STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435039	A. Building B. Wing	10/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50015 Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, and policy review the provider failed to ensure the care plan reflected the current individualized treatment needs for a tunneled chest catheter (a thin tube inserted into a vein in the chest, neck, or groin and tunneled under the skin to a large vein near the heart referred to as a central venous catheter (CVC) to allow access to the vein for medication administration) versus a peripherally inserted central catheter (PICC) inserted into a vein in the upper arm for one of one sampled resident (1). Findings include: 1. Review of resident 1's electronic medical record revealed: *Multiple references of the tunneled chest catheter as referred to as a PICC line multiple times by the resident's clinical nurse practitioner (CNP) and the nursing home staff. *A health status note dated 10/11/24, that indicated resident 1 had a tunneled chest catheter placed on 10/10/24 on the right side of her chest in the hospital. *Resident 1 would be returning to the facility and was to receive intravenous (IV) antibiotics. *Her diagnoses included: -End stage renal disease. -Dependence on renal dialysis. -Chronic pain. -Osteomyelitis (a bone infection that causes bone tissue inflammation and swelling). *Resident 1's care plan: -Did not reflect a tunneled chest catheter. -Indicated resident 1 was on antibiotic therapy related to an Osteomyelitis infection. (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Did not indicate the route of administration for her antibiotics. -Did not address dressing changes for the insertion site. *Physicians order summary dated 10/11/24 included orders for: -Ertapenem Sodium [an antibiotic] Injection Solution Reconstituted 1 Gram one time daily. -Flush PICC before and after med admin every shift. -PICC dressing change one time a day every Wed. for. -Remove chest suture from tunneled catheter in 6 weeks, order (written 10/10/24) one time only for suture care for 1 Day. *She had an interdisciplinary team (IDT) meeting on 10/17/24. *Her 10/14/24 Vascular Access Evaluation did not mention a tunneled chest catheter or peripherally inserted central catheter (PICC) line. *Her 10/21/24 Vascular Access Evaluation did not mention a tunneled chest catheter or PICC line. *Her 10/21/24 Brief Interview for Mental Status (BIMS) assessment score was 10 which indicated she had moderate cognitive impairment. *She was currently hospitalized . 2. Review of the provider's September 2019 Care Plans Policy revealed: *Individual, resident-centered care planning will be initiated upon admission and maintained by the intradisciplinary team throughout the resident's stay to promote optimal quality of life while in residence. *Physician's orders are referenced in the resident's care plan, but not rewritten into the care plan. *The formal care plan (multi-page) is completed/updated by the IDT members prior to the care conference.

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 51094 Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, and interviews with facility staff failed to ensure the safety of one of one sampled resident (1) whose tunneled chest catheter (a thin tube inserted into a vein in the chest, neck, or groin and tunneled under the skin to a large vein near the heart referred to as a central venous catheter (CVC) to allow access to the vein for medication administration) was removed by registered nurse (RN) (C), not trained to safely perform that task. Findings include: 1. Review of providers 10/25/24 DOH FRI report revealed: *Resident 1 is receiving intravenous (IV) antibiotics for osteomyelitis [a bone infection that causes bone tissue inflammation and swelling]. *She had a tunneled chest catheter placed in her right chest area and on 10/17/24, that tunneled chest catheter was removed by RN C. -Although resident 1 had questioned RN C about removing it, she was told it was no longer needed. -The nurse practitioner was not notified of the mistake (the removal of her tunneled chest catheter). -She had approximately 1 month of IV antibiotic treatment remaining at the time of the reported incident. 2. Review of resident 1's electronic medical record revealed: *Multiple references to a peripherally inserted central catheter (PICC) usually inserted into a vein in the upper arm rather than to the tunneled chest catheter or CVC that resident 1 had in her right chest. -Flush PICC line before and after medication administration every shift. -PICC dressing change to be completed every Wednesday. *She is currently hospitalized . *Resident 1's diagnoses included: -End stage renal disease -dependence on renal dialysis -chronic pain. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	-Osteomylelitis *She had a (brief interview of mental status) BIMS score of 10, which indicated moderate cognitive impairment. -Resident 1 was on an antibiotic therapy related to an Osteomyelitis infection. *On 10/10/24, she had a tunneled chest catheter placed at the hospital on the right side of her chest and returned from the hospital on 10/11/24. *On 10/17/24, an order from resident 1's nurse practitioner directed ok to remove PICC (a thin tube inserted into a vein in the arm, leg or neck and threaded into a large vein near the heart to allow long-term access to the vein) line. *On 10/18/24, an order was received from resident 1's nurse practitioner for placement of a new tunneled chest catheter to be placed on 10/22/24. 3. On 10/28/24 at 4:10 pm PICC line removal policy, and IV medication administration policy and PICC line training/education was requested from administrator B. -Administrator B did not provide a PICC line removal policy by the end of the survey on 10/29/24. *Staff training and education requested for RN C revealed the education packet did not include: -Tunneled chest catheter placement or removal. -IV medication administration. -Administrator B did not provide an IV medication administration policy. 4. Interview on 10/28/24 at 4:35 p.m. with RN C revealed: *He has been employed at the facility for one year and two months. *He had no training during his employment at the facility regarding: -IV medication administration. -The placement or removal of PICC lines or tunneled chest catheters. -He states the only training he received was what was included in the training packet he completed when he was hired. *He reported resident 1 had one PICC line present on the date that he removed the line. -He thought resident 1 had a PICC line present because that's the way it is noted in the chart. -He reported that the line he removed was located in resident 1's right upper chest. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	-He stated Sometimes PICC lines can be present in that location of the body. -He stated he was aware resident 1 had an order for antibiotics through 11/16/24. *He stated that he removed the PICC line because he got an order from the nurse practitioner to do so. -He stated, In my defense, I had the resident lie flat and hold her breath while I removed it. 5. Interview on 10/29/24 at 8:27 a.m. with assistant director of nursing (ADON) F revealed: -She participated in antibiotic stewardship and infection control. -Every morning, she receives a list of residents who were receiving an antibiotic. *Resident 1's antibiotic therapy was discussed at the intradisciplinary team (IDT) meeting on 10/17/24. -Note in resident 1's chart regarding the (IDT) meeting on 10/17/24 that indicated resident was not on an antibiotic, was written in error. -There was no order received by the facility to discontinue resident 1's IV antibiotic therapy. -Resident 1 was receiving IV antibiotic therapy on 10/17/24. 6. Interview on 10/29/24 at 9:36 a.m. with director of nursing (DON) A revealed: *He was aware that the nursing staff had received an order from the nurse practitioner to remove resident 1's tunneled chest catheter. *An order was not received to discontinue resident 1's IV antibiotic therapy. -He was aware that the day before resident 1's catheter was removed, her nurse practitioner came to the facility for a visit with her and documented to continue her IV antibiotics through 11/16/24. -He stated, Its possible that the nurse read the date of 11/16/24 and thought it said 10/16/24 as the date that the antibiotic therapy was to be completed. *He did not visualize the IV line that resident 1 had. *He stated that the facility received approximately one resident weekly with a PICC line present. -He stated the facility rarely receive residents with a tunneled chest catheter present. *He was not aware of any nursing education for the placement or removal of PICC lines or tunneled chest catheters. *He stated the pharmacy came on 9/12/24 to complete staff education for all nursing staff. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	*He states that the facility did not have a policy that includes PICC line removal or tunneled chest catheter removal. 7.Interview on 10/29/24 at 10:10 a.m. with Administrator B revealed: *She did not visualize the tunneled chest catheter that resident 1 had. -She was not aware of any policies regarding PICC line or tunneled chest catheter placement or removal. -She denied any education was provided by the facility to staff regarding PICC line or tunneled chest catheter placement or removal. *She denied any competencies regarding PICC line removals had been completed. 8.Interview on 10/29/24 at 11:10 a.m. with licensed practical nurse (LPN) E revealed she: *Had no education regarding IV antibiotic therapy while employed at this facility. *Did not administer any IV antibiotics to resident 1. *Denied being present at a pharmacy training in September 2024. 9.Interview on 10/29/24 at 11:15 a.m. with RN D revealed she: *Had administered IV antibiotics to resident 1 one time. *Had not had any training regarding IV antibiotic medication administration during her employment at this facility. *Was present at a pharmacy presentation in September 2024 but stated that no training was completed that day.