STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435049	A. BUILDING _____ B. WING _____	**03/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTARA SALEM	**500 COLONIAL DRIVE SALEM, SD 57058**

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

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F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** Based on interview and record review, the provider failed to ensure two of two sampled residents (29 and 32) who received hospice services had a significant change of condition Minimum Data Set (MDS) assessment done when they had been admitted to receive hospice services. Findings include: 1. Review of resident 32's record revealed he had been admitted to a hospice provider's services on 11/21/19. There was no significant change of condition MDS assessment completed at that time. 2. Review of resident 29's medical record revealed: *He had been admitted to a hospice provider's services on 10/18/19. *There was no significant change of condition MDS assessment completed at that time. 3. Interview on 3/3/20 at 4:00 p.m. with director of nursing B revealed she: *Was aware when a resident was admitted to hospice, discharged from hospice, or changed hospice providers a MDS significant change of condition assessment was to have been completed. *Did not know MDS assessment coordinator A had not completed those MDS assessments. Interview on 3/4/20 at 10:20 a.m. with MDS coordinator A revealed she had: *Not been aware until recently that a significant change of condition assessment was required when a resident was admitted to receive hospice services. *Been completing MDS assessments since 1999 and was not aware of that requirement until recently.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure one of one observed unlicensed assistive personnel (UAP) (C) had followed professional standards for medication administration for three of ten randomly observed medication administrations (7, 29, and 44). Findings include: 1. Observation on 3/4/20 at 11:09 a.m. of UAP C during medication administration for resident 7 revealed she had given the resident one tablet of [MEDICATION NAME] extended release (ER) 25 milligrams (mg). Review of resident 7's Medication Administration Record [REDACTED]. -That order had been in place since 7/10/19. *She was not the only staff person to have administered the medication incorrectly. Interview on 3/4/20 at 11:40 a.m. with UAP C revealed she was aware the medication name on the prescription label and MAR indicated [REDACTED]. Interview on 3/4/20 at 5:02 p.m. with director of nursing (DON) B revealed: *She agreed it was not the correct medication. *The order had been put in wrong, and the MAR indicated [REDACTED]. -She agreed that error should have been corrected. 2. Observation on 3/4/20 at 11:15 a.m. of UAP C during medication administration for resident 44 revealed: *She had given two tablets of vitamin D3, 25 micrograms (mcg). *She had not clarified with the nurse if that was the correct dose. Review of resident 44's MAR indicated [REDACTED]. Interview on 3/4/20 at 1:29 p.m. with UAP C revealed: *She realized it was the the wrong medication. *She had removed the vitamin D3, 25 mcg bottle from the cart and put in a bottle of vitamin D3, 1000 iu. -These bottles were facility stock supply from the pharmacy. *She was not aware two tablets of vitamin D3, 25 mcg was equal to two tablets of vitamin D3, 1000 iu. Interview on 3/4/20 at 2:24 p.m. with DON B revealed she was not aware the pharmacy had sent vitamin D3 in a 25 mcg dose. 3. Observation on 3/4/20 at 11:20 a.m. of UAP C during medication administration for resident 29 revealed: *He was to have had his blood pressure (BP) checked prior to the administration of his [MEDICATION NAME]. -His BP was 113/48. *She had given him one tablet of [MEDICATION NAME] 30 mg. Review of resident 29's MAR indicated [REDACTED]< (less than) 90 and notify physician - DO NOT D/C BP's. Interview on 3/4/20 at 1:29 p.m. with UAP C revealed: *She thought [MEDICATION NAME] was to increase BP. *She thought < meant greater than. *She was to hold the medication if the bottom number of his BP was higher than 90. Interview on 3/4/20 at 2:24 p.m. with DON B revealed: *She was not aware UAP did not know how to read the order. *She was going to have a nurse administer his [MEDICATION NAME] until the UAP had further training. 4. Review of UAP C's 10/9/19 Medication Administration Observation Report revealed: *She had not met the requirement of Correct medication verified by visual check of med (medication), label, and MAR. *She had a calculated error rate of 4.55%. Review of the provider's Medication Administration policy revealed: *To administer the following: right medication, right dose, right dosage form, right documentation, right route, right resident/patient, right time. *Verify the pharmacy prescription label on the drug and the manufacturer's identification system matches the MAR. *To check the original order and notify pharmacy if there was a discrepancy.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, revealed the provider failed to ensure one of three sampled residents (25) had appropriate pain management and ongoing pain assessments in place. Findings include: 1. Review of resident 25's medical record revealed: *She had been admitted on [DATE]. *She had a Brief Interview for Mental Status assessment score of twelve indicating moderate cognitive impairment. *Her [DIAGNOSES REDACTED]. Observation and interview on 3/3/20 at 2:50 p.m. with resident 25 revealed: *She was alert and able to answer questions appropriately. *She had pain in her left arm that was contracted. *She has just returned to her room from a bath and had told the staff person who assisted her about her pain. *She was supposed to have a rub down on her left shoulder, but the night nurse would not do it. *The staff did not do anything for her pain. *She rated her pain at an eight on a scale of zero to ten with zero being no pain and ten as the worst pain she could imagine. Review of resident 25's 1/19/20 pain assessment revealed: *She had almost constant pain that made it hard for her to sleep at night and affected her day-to-day activities. *She rated her pain at an eight on a zero to ten pain scale. -She had used the verbal descriptor of severe. *The pain affected her mood and socialization. *Resting helped with pain relief. *Staff assessment of her pain revealed non-verbal sounds, vocal complaints of pain, facial expressions, and protective body movements. *She was on Tylenol twice a day. -She had reported that did not help with pain. Review of resident 25's 1/20/20 quarterly Minimum Data Set (MDS) assessment revealed: *She was on a scheduled pain regimen. *She had not received as needed pain medications nor were they offered and declined. *She had not received non-medication intervention for pain. *She had almost constant pain that made it hard for her to sleep at night and affected her day-to-day activities. *She had rated her pain at an eight on a zero to ten scale. Review of resident 25's pain levels since completion of 1/20/20 MDS revealed on: *2/5/20 she rated her pain at zero on a zero to ten scale. *2/12/20 she rated her pain at seven on a zero to ten scale. *There were no other documentation of pain levels. Review of resident 25's February 2020 Medication Administration Record [REDACTED]. -Follow-up pain relief was documented as unknown. *There was not other documentation of as needed pain medications being administered. Review of resident 25's 1/29/20 care plan revealed: *Evaluate the effectiveness of my pain interventions. alleviating of my symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Consult with DR (doctor) if current pain med (medication) regime is not adequately controlling pain. *Try to anticipate my need for pain relief and respond immediately to any complaint of pain that I may have. *To have her rate her pain level prior to and after receiving pain medication. *She was to have non-pharmacological interventions such as elevation, repositioning, and distraction. *It stated she had an order for [REDACTED]. [REDACTED].*[MEDICATION NAME] Tablet 325 MG Give 2 tablet by mouth every 6 hours as needed for Elevated Temperature;Mild Pain AND Give 2 tablet by mouth two times a day for Mild Pain. Start date of 11/7/19. *Biofreeze Gel 4% Menthol (Topical [MEDICATION NAME]) Apply to Right shoulder topically every 12 hours as needed for Mild Pain. Start date of 12/25/19. *There was no order for [MEDICATION NAME]/[MEDICATION NAME] listed. Review of resident 25's discontinued physician's orders [REDACTED]. The discontinued reason was because it had not been used since September. Interview on 3/4/20 at 10:13 a.m. with licensed practical nurse (LPN) E regarding resident 25 revealed: *She had [MEDICAL CONDITION] and would say she had pain at times, but then a few minutes later she would tell you she had no pain. *She often refused prescription medications. *There was no process for monitoring resident's pain. *When she did her medication pass she would ask each resident how they were and if they had pain. *They did not do a formal assessment or document pain daily. Interview on 3/4/20 at 1:49 p.m. with MDS coordinator A regarding resident 25 revealed: *She was

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 0697 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) not aware of what was going on day to day in the facility. *She had not done the pain assessment for the MDS assessment. *A nurse on the floor had done the assessment on 2/19/20, and she had used it for her MDS assessment. -She had not done anything about her complaints of pain noted on that assessment. *She agreed that something should have been done about the resident's pain. Interview on 3/04/20 at 2:30 p.m. with director of nursing (DON) B regarding resident 25 revealed: *She had received therapy in the past for her arm contracture and would often refuse the service. *She was currently on a restorative program but would often refuse to participate. *She could not find documentation the physician had been notified of the pain or that any intervention had been put in place. *She agreed the nurse and the MDS coordinator should have done something about her pain after completing the above assessments. Review of the provider's September 2013 Pain Management policy revealed: *To include the resident and family in evaluation of pain, potential interventions, and goals. *Identify the potential cause(s) for resident pain. Evaluate alleviating and/or exacerbating factors. Review effectiveness of past and current treatment, as well as specific spiritual and cultural issues related to pain. *Determine appropriate interventions to manage pain and side effects. Appropriate interventions may include pharmacologic as well as non-pharmacologic interventions. *Notify physician if interventions are not effective in achieving resident comfort and/or functional goals.