

ORIGINAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
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NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH ST WILMOT, SD 57279
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000

INITIAL COMMENTS

Surveyor: 18560
A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 9/12/16 through 9/14/16. Wilmot Care Center Inc was found not in compliance with the following requirements: F221, F281, F371, F431, and F441.

F 000

**Addendums noted with an asterisk per 10/13/16 per telephone with facility administrator.*

PE/SDDOHEL

F 221
SS=E

483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

F 221

Administrator, DON and MDS coordinator have reviewed and updated the policy and procedure for the use of side rails as restraints and mobility/transfer devices. Residents 3, 7 and 8 were reviewed and assessments completed and Physician's Orders requested. Nursing staff were in-serviced on 10/5/2016 on the updated policy and procedure for side rails with training to be completed by 10/12/2016. All other residents currently using side rails have been reviewed for compliance and will be updated by PE/SDDOHEL 11/3/16. The DON or designee will audit side rail use, assessments and Physician's Orders once monthly times three months. The results of the audits will be presented by the DON or designee at the monthly QAPI meeting for further review.

11/3/2016

This REQUIREMENT is not met as evidenced by:

Surveyor: 18560
Based on observation, record review, interview, and policy review, the provider failed to obtain physicians' orders and assess for the appropriate use of side rails for three of three sampled residents (3, 7, and 8) observed with side rails. Findings include:

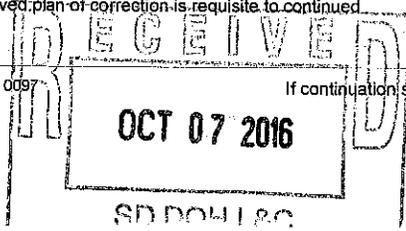
1. Observation on 9/12/16 from 3:30 p.m. to 4:00 p.m. revealed residents 3, 7, and 8 had side rails on their beds.

2. Review of resident 3's medical record revealed:

*He had been admitted on 10/15/10.
*His last revised on 11/11/15 care plan noted "The resident needs use of bed rails, assist with turning."

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>April [Signature]</i>	TITLE <i>Admin</i>	(X6) DATE <i>10/10/2016</i>
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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 221	<p>Continued From page 1</p> <p>*A 4/10/16 Weekly Summary/Monthly Summary form noted 1/2 bed rails for repositioning.</p> <p>*No physician's order for the side rails.</p> <p>*No quarterly assessments for the appropriate use of the side rails.</p> <p>3. Review of resident 7's medical record revealed:</p> <p>*He had been admitted on 4/13/15.</p> <p>*His last revised on 9/16/15 care plan noted "The resident is able to reposition in bed with one side rail on each side."</p> <p>*No physician's order for the side rails.</p> <p>*No quarterly assessments for the appropriate use of the side rails.</p> <p>4. Review of resident 8's medical record revealed:</p> <p>*He had been admitted on 11/29/12.</p> <p>*His last revised on 10/1/15 care plan noted "Top side rails used to assist with repositioning when in bed."</p> <p>*A November 2016 physician's order summary noted "May use side rails for positioning and transfers."</p> <p>*No quarterly assessments for the appropriate use of the side rails.</p> <p>5. Interview on 9/14/16 at 1:15 p.m. with registered nurse A, the director of nursing, and the administrator confirmed when side rails were used there should be a physician's order. Quarterly assessments for the appropriate use of the side rails should have been completed.</p> <p>Review of the provider's July 2013 Proper Use of Side Rails and Merry Walker policy revealed:</p> <p>*An assessment would be done to determine the resident's symptoms or reason for using the side</p>	F 221		

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F 221	Continued From page 2 rails. *When used for mobility or transfer an assessment would include a review of the resident's bed mobility; and ability to transfer between positions, to and from bed or chair, to stand and toilet. *Ongoing assessments for side rail would be done quarterly with the Minimum Data Set assessments.	F 221		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 A. Based on record review and interview, the provider failed to follow professional standards for monitoring of hypoglycemia symptoms for one of two sampled residents (8) with diabetes. Findings include: 1. Review of resident 8's medical record revealed he was diabetic. His blood sugars had been documented four times a day and at various times. Further review of resident 8's progress notes revealed: *On 5/17/16 at 10:19 p.m. "Blood sugar checked at 8:00 p.m. and was 31. Given ice cream and would only take a few sips of orange juice. Ate some applesauce. Resident ate 80% of supper and ate all hs [at bedtime] supplement. Blood sugar checked again at 9:30 p.m. and was 64."	F 281	Administrator and DON have created policies and procedures for the treatment of hypoglycemic incidents. These policies were reviewed with nursing staff on 10/5/2016 with training to be completed by 10/12/16. Director of nursing or designee will complete weekly audit of all diabetic resident charts, including resident 8, once a week times four weeks and monthly times two months. DON or designee will report results of all audits completed at the monthly QAPI meeting.	10/12/2016

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F 281 Continued From page 3

*On 5/20/16 at 9:39 p.m. "Residents blood sugar 62 given glucerna drink 100%."

*On 5/21/16 at 4:40 a.m. "Close watch on blood sugar tonight. Evening blood sugars were 67 and 62 with snack given. Midnight check 73 mg/dl [milligrams per deciliter], sugar free vanilla pudding given. Re-check 0315 [3:15 a.m.], 84 mg/dl. Continue to monitor and feed as needed."

*On 5/21/16 at 5:57 p.m. "Resident blood sugar 42 at 1630 [4:30 p.m.] given ice cream and rechecked at 1700 [5:00 p.m.] blood sugar 85 and resident going to dinner."

*On 5/22/16 at 6:28 p.m. "Resident blood sugar 59 given glucerna and taken to dinner. Will recheck at 2100 [9:00 p.m.]."

*On 5/23/16 at 9:42 p.m. "BS [blood sugar] at 1630 [4:30 p.m.] 60, CNA [certified nursing assistant] able to feed resident serving of ice cream."

*On 5/26/16 at 6:00 a.m. "Blood sugar 112, now 63, small glass oj [orange juice] given, tol [tolerated] well. Continue to monitor."

*On 5/31/16 at 11:40 p.m. "Resident had low blood sugars this shift 37 at 1645 [4:45 p.m.] was given glucose one tube per mouth. Fifteen minutes later BS 40 given Ensure half of can and part of sugar cookie."

*On 6/5/16 at 10:06 p.m. "Resident given can of Ensure drink after blood sugar of 61 this HS."

*On 6/20/16 at 11:33 p.m. "Resident has been in bed this shift semi alert, fed supper only took about half of meal. Blood sugar 58 given no insulin at supper."

*On 7/12/16 at 6:51 p.m. "Resident did not eat all his supper blood sugar was 57 before meal, was given Humulog 6 units."

*On 7/26/16 at 6:53 p.m. "Resident blood sugar 45 at 1700 [5:00 p.m.] was fed supper ate 70% of meal."

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F 281 Continued From page 4

*On 8/11/16 at 6:00 a.m. "Blood sugar 70 at 0500 [5:00 a.m.], was 53 at 0200 [2:00 a.m.] after 175 at hs, took only a few bites of pudding with additional sugar, 57 at 0315 [3:15 a.m.] Will give early breakfast."

*On 8/14/16 at 6:34 p.m. "Resident's blood sugar 42 given 8 oz. of Ensure and taken to supper."

*On 8/23/16 at 9:32 p.m. "Resident had blood sugar of 34 before supper was given ensure and sugar but did not take much after 45 minutes or so blood sugar up to 38. Glucagon 1 mg/1ml IM in Rt [right] thigh at 1815 [6:15 p.m.], Resident alert smiling but using slurred words. At 1900 [7:00 p.m.] blood sugar up to 90."

*On 9/4/16 at 6:35 a.m. "Blood sugar now 136 mg/dl. Was 67 mg/dl at 0200 [2:00 a.m.], given sugar free vanilla pudding with 3 added sugars, took 100% with much prompting. Blood sugar at 0400 [4:00 a.m.] 107 mg/dl."

*On 9/8/16 at 6:45 a.m. "Resident has struggled with low blood sugar thru the night, has not been symptomatic. Evening nurse reported resident blood sugar 111 at 5 pm, 65 at 9:30 pm. Was given ice cream. Recheck of blood sugar at 11:30 pm, 88 mg/dl. Given ice cream again at midnight. Recheck at 2 am, 104 mg/dl. Recheck at 5:30 am, 50 mg/dl. Ice cream given."

*On 9/8/16 at 11:56 p.m. "Resident's blood sugar 38 at HS was given Glucagon IM in right thigh and supplement. BS went up to 51 by 2200 [10:00 p.m.] will recheck again on night shift."

*There was no documentation of rechecks within fifteen to twenty minutes following his low blood sugar readings above.

Interview on 9/14/16 at 10:42 a.m. with licensed practical nurse E regarding resident 8 revealed:

*He was a very brittle diabetic.

*When he had low blood sugars she gave him

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F 281 Continued From page 5 F 281

something with protein and calories.
*She would recheck his blood sugar readings in fifteen to twenty minutes.
*The rechecks of his blood sugars should have been documented.

Interview on 9/14/16 at 1:15 p.m. with registered nurse A, the director of nursing, and the administrator confirmed low blood sugars should have been checked per their policy. The rechecks might have been done, but they had not been documented.

Review of the provider's undated Insulin Reference Sheet revealed management of hypoglycemia symptoms when blood sugar was less than 70 mg/dl included:
*Ingest 15 to 20 grams of sugars or carbohydrates.
*Check the blood glucose fifteen to twenty minutes later.
*If still less than or equal to 70 mg/dl, another 15 to 20 grams of carbohydrates should be given.
*Repeat the step until the blood glucose level was greater than 70 mg/dl.

Review of the Academy of Nutrition and Dietetics (formerly American Dietetic Association) Manual of Clinical Dietetics, 6th Ed., Chicago, IL, 2000, p. 326, revealed:
*Hypoglycemia should be treated immediately using the following guidelines:
-Give 15 grams glucose and wait fifteen minutes before retesting blood glucose.
-If glucose is still under 70 mg/dl, repeat 10 to 15 grams glucose.

Surveyor: 33488
B. Based on record review, interview,

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F 281 Continued From page 6
professional standard review, and policy review, the provider failed to follow professional standards and nursing scope of practice for pronouncement of death and release of the body for one of one sampled resident (10). Findings include:

1. Review of resident 10's medical record revealed on 7/13/16:
 - *At 5:00 p.m. a certified nursing assistant found she had "no respirations, no blood pressure, no pulse, and color pale."
 - *At 5:20 p.m. the family had been notified followed by the funeral home.
 - *At 6:29 p.m. her physician had been notified by email she had "passed away" at 5:05 p.m. "Can we get a cause of death?"
 - *There was no documentation to show the physician had replied back to the nurse's email.

Interview on 9/14/16 at 10:15 a.m. with registered nurse (RN) A and licensed practical nurse (LPN) E regarding resident 10's death revealed:
 *RN A stated they rarely called the physicians to notify them a resident's vitals had ceased.
 *LPN A usually emailed the physician and asked for a cause of death instead of calling them.
 *The family had always been notified first.
 *They were unaware pronouncing death was a medical diagnosis and beyond the scope of practice for a nurse.

Interview on 9/14/16 at 2:00 p.m. with the administrator regarding the death of a resident revealed she:
 *Was new to her position.
 *Was not aware it was considered beyond the scope of practice for a nurse to declare death of a resident as defined in South Dakota Codified law

F 281 Administrator and DON have created policies and procedures for the pronouncement of death and release of the body. These policies were reviewed with nursing staff on 10/5/16 with training to be completed by 10/12/16.
 Upon the death of ~~resident~~, DON or designee will complete an audit of resident record. DON or designee will report results of audits to monthly QAPI meeting.

1 [REDACTED]
 *PE/SDDO/H/EL
 *ARNY RES/DDE/H/EL

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F 281	<p>Continued From page 7 and by the Board of Nursing. *Agreed their policy had not directed nursing staff to: -Call the physician for pronouncement of death and an order to release the body. -Notify the physician prior to the family or the funeral home if it was after hours.</p> <p>Review of the provider's undated Death Of A Resident policy revealed: *Step 1, notify the DON. *Step 2, nursing staff would "Notify the physician during daytime hours. (When the nurse notifies the doctor of death, ask him for a statement on the possible cause of death)." *Step 24, (the last step in the policy's procedure) was document the physician had been "notified of death via phone." *There was no mention of when the physician would have been called after daytime hours.</p> <p>Review of Patricia A. Potter et al., Fundamentals of Nursing, 8th Ed., St Louis, MO, 2013, page 724, revealed documentation of end of life included the name of the health care provider who certified death.</p> <p>Review of South Dakota Codified Law 34-25-18 and 34-25-18.1 and the South Dakota Board of Nursing's position statement on pronouncement of death revealed: *The signing of the death certificate was a medical act by a physician, physician's assistant, or nurse practitioner. **"Since the Legislature did not provide that the act was delegable to anyone else the South Dakota Board of Nursing did not believe a licensed nurse could officially pronounce death."</p>	F 281		
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F 371
F 371
SS=E

Continued From page 8
483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY

F 371
F 371

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Surveyor: 18560
Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained during two of two meal services by two of two cooks (C and D).
Findings include:

1. Observation on 9/13/16 from 11:34 a.m. to 11:55 a.m. revealed cook C with gloved hands:
*Dished residents' meals using scoops and tongs.
*Rearranged carrots placed on a resident's plate.
*Removed buns from the serving pan with a deli paper touching the top of the bun with her gloved thumb.
*Had not been observed changing her gloves during the meal service to prevent cross-contamination when handling ready-to-eat (RTE) foods.
2. Observation on 9/13/16 from 5:10 p.m. to 5:41 p.m. revealed cook D:
*With gloved hands touched serving carts, bread bags, drawers, scoops, food covers, plastic wrap

All dietary staff were in-serviced on 10/4/2016 on the policy and procedure regarding glove use during meal service. The Dietary Manager will audit one meal per shift, per week for four weeks and then one meal per shift, per month thereafter to ensure the accuracy of the use of gloves. Results of the audits will be reported by the Dietary Manager or designee to the monthly QAPI meeting for further review.

10/04/2016

**including cooks C and D*
DEISDORFEL

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F 371	<p>Continued From page 9</p> <p>over food, meal cards, cooker door handle, cottage cheese container, bowls, and RTE sandwiches.</p> <p>*Periodically removed her gloves and washed or had not washed her hands prior to putting on a second set of gloves.</p> <p>*Continued throughout the meal service handling RTE sandwiches with gloved hands.</p> <p>Interview on 9/14/16 at 1:30 p.m. with the dietary manager revealed:</p> <p>*Gloves should have been used when only handling RTE foods.</p> <p>*He preferred RTE foods be handled with tongs or deli papers.</p> <p>Review of the provider's undated Food Preparation and Service policy revealed:</p> <p>**Gloves must be worn with handling food directly.</p> <p>*However, gloves can also become contaminated and/or soiled and must be changed between tasks.</p> <p>*Disposable gloves are single-use items and shall be discarded after each use."</p>	F 371		
F 431 SS=E	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be</p>	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 431	<p>Continued From page 10</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure: *One of one medication room was secured from unauthorized access by unlicensed personnel. *Controlled narcotic medication belonging to three randomly sampled residents (4, 9, and 12) were accounted for and easily reconciled in two of two medication carts. Findings include:</p> <p>1. Observation and interview on 9/14/16 from 10:30 a.m. to 11:30 a.m. with registered nurse</p>	F 431	<p>The cigarettes have been removed from the medication room.</p> <p>Extra keys for the medication room are held by the [REDACTED] Only the Charge Nurse has access to the medication room and has been instructed to have the key on his/her person throughout their shift, no unauthorized personnel shall be allowed in the medication room. All new medications have been removed from the bottom drawer of the medication carts.</p> <p>Administrator, DON and pharmacist reviewed and updated the policies and procedures pertaining to the storage and security of medications in the facility. These policies and procedures were reviewed with the nursing staff on 10/5/2016 and training will be completed by 10/12/2016 will all licensed nursing staff. DON or designee will complete weekly audits of the medication cart and medication room security times three weeks and weekly audits times two months. DON or designee will report results of all audits to the monthly QAPI meeting.</p> <p>10/12/2016</p> <p>*DON. RESDDO/HCL</p> <p>*Including residents 4, 9, and 12's. RESDDO/HCL</p>

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F 431	<p>Continued From page 11</p> <p>(RN) A and the director of nursing (DON) regarding the medication room and medication carts revealed:</p> <ul style="list-style-type: none"> *Inside the medication room were residents' cigarettes and a lighter. *Those cigarettes and the lighter were stored inside the medication room for safe keeping. *During the review of the medication room the housekeeping supervisor was observed to have walked in to the medication room retrieving the cigarettes and lighter for a residents. *RN A and the DON stated the room was commonly accessed by unlicensed personnel to retrieve cigarettes for residents who smoked. *They agreed the cigarettes should not have been kept in the medication room. *They agreed the medication room should not have been accessed unless staff were licensed and needed entry for medication administration purposes. <p>Observation and interview during the above date and time of the medication carts with RNA and the DON revealed:</p> <ul style="list-style-type: none"> *The bottom drawer of each cart was used for storage of new medication blister packs that had been received from the pharmacy but had not been currently in use. *In those drawers were five controlled narcotic medication blister packs that belonged to residents 4, 9, and 12. *Those controlled medications had not been counted by nursing staff until they were actively put into use. *All controlled narcotic medications were to have been counted for easy reconciliation. *Both RNA and the DON agreed they had no way of knowing how many new controlled narcotic medication blister packs were to have been 	F 431		
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F 431 Continued From page 12
stored in the bottom drawers of the medication carts.

Review of the provider's June 2013 Medication Administration General Guidelines policy revealed:

- *The controlled narcotic record for the previous drug count was to be compared with the supply available.
- *The nurse or nurse aide was responsible for the safekeeping of medications.
- *There was no mention of maintaining access to the medication room only by authorized licensed personnel.

F 431

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
SS=E

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

F 441

<p>Administrator, DON and lead Housekeeper reviewed and updated the policy and procedure for the disinfection of the whirlpool tub. Staff responsible for cleaning the tub have been provided a copy of the policy and individual education provided by 10/13/2016. Lead Housekeeper or designee will complete weekly audits of the whirlpool disinfection times three weeks and monthly audits times two months. Lead Housekeeper or designee will report the results of the audits to the monthly QAPI meeting</p>	<p>1</p> <p>10/13/2016</p> <p>2</p> <p>*including CNA B *PE/SPDH/EL</p>
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F 441 Continued From page 13

(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Surveyor: 35121
Based on observation, interview, manufacturer's instructions review, and policy review, the provider failed to follow manufacturer's instructions for disinfecting one of two whirlpool tubs during one of one observed whirlpool cleaning by certified nursing assistant (CNA) B.
Findings include:

1. Observation and interview on 9/13/16 at 2:34 p.m. with CNA B during disinfecting of the whirlpool tub located in the 100 hall revealed:
*She had:
-Added pre-mixed disinfectant solution to the foot well of the whirlpool tub.
-Scrubbed the interior surfaces of the whirlpool tub and chair with a brush and the disinfectant.
-Stated it needed to sit for fifteen minutes.
-Left the whirlpool room.
*The chair and some of the interior surfaces of the whirlpool tub had dried at 2:45 p.m.

F 441

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F 441	<p>Continued From page 14</p> <p>*She confirmed: -Those areas were dry. -She would routinely leave the whirlpool room and not monitor surfaces for dry areas. -The disinfectant instructions stated the whirlpool tub and chair surfaces were to remain wet for ten minutes. *She stated she had been trained on how to disinfect the whirlpool by another CNA years ago and had not received any further training.</p> <p>Interview on 9/14/16 at 12:26 p.m. with registered nurse (A) and the director of nursing revealed they: *Would have expected the CNA to follow the manufacturer's instructions for disinfecting the whirlpool. *Confirmed: -The disinfectant manufacturer's instructions were for surfaces to remain wet for ten minutes. -CNA B had not followed the correct procedure to disinfect the whirlpool tub according to the disinfectant manufacturer's instructions.</p> <p>Review of the provider's 4/17/14 Disinfecting of Whirlpool and Bath Chair Instructions Policy revealed to "Let disinfectant stay on surface for 10 minutes (Or, as recommended by the instructions on the disinfectant concentrate container.)."</p> <p>Review of the undated Penner patient care whirlpool disinfectant cleaner instructions revealed to "Wet all surfaces thoroughly. Allow to remain wet for 10 minutes."</p>	F 441		

ORIGINAL

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K 000 INITIAL COMMENTS

Surveyor: 32334
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 9/13/16. Wilmot Care Center Inc was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.

The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K051 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 051 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System

K 000 *Addendums noted with an asterisk per 10/17/16 per telephone with facility administrator.
LF/SDDO/H/EL

K 051



11/3/2016

*LF/SDDO/H/EL

*The administrator and maintenance supervisor have contacted an electrician regarding a bid for correcting the lighting in the tub room. The maintenance supervisor or designee will follow up to ensure completion of the project and will report to monthly QAPI meeting.
LF/SDDO/H/EL

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Opil [Signature]

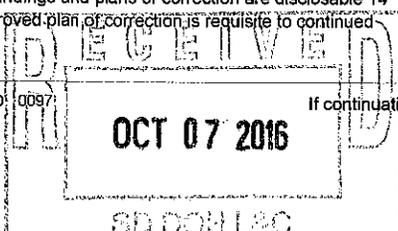
TITLE

Admin

(X6) DATE

10/6/2016

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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K 051	<p>Continued From page 1</p> <p>records are maintained and readily available. 18.3.4, 19.3.4, 9.6</p> <p>This STANDARD is not met as evidenced by: Surveyor: 32334</p> <p>Based on observation and interview, the provider failed to ensure the fire alarm system and its components would have provided effective warning for transmission of the alarm system at one of two fire alarm annunciator panels (at the nurse station). Findings include:</p> <p>1. Observation at 1:30 p.m. on 9/13/16 revealed a fire alarm annunciator panel at the nurse's station. That panel did not provide an alarm indicator for the alarm tied to the commercial kitchen hood fire suppression system. In the event the commercial kitchen hood fire suppression system activated setting of the fire alarm, that panel should be capable of addressing that particular alarm. A second fire alarm annunciator at the main fire alarm panel in the mechanical room did provide the proper indication of that fire suppression alarm however that panel is not a continuously occupied location and most staff are not knowledgeable about the whereabouts of that panel.</p> <p>Interview with the maintenance director at the time of the observation revealed he had not noticed the alarm indicator was not provided at the nurse station fire alarm panel. He indicated Automatic Building Controls Inc. was contracted to tie the commercial kitchen hood fire suppression system to the building fire alarm system on 7/5/16. He was unsure why the fire alarm contractor did not update that nurse station alarm panel with the new alarm signal.</p> <p>This deficiency has the potential to one of four</p>	K 051		
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K 051	Continued From page 2 smoke compartments.	K 051		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/14/2016
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S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 9/12/16 through 9/14/16. Wilmot Care Center Inc was found not in compliance with the following requirement: S158.	S 000	*Addendums noted with an asterisk per 10/17/16 per telephone with facility administrator. LF/SPDOH/EL	
S 158	44:73:02:14 Lighting Spaces occupied by people, machinery, and equipment within buildings and their approaches and parking lots shall have artificial lighting at a level for general safety. Each resident bedroom shall have general lighting and night lighting. A reading light shall be provided for each resident who can benefit from one. Each required exit shall be equipped with continuous emergency lighting. Emergency power shall be provided if the main source of power fails. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation, testing, and interview, the provider failed to ensure adequate lighting was available in one randomly observed location (west wing tub room). Findings include: 1. Observation at 1:45 p.m. on 9/13/16 revealed a tub room in the west wing. It appeared the lighting in that room was lower than the required minimum thirty foot-candles. Testing of the lighting with a light meter revealed the lighting in the center of the room at floor level was about ten foot-candles. Interview with the maintenance director at the time of the above observation and testing	S 158	 *LF/SPDOH/EL *The administrator and maintenance supervisor have contacted an electrician regarding the connection of kitchen hood fire suppression system to the nurse station annunciator. At this time instructions for locating the zone by referencing the fire panel in the mechanical room have been hung next to the nurses station annunciator. Education on the instructions →	11/3/2016 ²

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

April [Signature]

TITLE

Admin

(X6) DATE

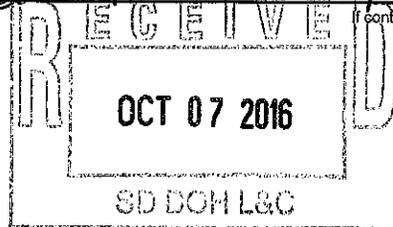
10/6/2016

STATE FORM

6899

GFY311

(Continuation sheet 1 of 2)



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/14/2016
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S 158	Continued From page 1 confirmed that condition. He indicated he was unaware that room required thirty foot-candles of lighting.	S 158	*for locating a fire will be completed by 10/20/16 with all staff by administrator or maintenance supervisor. Maintenance supervisor or designee will report to monthly QAPI meeting. LF/SDDO/H/EL	
S 000	Compliance/Noncompliance Statement Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 9/12/16 through 9/14/16. Wilmot Care Center Inc was found in compliance.	S 000		