STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVANTARA NORTON	3600 SOUTH NORTON AVENUE SIOUX FALLS, SD 57105

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 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, policy review, and job description review, the provider failed to follow professional standards for: *physician's orders [REDACTED]. *Medication had been obtained and given for one of eight sampled resident's (2). *An admission assessment had been completed for one of one sampled residents (1) *One of eight sampled residents (2) physician had been notified of medication that had not been given. Findings include: 1. During the 6/19/20 readmission of resident 1 his physician's orders [REDACTED]. He had not received many of his medications. He had not received all of his pain management medications from 6/19/20 to 6/23/20. He was hospitalized again on 6/23/20 due to increased pain. 2. Resident 2 had medications that had not been given due to not having been available and also medications he had refused. There was minimal documentation regarding those missed medications. His physician had not been notified of any of those missed medications. 3. Interview on 6/30/20 at 10:00 a.m. with assistant director of nursing B regarding a following physician's orders [REDACTED].*Did not have a policy for following physician's orders [REDACTED].*Had used the Lipponcott nursing manual for professional standards. Refer to F760.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the provider failed to ensure two of eight sampled residents (1 and 2) received medications as ordered by their physicians. Many of the medications that had not been administered had been used to treat significant medical conditions. Findings include: 1. Review of resident 1's medical record revealed: *He had been hosptalized on [DATE] and returned on 6/19/20. *The physician's medication orders on 6/19/20 included new prescriptions for: -Duloxetine Hcl Dr, 30 milligrams (mg) one tablet daily for pain. -[MEDICATION NAME] 4 mg; 4 mg twice a day for seven days, and then 4 mg daily until follow-up with his physician. The medication was for pain and inflammation. -[MEDICATION NAME] 20 mg, one tablet every twelve hours for pain. *He was to have continued the following scheduled medications of: -[MEDICATION NAME] 500 mg, two tablets twice a day for pain. -[MEDICATION NAME] 100 mg to equal 400 mg daily. -Eliquis 5 mg, one tablet twice a day to prevent blood clots. -Atorvastatin 40 mg, one tablet each bedtime to reduce cholesterol. -[MEDICATION NAME] bisulfate 75 mg, one tablet daily to prevent blood clots. -[MEDICATION NAME] 0.6 mg, one capsule daily for gout. -[MEDICATION NAME] 20 mg, one tablet daily for fluid retention. -[MEDICATION NAME] 300 mg, three capsules; three times a day for pain. -[MEDICATION NAME] 30 mg, one tablet daily for [MEDICAL CONDITION]. -[MEDICATION NAME] Hcl 500 mg, one tablet daily for diabetes. -[MEDICATION NAME] 100 mg, one tablet every twelve hours for blood pressure. -NAME] 40 mg, one table daily for stomach acid prevention. -Sennosides 8.6 mg, two tablets at bedtime for constipation. -[MEDICATION NAME] 80 mg, three times a day after meals for flatulence. -Tamsulosin Hcl 0.4 mg, one table daily for [MEDICAL CONDITION]. -[MEDICATION NAME] 100 mg, one tablet daily for diabetes. Review of resident 1's June 2020 Medication Administration Record [REDACTED]. *[MEDICATION NAME] 4 mg; 4 mg twice a day for seven days, and then 4 mg daily until follow-up with his physician. The medication was for pain and inflammation. *[MEDICATION NAME] 20 mg, one tablet every twelve hours for pain. *[MEDICATION NAME] 100 mg, one tablet daily. *He had not received the correct dose of the [MEDICATION NAME]. *He also had not received fifteen other medications that had been ordered. *He was readmitted to the hospital again on 6/23/20 for uncontrolled pain. Observation and interview on 6/30/20 from 4:30 p.m. through 4:45 p.m. with director of nursing (DON) A in the east medication room revealed medication blister packs with a pharmacy label for resident 1. Those medications included: *Two [MEDICATION NAME] 20 mg blister packs: one with fifteen tablets and one with two tablets. *[MEDICATION NAME] bisulfate 75 mg; four tablets. *[MEDICATION NAME] 0.6 mg; thirteen tablets. *Two blister packs of Eliquis 5 mg: one with eight tablets and one with seven tablets. *[MEDICATION NAME] 30 mg: four tablets. *[MEDICATION NAME] 100 mg: four tablets. *Kcl ER 20 milliequivilents (mEq): twenty tablets. *[MEDICATION NAME] ER 100 mg: thirty tablets. *Two blister packs of [MEDICATION NAME] 10 mg: one with forty tablets and one with twenty tablets. *[MEDICATION NAME] 2 mg: twelve tablets. *[MEDICATION NAME] 5 mg: twenty-eight tablets. *Calcium [MEDICATION NAME]-vitamin D: two tablets. *[MEDICATION NAME] Hbr 20 mg: four tablets. *[MEDICATION NAME] 12.5 mg: six capsules. *Solifenacin [MEDICATION NAME] 10 mg: twenty-seen tablets. *[MEDICATION NAME] 4 mg: twenty-four tablets. *Two blister packs of duloxetine Hcl Dr 30 mg: one with twelve capsules and one with fourteen capsules. *Two blister packs of [MEDICATION NAME] Hcl 500 mg: one with ten tablets and one with nine tablets. *[MEDICATION NAME] 100 mg: seven tablets. *Three blister packs of [MEDICATION NAME] 300 mg: two with thirty-three capsules each and one with eighteen capsules. *Atorvastatin 40 mg: seven tablets. *Two blister packs of [MEDICATION NAME] 100 mg: one with eight tables and one with one tablet. *[MEDICATION NAME] 300 mg: nine tablets. *NAME] 40 mg: six tablets. *Tamsulosin Hcl 0.4 mg: thirty capsules. DON A stated at that time the above medication blister packs were awaiting destruction. They were a combination of medications he had prior to his hospitalized from [DATE] to 6/19/20. She agreed those medications had been available to have been used for resident 1 on his return from the hospital on [DATE]. Interview on 6/30/20 at 3:49 p.m. with doctor of pharmacy E regarding resident 1 revealed: *The pharmacy had been notified he had returned to the facility on medicare A status on 6/19/20. *Later there was a note at the pharmacy stating, No longer on Medicare A status. *They had received his physician's orders [REDACTED]. *They had sent four medications to the facility (duloxetine, [MEDICATION NAME], and [MEDICATION NAME]). *In hind sight they should have sent out all new medication cards. *The usual routine was not to send out new medication cards if the facility had them. *If a resident was on Medicare A status they would have sent out all new medication cards. -Since he was not on Medicare A status they had only sent the new medications that had been ordered. Interview on 6/30/20 at 4:07 p.m. with licensed practical nurse (LPN) D regarding resident 1 revealed: *She had not been involved with his admission. *He had been admitted to the east wing. *She had taken care of him for one day after he had returned. *She was not responsible for admission assessments. *She had completed his Medicare assessment on 6/22/20 when she had taken care of him. *She had administered his medications to him on 6/22/20. -He had brought up to her about not getting all of his medications. *She knew DON A, assistant director of nursing B, and therapy were looking into it. *She had given him two medications. -She had questioned why he was now on fewer medications but knew DON A had been checking into that issue. *She had not checked his orders. *She found out in report he had returned to the facility and was receiving some type of [MEDICAL CONDITION] treatment. Interview on 6/30/20 at 5:13 p.m. with registered nurse (RN) C regarding resident 1 revealed: *He had returned to the facility on [DATE]. *She had been working the 6:00 a.m. to 6:30 p.m. shift that day. *She had signed off on his admission orders [REDACTED]. *She had only been employed at the facility for six months. *She had never worked with the facility's computer program they used for resident's electronic medical records. *She had received some training during orientation on how to work with the computer program but could not recall what had been done in training. *She had asked infection control/wound nurse F how to read the new prescriptions and how to input the new orders. -Infection control/wound nurse F had told her to do Steps A, B, C and then save. *She was not sure if she had done it correctly. *She knew when a

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 0760 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) resident had been readmitted the orders could be reactivated but was unsure how it was done. *She did not know how the orders had ended up in the Q. *There should have been a double check by staff on his orders. *She had not seen resident 1 again after she had admitted him. *She could not recall if she had completed his assessment. -The certified nursing assistants probably obtained his vital signs. *She stayed until 8:00 p.m. trying to get his admission orders [REDACTED]. *She had told doctor of pharmacy E he was not on Medicare A when he had returned to the facility. -She was not well versed on Medicare A. *After the incident with resident 1 she had received some retraining. They were going to hold Medicare meetings and teach them more about Medicare A. *She was unaware his unused medications were stored in the medication room. 2. Review of resident 2's interdisciplinary progress notes from May 2020 through June 2020 revealed his: *[MEDICATION NAME] oxalate 10 mg, tablet take 0.5 mg tablet daily had not been given due to med not available on 5/1/20 and 5/2/20. *[MEDICATION NAME] oxalate 10 mg, tablet take 0.5 mg tablet daily had been documented as wrong dose. *[MEDICATION NAME] 1 mg capsule each morning had not been given due to med not here on 5/7/20, 5/9/20, 5/10/20, and 5/13/20. *[MEDICATION NAME] 1 mg capsule each evening had not been given due to med not here on 5/7/20. *[MEDICATION NAME] 0.5 mg capsule each evening had not been given due to no med on 5/9/20, 5/10/20, 5/11/20, 5/12/20, and 5/13/20. *[MEDICATION NAME] 0.5 mg capsule each bedtime had not been given due to not available on 5/8/20, 5/9/20, 5/10/20, 5/11/20, and 6/9/20. *Xarelto 10 mg tablet each bed time had not been given due to not in stock on 6/8/20, 6/9/20, 6/20/20, 6/27/20, 6/28/20, and 6/29/20. *Tresiba insulin on 5/9/20 had been marked prior shift and on 5/23/20 had been marked prior shift duty, unknown if given. Review of his May 2020 and June 2020 MARs revealed he had refused the following medications: [REDACTED]. 5/16/20, 5/17/20, and 5/23/20. *Latanoprost solution 0.005%, one drop in both eyes at bedtime refused on: 5/1/20, 5/2/20, 5/4/30, 5/10/20, 5/22/20, 5/27/20, and 5/4/20. Review of resident 2's 6/3/20 physician's orders [REDACTED]. *[MEDICATION NAME] had been prescribed for kidney transplant status. *Xarelto had been prescribed for history of [MEDICAL CONDITION] or embolism. *Tresiba had been prescribed for type 2 diabetes mellitus. Interview on 6/30/20 at 5:30 p.m. with DON A regarding resident 2 and staff education revealed: *They were in the process of working with the nursing staff on reeducation on how to complete new admissions. *They had completed a performance improvement plan (PIP) on staff education and new admissions. *Resident 2's Xarelto was in the top drawer of the medication cart. *Her expectations for resident 2's Tresiba insulin would have been to visit with the last shift and see if they had given him the medication. Review of the provider's reviewed 7/30/19 Admission and Readmission policy revealed: *Assess resident and fill out assessment sheet. *Verify orders from the hospital with physician or on-call physician. *Obtain physician orders [REDACTED]. *Carry out physician orders. Review of the provider's September 2010 Ordering and Receiving Non-Controlled Medications policy revealed: *All new medication orders are transmitted to the pharmacy. *Repeat medications (refills for a new supply) are ordered by writing the medication name and prescription number, or applying the peel-off bar coded label from the prescription label on the reorder sheet and faxing or otherwise transmitting the order to the pharmacy. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand. Review of the provider's September 2018 Medication Administration General Guidelines policy revealed, Medications are administered in accordance with written orders of the prescriber. Review of the provider's 8/24/18 Registered Nurse job description revealed: *Place pharmacy orders, for and administer all newly prescribed medications and document. *Assist with new admissions, re-admissions and assist with the transfer of Guests (residents) to different rooms within the facility. *Carry out direct contemporaneous charting in your shift. *Completes medical records documenting care provided and other information in accordance with nursing policies while maintaining strict confidentiality.