STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435078	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVERA EUREKA HEALTH CARE CENTER	202 J AVENUE POST OFFICE BOX 40 EUREKA, SD 57437

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0554 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Allow residents to self-administer drugs if determined clinically appropriate.** Based on observation, interview, record review, and policy review, the provider failed to ensure consistency in assessment and implementation of self-administration of medication for six of nine sampled residents (4, 22, 29, 30, 40, and 46) Findings include: 1. Observation and interview on 3/11/20 at 9:45 a.m. with certified nursing assistant (CNA) A revealed: *A tube of Aspercreme in the tub room on a one drawer stand. The Aspercreme had a pharmacy label on it for resident 22. *She stated the CNAs applied the Aspercreme or a similar type of topical pain ointment on the residents for pain. She stated they had been instructed by the nurses to apply those medications. Review of resident 22's medical record revealed: *A 3/26/18 physician's order for Aspercreme. Apply to affected areas twice daily for pain. *There was no physician's order received for her to have self-administered the Aspercreme. *There were no self-administration of medications assessments. *Her 8/16/19 last reviewed care plan revealed pain interventions that included: Administer Tylenol 650 mg (milligram) bid (twice daily) and prn (as needed) and aspercreme bid as ordered (nurse). 2. Observation on 3/11/20 at 10:00 a.m. in resident 46's room revealed a tube of Aspercreme in her bathroom. Review of resident 46's medical record revealed: *A 9/6/18 physician's order for Aspercreme to apply to both knees as needed. Could be kept at bedside. *She had a [DATE] self-administration of medication assessment. That assessment revealed (resident name) requires assistance with the adminstration of her meds (medication) for the safety of both (resident name) and others around her R/T (related to) her cognitive impairment AEB (as evidenced by) BIMS (Brief Interview of Mental Status) score of 0 (zero) and Dx. (diagnosis) of dementia. *Review of her 2/27/20 care plan under her pain assessment interventions revealed, May administer Aspercreme PRN for bilateral knee discomfort. 3. Interview on 3/11/20 at 10:30 a.m. with CNA A revealed she stated quite a few of the residents had the above medication in their rooms for the CNAs to apply. Interview on 3/11/20 at 10:45 a.m. with registered nurse (RN) E revealed the nurses should have applied those ointments. She was not aware the CNAs had been applying those medications. 4. Observation on 3/11/20 at 3:15 p.m. of resident 30's bathroom revealed a tube of muscle rub cream in her bathroom. Review of resident 30's medical record revealed: *A 10/9/19 physician's order DC (discontinue Aspercreme when gone - ctn (continue) Muscle Rub Cream affected areas PRN. (May keep in room). *A self-administration of medications assessment on 9/11/18 revealed she had been able to self-administer medications. On 2/27/19 it stated no. Monthly checks had been done but it was not clear which medications were checked 10/9/19. *A 1/27/20 self-administration of medications assessment revealed (Resident name) requires assistance with administration of all her meds for the safety of both (resident name) and others around her due her physical functional limitations of her shoulders. *Review of her 1/28/20 last reviewed care plan revealed a 9/11/18 self-administration intervention: (Resident name) is not able to administer her medications safely due to limited function to her upper extremities. The nurse administers them to her. 5. Observation and interview on 3/11/20 at 3:30 p.m. with resident 40 revealed she had a tube of Aspercreme ointment in a drawer under her television. She stated she had the CNAs apply it to her legs. Review of resident 40's medical record revealed: *A 8/29/15 physician's order for Aspercreme May keep at bedside and apply to skin topically as needed. *Her self-administration assessment after set-up on 2/17/20 revealed: (Resident name) is alert and physically able to self-administer her own meds after set-up in regards to the safety of both (resident name) and others around her. It did not address her ability to self-administer her topical medications. *Review of resident 40's 2/20/20 last reviewed care plan revealed a 2/14/16 intervention for the self-administration of medications. May administer own meds after set up assist. 6. Observation and interview on 3/11/20 at 4:00 p.m with resident 29's husband revealed: *A tube of Aspercreme ointment was in her bedside table. *Resident 29's husband stated the CNAs applied that when they assisted her in the morning. Review of resident 29's medical record revealed: *She had no physician's order for the self-administration of medications. *A self-administration of medication after set-up assessment on 1/27/20 stated she required total assistance with her medications. 7. Observation on 3/11/20 at 4:15 p.m. of resident 4's room revealed a tube of Aspercreme in her room. Review of resident 4's medical record revealed: *A 9/25/19 physician's order: (Resident name) may administer her medications safely after setup with harm to other residents. *There was no order for her to keep any medications in her room to self-administer. *A 12/16/19 self-medication administration after set-up assessment revealed (Resident name) is alert and physically able to self-administer her meds after set-up - nursing staff report that she takes her meds as they are given to her. *Review of her 12/17/19 last revised care plan revealed no information on the self-adminstration of Aspercreme and her keeping it in her room. 8. Interview on 3/12/20 at 9:30 a.m. with director of nursing F revealed: *A self-administration of medications comprehensive assessment was completed on admission in the electronic medical record (EMR). *Then every quarter she completed a hand written assessment. *That assessment did not include all the same questions as the assessment on the EMR and usually only addressed oral medications. *She was not aware the CNAs had been applying the Aspercreme. *She did state the above residents had a physician's order for having the medication at bedside. *She did not know that was only if the resident was able to self-administer which included topicals. Review of the provider's last revised November 2018 Self-Administration of Medication policy revealed:*An assessment of the residents' ability to self-administer medication will be performed by the IDT (interdisciplinary team) every three months, based on changes in the residents' medical decision-making status, and as needed, *A physician's order will be obtained and recorded in the chart. The order also will include which specific medications can be kept at the bedside.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate processes were in place for the delegation of medication administration by certified nursing assistants (CNA) for six of nine sampled residents (4, 22, 29, 30, 40, and 46). Findings include: 1. Observation and interviews revealed CNAs had been administering a topical physician ordered medication. Medication administration was not included in the CNAs scope of practice. Refer to F554.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure: *Appropriate hand hygiene and glove use during two of four sampled residents (19 and 40) personal care by four of five certified nurse assistants (CNA) (C, D, H, and I) was used. *Mechanical lifts had been sanitized by three of three CNAs (D, H, and I) between residents' use during two of two observations. *Appropriate hand hygiene and glove use during one of two sampled resident (47) dressing changes by one of two nurses (E) was done. Findings include: 1. Observation on 3/10/20 at 8:45 a.m. revealed: *CNA C entered resident 19's room and put on gloves. She had not completed any hand hygiene. *With those same gloves she retrieved the resident's clothes from her closet, raised the bed, put lotion on both of the resident's legs, put on her support stockings, and her shoes. *Put on new gloves and without performing any hand hygiene she assisted the resident with washing her face, hands, and back. *Removed her gloves and used hand sanitizer then retrieved a standing

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

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) lift from the hallway. *Entered the room with the lift and put on gloves. *CNA C and CNA D assisted the resident to a standing position with the lift. *Moved the resident into the bathroom with the lift, and CNA C removed the resident's incontinence brief. She removed her gloves and did not perform any hand hygiene. *After resident 19 had finished on the toilet CNA D provided perineal care. She used the same disposable wipes to clean from front to back twice and then used a second cloth in the same way. *When they had put resident 19 in her wheelchair CNA D removed the standing lift from the room and took it into another resident's room. *She had not sanitized her hands or the standing lift. Review of resident 19's 1/8/20 care plan revealed: *A goal to be free from infections through the next target date. *A intervention: History: Noted a discharge [DIAGNOSES REDACTED]. Interview on 3/12/20 at 9:30 a.m. with director of nursing (DON) F revealed: *CNAs C and D had not followed proper handwashing and glove use. *She monitored handwashing and glove use on a regular basis. *She was aware resident 19 had been classified as a CRE bacteria carrier. *Staff had not been instructed on any enhanced precautions. 2. Observation and interview on 3/11/20 at 9:28 a.m. of registered nurse (RN) E with resident 47 during a dressing change revealed: *She cleaned the wound. *Then she removed her soiled gloves. *She had new clean gloves on the barrier with her dressing supplies and when she had reached for them one glove had fallen into the contaminated sink. -She picked up the glove and put both the gloves on. *She did not perform hand hygiene between changing her gloves. *After the dressing change was completed she removed her gloves and washed her hands at the sink. -She did not wash her hands for twenty seconds. *She had agreed she should have washed her hands between glove use. *She had not noticed her clean glove had fallen into the sink. *Agreed her hand washing time was not long enough. 3. Observation and interview on 3/10/20 at 2:53 p.m. of CNAs H and I assisting resident 40 revealed: *Both CNAs had clean gloves on and were assisting the resident to change a soiled incontinence brief in bed. *CNA I had performed perineal (peri) care, and then with those same contaminated gloves on she: -Had applied protective ointment to the resident's bottom. -Assisted the resident into a new incontinence brief. -Pulled up her pants. *CNA I then changed her contaminated gloves with no hand hygiene in between. *CNA H had assisted CNA I with rolling the resident back and forth in the bed to complete the task then removed her gloves. -She did not perform hand hygiene after removal of those contaminated gloves. *Then they put the Hoyer sling under her. *After CNA I removed her contaminated gloves, and did not perform hand hygiene she grabbed the mechanical lift. *Both CNAs assisted to hook the resident in the Hoyer sling to the mechanical lift and put her into her wheelchair (w/c). *CNA H had taken candy out of drawer, given it to the resident, and then proceeded to comb her hair. -She still had not performed hand hygiene. *CNA I pushed the mechanical lift out of the room and left it in the hallway, then she took the garbage to the dirty utility room, and then performed hand hygiene when she was back in the hall. *CNA H assisted the resident in her w/c down the hall to an activity, and then stopped to perform hand hygiene. *Both CNAs agreed: -They should have performed hand hygiene each time they removed their gloves and before leaving the resident's room. -The mechanical lift could be contaminated due to them not performing hand hygiene. *CNA I thought the night shift cleaned the lifts. *CNA H said she would have cleaned the mechanical lift if it was visibly soiled otherwise housekeeping cleaned them. Interview on 3/11/20 at 8:14 a.m. with housekeeping manager J revealed: *Housekeeping did not clean the mechanical lifts. *Nursing was responsible to clean the mechanical lifts. Interview on 3/12/20 at 10:40 a.m. with DON F about the above observations revealed: *She agreed staff should have washed their hands with each glove change and before leaving a resident's room after care. *She agreed the mechanical lift should have been cleaned. *The night shift CNAs had a cleaning schedule, and the mechanical lifts were on the schedule. *The CNAs had been educated to use the sanitizer wipes on the mechanical lifts after use if it had become contaminated. *The housekeepers did not clean the mechanical lifts. Surveyor: 4. Review of the provider's last reviewed (NAME)2020 Hand Hygiene policy revealed: *Wash hands with soap when visibly dirty, contaminated with blood or body fluids. *To use friction for twenty seconds. *Change gloves when moving from a contaminated area to a clean area of care. *Always wash hands or use alcohol cleaner after the removal of gloves. Review of the provider's last reviewed January 2020 Disinfection of Non-Critical Patient (resident) Care Equipment policy revealed: *Non-critical resident care items between/after each resident use. *They require low level disinfection by cleaning periodically with a disinfectant, detergent, or germicide.