STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435051	A. BUILDING _____ B. WING _____	**03/12/2020**

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

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.** Based on observation, interview, record review, and policy review, the provider failed to ensure: *Physician's orders for oxygen saturation level check for one of one sampled resdient (16) with an order was followed. *Physician's order for suture removal was followed or clarified for one of one sampled resident (35) with sutures. *Care provided by one of one registered nurse (RN) (J) was conducted with dignity and respect for one of one sampled resident (45). *Appropriate positioning was completed by one of one staff RN J for one of one sampled resident (45) with a tube feeding. Findings include: 1. Observation on 3/10/20 at 10:00 a.m. of resident 16 while in his room revealed an oxygen concentrator and a continuous positive airway pressure machine (C-PAP). The resident stated he did not use the oxygen during the day but used the C-PAP at night. Review of resident 16's medical record revealed: *A 12/7/19 physician's order that stated to monitor oxygen saturation levels every shift to maintain them at greater than 89%. *An oxygen saturation level scheduled for the a.m. and p.m. shift on his March 2020 treatment administration record (TAR). *No documentation of oxygen saturation level results that verified they had been at least 89%. Interview on 3/12/20 at 8:50 a.m. with director of nursing (DON) B and registered nurse (RN) C confirmed the above finding. DON B stated she agreed there should have been documentation of the pulse oximetry results to verify they had been at least 89%. 2. Interview on 3/10/20 at 10:30 a.m. with resident 35 and his wife in the resident's room revealed: *He had fallen in his room on 2/22/20. *He had required stitches on his lower left leg. *His wife stated: -They were suppose to take them (stitches) out in ten days but had not. -She had finally asked them to take the stitches out. -The stitches had been removed Friday (3/6/20). -They (stitches) were pretty tight by then. Review of resident 35's medical record revealed: *A 2/22/20 After Visit Summary from the hospital emergency department visit stated: Sutures should be removed in 10 days. The visible stitch in the middle of the wound can be snipped and the long ends pulled from each end. *An order on the March 2020 treatment administration record stated: Monitor laceration to LLE (left lower extremity) every shift for S/S (signs and symptoms) of infections, change dressing if soiled or it falls off. Remove sutures to L lower leg in 10 days. *There had been no documentation those stitches had been removed until 3/6/20 at 5:20 p.m. That had been thirteen days. That had been three days after the order to have removed them. Interview on 3/12/20 at 8:55 a.m. with RN/unit manager C revealed: *The wound care RN K: -Had looked at resident 35's stitches on 3/3/20 and directed the staff nurse not to remove them. -Had not documented the condition of the resident's stitches or why the above nursing order had been made. -Had not notified the resident's physician regarding his stitches and why they had not been removed. *She agreed they had not followed the resident's physician's orders for removal of his stitches. Interview on 3/12/20 at 9:20 a.m. with wound care RN K confirmed the above interview. She stated she had not called resdient 35's physician for clarification regarding his suture removal. Interview on 3/12/20 at 9:30 a.m. with DON B confirmed the above findings. She stated regarding professional standards of practice the provider followed the Lippincott Nursing Manual. Patricia A. Potter et al., Fundamentals of Nursing, 9th Ed., Elsevier, St. Louis, Mo., 2017, p. 311, revealed: The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care provider's orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient (resident). 3. Observation and interview on 3/10/20 at 8:35 a.m. with RN J while administering resident 45's medications revealed: *She had performed hand hygiene prior to preparing medications and entering the resident's room. *The resident was lying on her back in bed with pillows beneath her neck and head. *She wore an incontinence brief. -The bed sheet she was laying on was visibly wet underneath her brief, in front of her brief, and along the sides of her brief. *RN J stated the sheet was wet with urine. *She proceeded to administer the resident's [MED], applied a topical medication behind the resident's ears, disconnected her tube feeding, attempted to administer the resident's medications through the feeding tube, and reconnected the tube feeding. *RN J stated she had not thought to change the resident's wet brief herself or have an unlicensed assistive person change the resident prior to medication administration. 4. Observation and interview on 3/11/20 at 3:55 p.m. with RN J while starting resident 45's gastric tube feeding revealed: *She had performed hand hygiene prior to entering the resident's room. *The resident was lying on her back in bed with pillows beneath her neck and head. *RN J started the gastric tube feeding. *She confirmed the resident was not positioned in a manner that would have prevented aspiration. -She stated the head of her bed should have been positioned at a thirty degree angle during medication administration and tube feedings. 5. Interview on 3/12/20 at 9:00 a.m. with director of nursing B revealed: *She would have expected resident 45's incontinence brief had been changed prior to medication administration or tube feeding. *She would have expected the head of resident 45's bed to have been positioned at a minimum thirty degree angle prior to medication administration or tube feeding. Review of the revised September 2019 Medication Administration via Gastric Tube policy revealed: *Procedures: -16. Instruct resident to remain in Semi-fowler's position (lying on one's back in a bed which is inclined at an angle of thirty to forty-five degrees) for at least 1 hour after feeding/medication administration to prevent aspiration, if resident able.
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, and policy review, the provider failed to: *Ensure appropriate hand hygiene and glove use was used during two of two sampled residents (2 and 20) personal care by three of four certified nurse assistants (CNA) (D, E, and G). *Follow manufacturer's instructions for cleaning and disinfecting the west Cascade whirlpool tub by one of one CNA (M) during one of two tub cleanings.Findings include: 1. Observation on 3/10/20 at 2:15 p.m. of CNAs D and E outside of resident 20's room revealed:*A sign next to the door for contact precautions:-Gown and gloves were to have been worn when entering the room.*Both residents in that room had colonized Carbapenem Resistant [MEDICATION NAME] (CRE).*A plastic container with drawers sat next to the door with gowns, gloves, and masks.*Both CNAs performed hand hygiene and put on gowns and gloves.*Resident 20 was dressed and sitting in her electric wheelchair (w/c).*The resident stated her pants and the w/c cushion were wet with urine due to her catheter leaking.*CNA D and E slid a mechanical lift sling behind the resident's back and underneath her.*Without changing gloves or performing hand hygiene CNAs D and E:-Moved the total body mechanical lift in front of the resident.-Secured the sling straps onto the lift.-Used the control to lift the resident out of the w/c and placed her onto her bed.*With those same gloves on they:-Removed her wet pants.-Grabbed a container of wet wipes and put it on the bed.-Removed her brief.-Cleaned the front of her.-Rolled her onto her left side.--There was bowel movement (BM).-Cleaned the back of her numerous times while she continued having a BM.-Held onto her hip and shoulder to keep her up on her side while continuing to have a BM.*The resident stated it might take a while for her to finish and asked them to loosely place a brief on her.-She would call them when she had finished.*They removed their gloves.*Without performing hand hygiene they put on new gloves*Placed a clean brief under her.*Rolled her onto her back and lightly secured the brief.*Rolled her onto her left side, placed a pillow between her knees, and covered her with her blanket.*Grabbed the

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) trash and put the sling into a separate bag.*Removed their gown and gloves at the door and threw them into the trash can.*Took the trash and bagged sling out of the room.*Then performed hand hygiene.Interview on 3/10/20 at 3:26 p.m. with CNAs D and E related to the above observation revealed:*They both agreed they had not removed their dirty gloves and performed hand hygiene:-After coming in contact with urine and touching clean equipment.-After removing the resident's brief and cleaning her.*Both agreed they had missed opportunities for glove changes and hand hygiene.*CNA D stated:-Gloves should be changed After every contact.-She did not wash her hands after the one time she changed gloves due to her not wanting to leave the resident unattended on her side.-Resident 20's Catheter never leaks, so we were not in a normal routine. 2. Observation on 3/10/20 at 10:27 a.m. with CNA G during personal care for resident 2 revealed she: *Cleansed her hands with sanitizer, applied clean gloves, and assisted resident to the toilet. -Removed resident's urine soaked brief, placed the used brief into the garbage can, assisted her onto the toilet, removed her gloves and put clean gloves on her unwashed hands. -Assisted the resident to partially dress with clean clothes, completed perineal care for her, then removed her gloves and put clean gloves on her unwashed hands. -Assisted her to stand, applied a clean brief, pulled up her pants, assisted her to the wheelchair, removed the gait belt, removed her gloves, and did not wash her hands. -Used her ungloved, unwashed hands to put the gait belt in resident's nightstand drawer, pulled the trash liner containing the urine soaked brief out of the garbage can, set the same trash liner on the floor, then placed a new trash liner in the trash can. -Washed her hands in the bathroom sink. With ungloved hands she picked up the same soiled trash liner off the floor, opened the room door, and carried the soiled trash liner to the hallway utility room. -Opened the utility room door after touching the soiled liner with ungloved hands. 3. Interview on 3/12/20 at 9:58 a.m. with director of nursing B regarding the above hand hygiene and glove use revealed: *She agreed hand hygiene and glove use had not been performed correctly. *Stated the facility had been auditing that and would continue to audit hand hygiene and glove use with repeated education of staff. Review of the provider's October 2019 Hand Hygiene policy revealed (in part): *When hands are visibly soiled employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water. *If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] for all the following situations: -Before and after direct contact with residents. -When entering and leaving a resident care area/room. -Before donning and after removing gloves. -Before moving from a contaminated body site to a clean body site during resident care. -After contact with resident's intact skin. -After handling used dressings, contaminated equipment, ect.; -After contact with body fluids, mucous membranes and non-intact skin or dressing, provided hands are not visibly soiled.*The use of gloves does not replace handwashing/hand hygiene. 4. Observation and interview on 3/11/20 at 4:43 p.m. of CNA M while performing a whirlpool tub cleaning in the west bath house revealed:*She had been a CNA and had been completing baths for approximately five years.-She had started working at this facility in January 2020.*She put on gloves and removed a 14 ounce (oz) bottle of Classic Whirlpool Disinfectant cleaner from the cabinet.*She filled the tub with hot water to approximately six inches from the tub rim.-That had been approximately 50 to 60 gallons of water.*She added four ounces of Classic Whirlpool Disinfectant cleaner.*At 4:56 p.m. she turned on the jets and began scrubbing the tub.*At 5:03 p.m. she stopped scrubbing, turned off jets, and released the plug to drain the water.*Stated she had let it sit for ten minutes and knew that, because she had watched the clock on the wall. -She stated the east bath house had a timer she could set.*At 5:05 p.m. she moved the bath chair and scrubbed underneath it.*At 5:09 p.m. she stopped scrubbing.-Blew the jets out.-Rinsed the tub with a hand held sprayer.-Blew the jets out again. *She grabbed bleach wipes from the cabinet and wiped the outside of the tub.*She had learned the above procedure of cleaning while being at another facility.-It had the same type of tub.*She stated that was her usual way of cleaning the tub.Observation, interview, and audit review on 3/12/20 at 10:34 a.m. with infection control registered nurse (RN) K revealed:*Three signs had been posted on the rear door of the west bath house consisting of:-Tub Cleaning procedure.-Classic Whirlpool Disinfectant Cleaner.-Instructions for Classic Whirlpool Disinfectant Cleaner.*She stated the tub was disinfected two times that was at the end of a shift.*She stated there was a bottle of disinfectant labeled Classic Disinfectant cleaner that was sprayed on the outside of the tub and wiped to clean it.*They filled the tub with hot water and added 2 oz of disinfectant per gallon of water.-She was unaware how many gallons of water the tub held.*She believed the CNAs knew how many gallons it held and had added the correct amount of disinfectant when cleaning the tub.*They scrubbed everything in and outside of the tub for four or five minutes.Continued observation and interview with infection control RN K revealed:*She had two completed whirlpool cleaning audit forms in her hand. -One had been completed by her on 3/4/20 and had been documented as performed correctly.*After she read her audit form she stated the disinfectant should remain wet on the tub for at least ten minutes.*She had only seen that one tub cleaning.-She believed it had been done correctly.*She was unsure how to clean the tub and would have to read the tub manual to ensure the proper cleaning procedure.*She removed two of the three signs on the rear of the west bath house door stating: -They were confusing.-Only one of the signs needed to be left and should be followed.*She left the Classic Whirlpool Disinfectant cleaner sign. *It stated:*Central's Classic Whirlpool Disinfectant Cleaner can be used to disinfect hard, non-porous, inanimate surfaces including (Fiberglass and stainless steel tubs and chair surfaces, chrome plated intakes and lifts, patient transfer equipment, etc.) Formulated for use in hospitals, nursing homes, clinics, and other institutions.-Sanitizing: At two ounces per gallon of water CLASSIC Whirlpool Disinfectant Cleaner is an effective sanitizer on hard non-porous, non-food environmental surfaces.-USE DILUTION: Two ounces per gallon of water.-CONTACT TIMES: Disinfection: 10 minutes Sanitizing: 30 seconds.*There were no other instructions on the door that stated how to correctly clean the tub. Continued interview on 3/12/20 at 9:16 a.m. with infection control RN K concerning whirlpool tub cleaning revealed she:*Had found the owner's manual for the tub.*Stated the tub held 64 gallons of water.*Stated:-When cleaning the tub it was to have been filled with hot water to just below the rim of the tub.-Two oz of disinfectant was to have been added for each gallon of water.--That would have been approximately 128 oz of disinfectant which was equal to one gallon of disinfectant. Interview on 3/12/20 at 10:19 a.m. with unit manager C revealed:*The manual that infection control RN K had been referring to had been the manual for the Impera whirlpool tub. -Not the tub in the west bath house that was a Cascade Whirlpool.*She would have expected infection control RN K to be able to state the steps required to clean their tubs correctly.*Infection control RN K needed to know the correct procedure to educate and perform tub cleaning audits correctly.-That was important for infection control.*She stated filling the tub with 64 gallons of water and adding 2 ounces of disinfectant per gallon did not sound correct. Review of the undated Cascade Sit-Bath System 6900 owner's manual revealed:*System Cleaning (After Every Bath)-1. Close and lock the door.2. Press the Tub Fill Button and turn the Temperature Control Knob all the way to the left to its warmest level to heat the disinfectant solution and maximize its effectiveness.3. Remove any visible tissue, residue, or fluids from the tub by pressing the Shower Button and rinsing the inside tub surfaces with the shower sprayer. 4. Press the Fill Button again to turn off the water. Allow the tub to drain, and place the drain plug over the drain.5. On Whirlpool Tubs press and hold the Disinfect Button located on the left side of the tub. As the button is held down, the properly mixed cleaning solutions running through the disinfecting the pump and motor. release the button after you see solution coming out of both jets and you have 1 to 1/2 gallons of disinfectant solution in the foot well of the tub.7. Using the long-handled brush .thoroughly scrub all interior surfaces of the tub with the solution that remains in the foot well of the tub. Let disinfectant stay on surface for 10 minutes. (Or, as recommended by the instructions on the disinfectant concentrate container).8. Remove the plug from the drain.9. On Whirlpool Tubs spray water from the shower sprayer into both outlets until clear water appears from the inlet.10. Rinse the tubs interior surfaces thoroughly with the shower sprayer.16. Visibly check that the tub was effectively cleaned during the disinfecting procedure. if not, repeat the procedure.Request on 3/12/20 at 7:50 a.m. for the facility tub cleaning policy from infection control RN K revealed the only policy they followed was the Classic Whirlpool Disinfectant cleaner instructions. Those were taped to the back of the door of the west bath house.