Review of resident 1's skin evaluations revealed on: *The 10/4/20 admission assessment skin section indicated: -Her skin appeared to be normal. -Her skin turgor was elastic. -She had a mid back surgical incision. -She had no vascular access placement. -Her Braden Scale skin evaluation score was eleven that indicated high risk for impaired skin integrity. *The 10/12/20 skin evaluation indicated: -Her skin appeared to be normal. -Her skin turgor was normal. -She did not have any alteration in her skin integrity. -Her Braden score was thirteen that indicated high risk for impaired skin integrity. *The 10/19/20 skin evaluation indicated: -Her skin appeared to be normal. -Her skin turgor was normal. -She had a surgical incision to her lower back. -Her Braden score was thirteen that indicated high risk for impaired skin integrity. *The 10/26/20 skin evaluation indicated: -Her skin appeared to be normal. -Her skin turgor was normal. -She had a surgical incision to her lower back left side. -Her Braden score was sixteen that indicated high risk for impaired skin integrity. *There was no documentation that described anything about the surgical incision. *There was no documentation regarding the blister on her left flank. Review of resident 1's daily nursing evaluations	F 658		

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from 10/5/20 through 10/28/20 revealed:
*Evaluations completed on 10/5/20, 10/6/20, 10/7/20, 10/8/20, 10/10/20, 10/11/20, 10/12/20, 10/14/20, 10/15/20, 10/16/20, 10/17/20, 10/19/20, 10/21/20, 10/22/20, 10/23/20, 10/24/20, and 10/25/20 did not include any information about her surgical incision, dressing changes, or the blister to her left flank.
*Evaluations had not been completed on 10/9/20, 10/13/20, 10/18/20, and 10/20/20.
*The evaluation on 10/26/20 indicated a wound that required a dressing change. Description of the wound was documented as "Surgical incision serous bloody drainage."
*The evaluation on 10/27/20 indicated a wound that required a dressing change. Description of the wound was documented as "Incision to lower back draining clear fluid, foul smelling."

Review of resident 1's October 2020 medication and treatment administration records revealed:
*From 10/11/20 through 10/23/20: "Wound Care: Keep clean/dry. Change dressing (change dressing on post op day number 7 to dry gauze. Change daily thereafter. Do not allow incision to get wet with bathing. Monitor incision for signs and symptoms of infection daily and if these occur, promptly contact [surgeons name]."
*Only the above days had been initialed indicating that had been done.

Review of resident 1's interdisciplinary progress notes revealed:
*On 10/5/20 at 12:48 a.m.: "Unable to assess surgical incision at this time. Order received not to remove aquacel dressing for 7 days and do not get incision wet."
*On 10/11/20 at 5:27 a.m.: "Changed resident's surgical dressing with dry gauze per order.

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Incision is intact with no redness, swelling or drainage present. Nursing will continue to monitor."
*On 10/11/20 at 5:20 p.m.: "....c/o [complained of] much itching in her lower back, gauze dry and intact."
*On 10/23/20 at 4:08 a.m.: "Faxed [fax] sent to Dr. [name] requesting an order to DC [discontinue] IS [incentive spirometer] q1h, CMS checks and dressing change to wound at the back of her neck as it is closed with no redness or drainage noted." Her surgical incision was located on her lumbar region.
*On 10/24/20 at 3:02 a.m.: "Received fax back from Dr. stating "yes" to D/C request."
*On 10/28/20 at 9:20 a.m.: "Call to Dr. [doctor] regarding change of status, unable to feed self and hold head up. Order to send to [hospital name] Emergency Department for evaluation. Husband [name] notified of pending transfer daughter [name] also notified."
*On 10/28/20 at 12:30 p.m. "Call from [hospital name] ER [emergency room] will be admitted to Post surgical incision infection."

Review of resident 1's hospital documentation on 10/28/20 revealed:
-10/28/20 emergency room visit notes:
--"Pt. [resident] complaint from nurse triage: Pt. was dx [diagnosed] with UTI [urinary tract infection] yesterday, staff report change in baseline mental status in the past 24 hours. Had back surgery in the beginning of October and has been itching at incision site per nursing home staff."
--"Presenting symptoms: 70-year-old female was transferred from nursing home because of fever and lethargy in appearance. She was diagnosed having positive UTI yesterday. And the staff at

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nursing home reporting that she seems has declining mental status. Additionally she has a fever. She had a spinal operation end of last month. It seems patient reported some itching over the operation site. There is no wound checked by the staff at nursing home."
--"Skin Details: Over lumbar spine area there is a separation of recent operation wound. Positive yellowish and clear drainage coming from the deep side of the operation wound. Surrounding skin has positive erythematous changes with increasing local temperature, consistent with infected surgical wound."
-Her 10/28/20 hospital admission diagnoses included:
-"Severe sepsis with acute encephalopathy on admission, likely related to bacteremia, lumbar surgical site infection. Staphylococcus aureus bacteremia/MRSA [methicillin resistant staphylococcus aureus], follow-up blood cultures obtained on October 31 and negative. Lumbar surgical site infection, with gross purulence deep to fascia, status post debridement 10/28. Status post L4-5 laminectomy and L3-5 lumbar fusion 9/29. Acute encephalopathy, suspected toxic metabolic, improved. Unlike meningitis."

Review of resident 1's 11/5/20 provider's readmission documentation revealed:
*11/5/20: admission nursing assessment revealed her skin appearance was normal, her skin turgor was elastic, and she had a vascular access.
*There were no descriptions of the post surgical site infection to her lumbar area.
*There were no descriptions of what type of vascular access she had, where it was located, site assessment.

Review of resident 1's following interdisciplinary

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progress notes revealed:
*On 11/6/20 at 2:41 a.m.: "Resident remains in isolation room.....trunk brace in position. PICC [Peripherally inserted central catheter] line in right arm."
-On 11/6/20 at 7:41 p.m.: "Rewrapped right arm with ace wrap to protect picc line from being pulled on."
-On 11/7/20 at 1:30 p.m.: a note that described her increased lethargy, inability to follow directions. inability to support herself when sitting up, had to be fed her breakfast. Physical therapy had reported her having some symptoms possibly consistent with a stroke. Neurochecks had been done initially and her PCP [Primary Care Physician] had been notified by fax. Her dressing to her lower back was weeping and was reinforced by 4 x 4 gauze.
-On 11/8/20 at 12:48 a.m.: "Resident spinal dressing leaking, reinforced with gauze and tape."
-On 11/8/20 at 2:00 p.m.: "Dressing to her lower back have been reinforced with 4x4 as lower half have started to come off."
-On 11/9/20 at 9:38 a.m.: "Arousal is diminished unable to follow cues. Grimacing noted but denies pain. Unable to focus on tasks. Left arm is pulled into body and hard to move. cognition diminished. Dr. [name] updated on condition order to send to Emergency room for evaluation."
-No documentation had been completed of when she had left for the emergency department, when she returned, or if there were new physician orders.
-On 11/11/20 at 11:46 p.m.: a note that the PICC line in the left anticubital had been pulled out. The on call physician was notified and asked for the information to be faxed to his office, and it would be evaluated.

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F 658	Continued From page 16 Review of resident 1's daily nursing evaluations after her facility readmission on 11/5/20 revealed: *No evaluation had been completed on 11/6/20 or 11/10/20. *On 11/7/20 it had been documented she received intravenous (IV) vancomycin daily. -There was no assessment of her PICC line or the wound dressing. *On 11/8/20 it had been documented she had a wound that required a dressing change. The description of the wound was "dressing reinforces with 4x4." She continued to receive IV vancomycin daily. *On 11/9/20 it had been documented she had a surgical wound. "Surgical incision sutures and staples intact with red/orange drainage foul smelling. Cleansed and covered with ABD [abdominal] pad. She continued on the IV vancomycin. Interview on 11/13/20 at 10:00 a.m. with director of nursing (DON) C revealed resident 1 had been re-admitted to the hospital again on 11/11/20 for increased confusion, delirium, and her PICC line had been pulled out. Review of resident 1's physician notification faxs revealed her PCP had been notified on: *10/17/20 at 2:23 a.m. that she had been lowered to the floor by staff without any injury. Her PCP responded back with a check mark on 10/19/20 at 1:13 p.m. *10/18/20 at 3:30 p.m. she had been trying to walk without assistance in her room and fell on her stomach. No injuries were noted. Her PCP responded back with a check mark on 10/19/20 at 1:13 p.m. *The neurosurgeon had not been notified of those falls.	F 658		

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Interview on 11/13/20 at 3:30 p.m. with administrator A and DON C confirmed the documentation did not show what nursing care had been given to resident 1 for her surgical wound. DON C agreed she had been notified by the hospital of resident 1's infection to her surgical wound. She had not yet followed-up on that information. DON C stated the reference for professional standards was from a Lippincott nursing manual.

Review of the provider's September 2019 Skin Program policy revealed:
*A baseline assessment of the resident's skin status would be completed upon admission/readmission by the completion of the nursing admission/readmission user defined assessment examination. That would have included a physical exam of the resident's skin, a risk assessment using a risk assessment tool, and a comprehensive assessment of the resident's history and physical condition. A plan of care would have been put in place for residents that were identified with actual skin breakdown or at-risk for skin breakdown.
*A comprehensive wound assessment would have been completed if there was a pressure injury.
*There was no process for surgical incisions.

Review of Sandra M. Nettina, Lippincott Manual of Nursing Practice, 11th Ed., 2019, p.15, revealed:
*Common departures from the standards of nursing care included the failure to assess the resident properly, follow physician orders, follow appropriate nursing measures, communicate information about the resident, adhere to facility

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