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 _____	**06/09/2020**

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 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, policy review, and review of the Environmental Protection Agency (EPA) List N (Disinfectants for Use Against [DIAGNOSES REDACTED]-CoV-2), the provider failed to ensure infection control procedures and practices were followed: *Cleaning and disinfection of shared resident equipment by two of two observed certified nurse aides (CNA) (E and F). *Cleaning and disinfecting of insulin injection devices by one of one licensed practical nurse (LPN) (G). *Cleaning and disinfection of the unit dedicated to residents who had tested positive for coronavirus disease 2019 (COVID-19) and residents exposed to COVID-19 who had tested negative. *Storage of personal protective equipment (PPE) by two of two CNAs (C and E). Findings include: 1. Interview on 6/9/20 at 10:15 a.m. with administrator A revealed the facility had fifteen residents with active COVID-19, one resident who had recovered from COVID-19, and nine employees who had tested positive for COVID-19 since mass testing had occurred on 5/22/20. 2. Observation and interview on 6/9/20 at 12:30 p.m. of certified nurse aide (CNA) E on the dedicated unit referred to above revealed: *Staff had consistent resident assignments throughout their shift. -Either residents who were COVID-19 positive or residents exposed to COVID-19. -All residents were quarantined in their rooms. *She had taken resident 1's temperature, blood pressure, and pulse oximetry reading. *She exited the room, removed her gloves, performed hand hygiene, and put on a new pair of gloves. *She used a Microdot Bleach Wipe to disinfect the surfaces of the used thermometer, pulse oximeter, and blood pressure cuff. -Each item was wiped for less than five seconds. *She performed hand hygiene, applied new gloves, and entered the room shared by residents 2 and 3. -She took their temperatures, blood pressures, and pulse oximetry readings. *She exited that room, removed her gloves, performed hand hygiene, and put on a new pair of gloves. *She used a Microdot Bleach Wipe the thermometer, pulse oximeter, and blood pressure cuff. -Each item was wiped less than five seconds. *She stated resident equipment was allowed to sit three to five minutes after she wiped it and before using it again. *She confirmed she had not disinfected the equipment she used between the above care for residents 2 and 3. 3. Interview with CNAs C and E regarding PPE use revealed: *They wore their N95 masks out of the building at the end of their shifts. *They kept those masks in a paper bag in their personal vehicles in a place where the bag would be warm. 4. Interview on 6/9/20 at 12:45 p.m. with registered nurse (RN) D regarding cleaning and disinfection of the dedicated unit revealed: *Caregivers were responsible for daily cleaning and disinfection of that unit. *There was An Environmental Disinfectant Log Common Touchpoints documentation tool to record that activity. -It included a list of high touch surfaces throughout the unit. -That activity was scheduled in the morning, evening, and during the night. Review of the June 2020 documentation log referred to above revealed: *Cleaning and disinfection had been recorded nine of nine morning opportunities, two of eight evening opportunities, and zero of eight opportunities during the night shift. *RN D confirmed the information on that tool. -She stated CNA F had cleaned and disinfected the unit in the morning during June 2020 but could not speak to cleaning on the evening shift or night shift. -She was uncertain who was responsible for monitoring that documentation tool. 5. Observation and interview on 6/9/20 at 11:45 a.m. in the hall on the unit dedicated to residents suspected or confirmed positive for COVID-19 of CNA C while she cleaned vital sign equipment revealed she: *Placed two Clorox Healthcare Bleach Germacidal Wipes (Clorox wipe) on top of each other on an over-the-bed table. *Placed another Clorox wipe on that same over-the-bed table. *Put the blood pressure cuff and stethoscope on top of the two Clorox wipes. *Put the thermometer and pulse oximeter on top of the single Clorox wipe. *Removed another Clorox wipe from the container and wiped off the thermometer, pulse oximeter, and stethoscope with the same wipe. -That wipe had not remained wet during that entire cleaning process. *Used the remaining two wipes to clean the blood pressure cuff. *The vital sign equipment had only been wet with the Clorox wipe solution fifteen seconds or less. *She was unaware of how long the vital sign equipment was to have remained wet with the Clorox wipe to be effective. -They are just wet until they are dry. 6. Observation and interview on 6/9/20 from 12:00 noon through 12:30 p.m. in the hall on the unit dedicated to residents suspected or confirmed positive for COVID-19 of licensed practical nurse G revealed: *She: -Administered insulin to two unidentified residents. -Used a separate Clorox wipe and wiped off the insulin injection devices when she was done. -Stated she just wiped them off and put them away. -Stated the cleaning process for the injection devices was the same for all residents on the dedicated unit. -Had been unsure how long the injection devices should have stayed wet from the Clorox wipe to have been effectively cleaned. *Both of the injection devices had not remained wet with the Clorox wipe solution for more than fifteen seconds. 7. Interview on 6/9/20 at 1:30 p.m. with administrator A, director of nursing B, and nurse consultant H regarding resident equipment use, PPE storage, and unit cleaning and disinfection revealed: *It was DON B's expectation resident equipment was disinfected between resident use. -Cleaned equipment surfaces remained wet for the time recommended by the product label. *Staff had not been educated to store their N95 masks in personal vehicles. -It was her expectation N95 masks had been placed in labeled brown bags at the exit door of the designated unit at the end of a shift. *DON B stated high touch areas in the facility were expected to be cleaned three times per day using the documentation tool in finding 4. -She was unaware staff documentation on the designated unit did not reflect that. *It was the responsibility of the Infection Preventionist to monitor that data. -She was currently filling the Infection Preventionist role. Review of the EPA List N product registration (-1) information for Microdot Bleach Wipes revealed the contact time for that product was thirty seconds. Accessed on 6/10/20 at 11:00 a.m. from the Internet: at https://www.cloroxpro.com/products/clorox-healthcare/bleach-germicidal-disinfectants/?Healthcare Bleach Germicidal Wipesrevealed: Efficacy,Virus, Kill Time Human coronavirus 1 min. Review of the revised May 6, 2020 Strategies for Optimizing PPE for COVID-19 revealed: *Masks: -c. .The folded mask can be stored between uses in a clean paper bag with employee's name written on it. Bag will need to be closed and folded when storing mask. Review of the revised April 10, 2020 Cleaning and Disinfection COVID-19 policy revealed: *Cleaning during Covid-19 Pandemic: -High touch physical plant areas will be cleaned at least three times per day. -Cleaning and disinfection will be completed after use of shared equipment.

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