STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435048	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Groton	1106 North Second Street Groton, SD 57445

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49958 Based on record review, interview, observation, and policy review, the provider failed to ensure resident care plans were revised to reflect the current enhanced barrier precautions (EBP) need for three of eight sampled residents (11, 15, and 32) who required EBP. Findings include: 1. Review of resident 11's Skin Alteration Evaluation completed on 7/22/24 revealed resident 11 had a pressure ulcer (damaged skin and tissue caused by sustained pressure) to her left calf. Review of resident 11's care plan revealed: *[Resident 11] has an actual impairment to skin integrity due to left calf hematoma and pressure ulcer. *It had not been revised to indicate the need for EBP. Interview on 7/31/24 at 2:58 p.m. with director of nursing (DON) B: revealed: *Resident 11 was readmitted to the facility on [DATE] with a wound vacuum (a device that removes pressure and fluid from a wound) to her left lower leg. *She expected that all residents with a wound would be on EBP. *She would have updated a care plan at the resident care conferences or whenever something changed. *She confirmed that resident 11's care plan had not been updated to reflect EBP. Review of the provider's August 23, 2023 Advanced Care Planning policy revealed it was a process used to identify and update the residence preferences regarding care and treatment . 50935 (continued on next page)

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 - Some	2. Observation on 7/29/24 at 4:19 p.m. of residents 15 and 32's doors revealed they had Enhanced Barrier Precautions (EBP) signs hung on their doors with drawered bins of PPE available outside of those resident's rooms. Review of resident 32's care plan revealed: *The resident had an indwelling foley catheter. *Her care plan did not indicate the need for Enhanced Barrier Precautions (EBP). Review of resident 15's care plan revealed: *The resident had an open wound to his coccyx region. *His care plan did not indicate the need for EBP. Interview on 7/31/24 at 2:27 p.m. with registered nurse (RN) unit manager C revealed: *She believed EBP would have been indicated in the resident's care plans. *She and DON B were responsible for updating resident's care plans. Interview on 7/31/24 at 3:00 p.m. with DON B revealed: *Residents 15 and 32 should have EBP included in their care plans. *Verified EBP had not been revised on their care plans. Review of the provider's September 2019 Care Plan policy revealed: *Data/Problems/Needs/Concerns are a culmination of resident social and medical history, assessment results and interpretation, ancillary service tracking, pattern identification, and personal information forming the foundation of the care plan. The care plan is broken down into separate focus areas: Psycho-Social, Quality of Life, Comfort/Pain/Sleep, Death & Dying, Behavior, Communication, Nutritional Status, Bowel & Bladder Function, Hygiene ADL's/Skin, Safety/Vulnerability, Mobility/Fall Prevention, Medications and Special Attention for Other Physical Conditions. *Care plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50916 Based on observation, manufacturers' instructions review, and policy review the provider failed to ensure two of two randomly observed residents' (21 and 26) insulin had been administered according to the instructions for use by one of one registered nurse (RN) F. Those observations created a medication error rate of 9.68%. Findings include: 1.Observation on 7/30/24 at 7:59 a.m. with RN F during resident 21's Aspart and Degludec insulin administration revealed: *She had not primed the Aspart insulin pen needle prior to setting the dose of insulin. *She had not primed the Degludec insulin pen needle prior to setting the dose of insulin. *She administered the insulin to resident 21. 2.Observation on 7/30/24 at 10:57 a.m. with RN F during resident 26's Lispro insulin administration revealed: *She had not primed the Lispro insulin pen needle prior to setting the dose of of insulin. *She administered the insulin to resident 26. Review of the 2020 Insulin Lispro Injection KwikPen manufacturer's instructions for Use obtained from the Lispro Injection KwikPen box on 7/30/24 revealed: *Prime before each injection. *If you do not prime before each injection, you may get too much or too little insulin. *Instructions to prime insulin pen: -The dose knob should be set to two units. -While holding the pen with the needle pointing up, tap the cartridge to move the bubbles to the top. -Push the dose knob until 0 is seen in the dose window. -Insulin should be seen at the tip of the needle. -If insulin is not there, then repeat priming steps. Review of the provider's revised January 2018 Specific Medication Administration Procedure policy revealed: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*For pen devices, dial dose as instructed by pen manufacturer. *There was no mention of specific use for insulin pen devices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45383 A. Based on observation, interview, and policy review, the provider failed to ensure one of one registered nurse (RN) unit manager C had performed glove changes during a dressing change for one of one sampled resident (15). Findings include: 1. 0bservation on 7/30/24 at 9:16 a.m. of RN unit manager C performing a dressing change with resident 15 revealed: *She applied PPE (personal protective equipment). *She wheeled a tray into the room and laid a barrier down for the dressing supplies. *She placed the dressing supply container on a pillow in the resident's wheelchair. *She lowered the blinds in the resident's room. *With those same gloved hands she: -Adjusted the tray. -Lowered resident 15's shorts and brief. -Retrieved her walkie from her pocket and used it. -Assisted resident 15 to the bathroom with his shorts and brief half way down. -Pulled his walker from out in front of him. -Retrieved a garbage bag. -Removed the resident's soiled shorts and brief. -Retrieved her walkie and used it again. -Removed the resident's socks. -Used a peri wipe to clean feces from his legs. -She removed those gloves and performed hand hygiene. *She applied a new pair of gloves and retrieved a clean brief and a pair of the resident's shorts. *With those same gloved hands she assisted him with a new pair of gripper socks and provided peri care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She removed her gloves and performed hand hygiene and put on a new pair of gloves. *With those gloved hands she: -Used wound cleanser and cleaned the wound with gauze. -Opened the collagen packet, and applied ointment to the resident's wound bed. -Removed her gloves, performed hand hygiene and applied a new pair of gloves. *She poured collagen onto her gloved hand and applied it to the wound. *She asked for assistance to retrieve a sharpie marker from her pocket and used it to date the dressing. *She applied skin prep around the wound, applied the dressing to resident 15's coccyx, and removed his soiled shorts. *She removed those gloves and performed hand hygiene. *She applied a new pair of gloves and with those gloved hands she: -Assisted with dressing the resident with a new pair of shorts. -Cleaned the feces off of the floor and removed the garbage from her tray. -Continued to clean the feces off of the floor. -Removed the garbage bags and dirty laundry bag. -Replaced the garbage bags in the two garbage bins. -Opened the resident's blinds. *She removed her gown and gloves and performed hand hygiene. *She retrieved the resident's dressing supplies from the tray and placed them in the garbage, and removed her gloves. *She performed hand hygiene and applyied a new pair of gloves. *Used sani-wipes to clean her dressing tray. *She then removed those gloves and without washing her hands she, replaced the dressing supply container back into the medication cart without sanitizing it. Interview on 7/31/24 at 2:41 p.m. with RN unit manager C regarding the above dressing change revealed: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She agreed that she had missed some opportunities when she should have changed her gloves or washed her hands. *She agreed her pocket was not a clean area for her marker to have been placed and then used. *She agreed she had performed unclean tasks and then opened the resident's blinds with soiled gloves or washed hands. *She agreed she had not sanitized the resident's dressing box before she returned it to the medication cart. Interview on 7/31/24 at 3:30 p.m. with director of nursing (DON) B and regional nurse consultant H regarding the observed dressing change revealed: *They agreed that RN unit manager C should have changed her gloves when going from a dirty task to a clean task. *They agreed that RN unit manager C should have sanitized resident 15's dressing container prior to putting it back in the medication cart. Review of the provider's February 2024 Hand Hygiene Policy revealed: *Before moving from a contaminated body site to a clean body site during resident care, (e.g., after cleaning perineal area and prior to proceeding to another area of body or dressing resident. Gloves should be removed, hand hygiene performed and new pair of gloves applied). 49958 B. Based on observation, interview, and policy review the provider failed to ensure: *One of nine sampled residents (11) had been placed on enhanced barrier precautions (EBP). Findings include: 1.Observation and interview on 7/29/24 at 4:24 p.m. with resident 11 revealed: *She had returned from the hospital a few days ago after a surgical procedure for a wound on her left leg. *There was a wound vacuum (a device that removes pressure and fluid from a wound) on the arm of her recliner and attached to her left lower leg., *There had not been any signage on the door that indicated she was on EBP. Observation on 7/30/24 at 11:45 a.m. with resident 11 revealed: *The director of rehabilitation (DOR) G was standing in resident 11's bathroom doorway when the surveyor entered the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-She was not wearing a gown or gloves. -She stated she was assisting the resident with toileting and asked the surveyor to come back in a few minutes. Interview on 7/30/24 at 1:25 p.m. with resident 11 revealed staff does not wear a gown when providing any of her care, however, they wore gloves for personal private area care. Observation and interview on 7/31/24 at 8:44 a.m. with DOR G revealed: *She was in resident 11's room. -Resident 11's room had a sign on the door that indicated EBP were to be followed and a cart outside that room contained gowns and gloves. *She stated, Gowns and gloves are needed if we are doing ADL [activities of daily living] tasks; like if she needs toileting. *She confirmed that she had worked on toileting with resident 11 on 7/30/24 and that the sign indicating EBP and the cart with gowns and gloves had not been there at that time. *She did not know when EBP had started for resident 11. Interview on 7/31/24 at 2:58 p.m. with director of nursing (DON) B: revealed: *Resident 11 was readmitted to the facility on [DATE] with a wound vacuum device to her left lower leg. *She expected that all residents with a wound would be on EBP. Review of the provider's June 21, 2024 Enhanced Barrier Precautions policy revealed Enhanced Barrier Precautions (EBP) should be used for all residents with wounds or indwelling devices. 50916 C. Based on observation, interview, and policy review, the provider failed to ensure appropriate glove use, hand hygiene, and catheter care technique had been performed during one of one sampled resident's (27) foley catheter care by one of one certified nursing assistant (CNA) D. Findings include: 1.Observation and interview on 7/31/24 at 1:52 p.m. with resident 27 during his foley catheter care revealed CNA D: *Did not perform hand hygiene before she put on personal protective equipment (PPE) for resident 27 who was on enhanced barrier precautions (EBP). *She did not change gloves or wash her hands after she emptied the foley catheter and began his catheter care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*She cleaned the resident's groin area first and ended at the catheter insertion site with that same towel. *She placed the unclean, wet towel on a dry towel, which she then used to dry the resident. *She did not change her gloves or wash her hands before, during, or after she provided catheter cares for the resident. *When asked about hand hygiene and changing gloves during resident cares, CNA D stated if she already had been wearing gloves, she would have performed all of cares for the resident and she would only have changed them if she was going to help another resident with their cares. Interview on 7/31/24 at 3:23 p.m. with registered nurse unit manager F revealed: *The CNA should have washed her hands before she applied PPE, after she emptied the foley catheter, and whenever she would have gone from soiled to clean items. *The CNA should have cleaned from the catheter insertion site and worked outward to not introduce bacteria to the opening. *She stated the groin should have been cleaned last. *She would have expected staff to have used clean wipes or towels after each time the area was wiped. Review of the provider's revised February 20, 2024, Hand Hygiene policy revealed: *Hand hygiene with alcohol-based hand rub must be done: -7) b. When entering and leaving a Resident care area/room. - c. Before donning and after removing gloves. - g.after cleaning perineal area and prior to proceeding to another area of body or dressing resident. Gloves should be removed, hand hygiene performed, and new pair of gloves applied. - h. After contact with residents' intact skin. - k. After contact with body fluids .