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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435133	A. BUILDING ____ B. WING ____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	608 1ST STREET NE WESSINGTON SPRINGS, SD 57382

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F 000	INITIAL COMMENTS Surveyor: 45383 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/21/22 through 3/23/22. Weskota Manor Inc. was found not in compliance with the following requirements: F657 and F686.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657	The Director of Nursing reviewed and revised the Interdisciplinary Care Planning policy on 4/13/2022. The Director of Nursing will educate the Interdisciplinary Care Team on 4/21/2022 on the Interdisciplinary Care Planning policy. The Interdisciplinary Care Team completed a significant change MDS for resident 28 on 3/24/2022 due to decline in residents status. On 4/12/2022 the Food Service Manager obtained an updated diet order of IDDSI Level 3 for resident 28. The Food Service Manager updated resident 28's care plan on 4/13/2022 to include the current diet order and current timeframes of when resident 28 receives supplements. The Registered Dietician completed a new Nutritional Risk Assessment on resident 28 on 4/14/2022 to include current nutritional information. The Social Service/Activity Manager updated resident 28's care plan on 4/5/2022 on the activities resident 28 does to fulfill resident's needs and the alternate communication method used to communicate with resident 28. The Interdisciplinary Care Team reviews residents care plans quarterly making sure the care plans reflect accurate information based on residents current status. Each Interdisciplinary Care Team member reviews their department focus areas and interventions on the care plan during each resident's assessment time and updates as needed. The Interdisciplinary Care Team will review and monitor at each resident's quarterly assessment period that care plans are accurate and reflect the residents current status. The Infection Preventionist or designee will report the results of this review to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.	5/12/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nikki VonEye	Administrator	4/14/2022

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.

APR 25 2022
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F 657	Continued From page 1	F 657	The Infection Preventionist or designee will report the results of the Interdisciplinary Care Team's quarterly review of each resident's care plan and the care plan reflects current and accurate information of the residents current status. NV 4/25/2022	

This REQUIREMENT is not met as evidenced by:
Surveyor: 06365
Based on observation, interview, and record review, the provider failed to revise care plans to address the status for 1 of 12 sampled residents (28). Findings include:

1. Observations and interviews with resident 28 on 3/21/22 at 3:00 p.m. and 4:24 p.m. and on 3/22/22 at 8:30 a.m and 11:00 a.m. revealed:
*She was in bed with the head of the bed raised at 75 degrees.
*She was holding onto a tablet watching music videos and pushed the pause button to visit.
*Her physician said her "motor neurons are shutting down her motor skills."
*She had limited ability to move including the movement of her mouth.
*She decided to use syringes for eating instead of tube feeding when she started having trouble swallowing her food.
*Staff now assisted her with food syringes because she no longer had the strength to do that.
*Her voice was going, and she would not be able to speak much longer.
*She started receiving hospice services in November 2021.

Review of the order summary report revealed a physician order dated 10/23/21 for a "Heart Healthy Diet Pureed - Level 4 texture, Regular consistency."

Review of the 2/10/22 Minimum Data Set (MDS) noted several areas of decline when compared to the 8/26/21 quarterly MDS and the 11/18/21 significant change in status MDS, including:

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F 657	Continued From page 2 *Increased staff assistance needed for transferring and eating. *Increased symptoms of a swallowing disorder. *A severe weight loss of greater than 10% in 6 months. *Stage 2 pressure ulcer. Review of the nutritional risk assessment dated 3/10/22 revealed the registered dietitian noted: *The resident's current food intake was greater than 75 percent. *The resident had Stage 1 and 2 pressure ulcers. *Swallowing difficulties included pocketing of food items and drooling. *A might shake supplement was recommended with meals, at 10:30 a.m., 3:30 p.m., and at HS (hour of sleep). *The texture of the diet was for "pureed/blended fluid." *The resident had a 2 percent weight gain in the past 30 days. *The resident was "completely fed by staff via syringe per [resident] request and [physician] order. Review of the care plan revealed the following were not consistent with the resident's status: *A focus revised on 11/15/21 for "recommending a general surgery consult for feeding tube. Obtained declined feeding tube" with an intervention revised on 10/15/21 to "proceed with MRI and consult for feeding tube. Arrangements to follow. Completed on 10/14/21." *A focus revised on 11/29/21 of "limited physical mobility" had a goal to "continue ability to feed myself after staff set-up" without applicable interventions related to that goal. *A focus revised on 3/22/22 for "Fortified Heart Healthy level 4 pureed regular consistency	F 657		

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F 657	Continued From page 3 liquids. Supplement with meals and 3:30 [p.m.] and HS snack" had a contradictory intervention revised on 10/26/21 for "Staff will give me a supplement at meals and at 10:30 [a.m. and] 3:30 [p.m.] snack and HS snack." and four duplicative interventions including: -On 10/26/21, "Staff will serve me a Fortified Heart Healthy level 4 Pureed diet with regular liquids. -On 2/1/22, "May use syringe for food and liquids per residents request. May thin food to adequate consistency to pass through syringe. Staff to assist with loading syringe with food and fluids. Staff may assist resident using the syringe per residents request as long as she is awake and alert. Res feels she has better intake using this method." -On 2/13/22, "I have my liquids and food put in syringes. They need to be thin to go thru the syringe Staff to assist with filling and feeding me with them." -On 2/17/22, "I have requested assistance with syringe feeding due to increased weakness." *A focus revised on 3/18/21 for "not choosing to attend many group activities" had a goal to "attend and participate in activities of my choice 2-3 times per week." *A focus revised on 6/10/21 for "usually understood and usually understands...My speech is sometimes slurred and soft spoken" without interventions related to alternate methods of communication. Interview on 3/22/22 at 3:42 p.m. with social service/activity manager H revealed: *The hospice social worker had brought in "something for her to use" as an alternate communication method." *The resident does not attend activities and was	F 657		

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F 657	Continued From page 4 currently able to direct staff to assist her as needed. Interview on 3/23/22 at 1:53 p.m. with dietary manager K revealed: *The normal pureed food was too thick for the resident to pull up into the syringes by herself. *The pureed food needed to be thinned out. *Now it had gotten too hard for the resident to push the thinned pureed food through the syringes into her mouth. *They had been giving her a "mighty shake" (supplement) in the morning and afternoon between meals and in the evening, but the resident said she "wasn't hungry" for the morning supplement so it was only provided in the afternoon and evening. *They were trying to follow International Dysphagia Diet Standardization Initiative (IDDSI) but the diet order listed on the care plan was not consistent with the level of consistency that was currently being used. *It should be ordered as an IDDSI level 3 liquidized and moderately thick food with thin drinks.	F 657		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		

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F 686	Continued From page 5	F 686		

F 686 Continued From page 5

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Surveyor: 45383
Based on observation, interview, record review, and policy review, the provider failed to ensure two of two sampled residents (2, 28) with a facility acquired pressure ulcer received ongoing assessments and interventions to have prevented the pressure ulcer. Findings include:

1. Observation on 3/21/22 at 3:00 p.m. of resident 2 revealed she had been seated in her wheelchair in the hall way.

Observation on 3/22/22 at 8:30 a.m. of resident 2 revealed she had been seated in her wheelchair in the dining room.

Interview on 3/21/22 at 5:00 p.m. with licensed practical nurse O regarding skin treatment for resident 2 revealed:
*She received normal saline dressing change twice a day to the affected area.
*While staff had already completed treatment prior to the surveyor arrival, request was made to observe other skin treatments.

Review of resident 2's electronic medical record revealed inconsistencies in documentation between different portions of the record that included:
*She was admitted on 1/26/18.
*She had a Brief Interview for Mental Status (BIMS) of 6 indicating very severe impairment.

Provider's Plan of Correction (F 686):

The Director of Nursing reviewed and revised the Prevention of Pressure Ulcers policy on 4/4/2022. The new process began 4/4/2022. The Director of Nursing educated the charge nurses on 4/4/2022 on the new process for monitoring resident's skin. The charge nurses complete a skin assessment on all residents weekly and documents accordingly in the residents Treatment Administration Record (TAR). If resident has a new skin issue the charge nurse completes an incident report in EMR Risk Management and also completes the Skin Only Evaluation form. If resident has an ongoing skin issue, the charge nurse completes the Skin Only Evaluation form in EMR. The Director of Nursing will have a follow-up meeting with charge nurses on 5/3/2022 to review the process for skin assessments is being completed accurately.

Skin Only Evaluation forms were completed on resident 2 on 3/28/2022, 4/1/2022, 4/4/2022, 4/11/2022 and completed on resident 28 on 3/26/2022, 3/28/2022, 3/31/2022, 4/5/2022, 4/12/2022.

On 4/14/2022, the MDS Coordinator updated resident 2 and 28's care plans to include interventions to follow based on the Prevention of Pressure Ulcers policy. The Food Service Manager consulted with the Registered Dietitian and no new interventions for residents 2 and 28 were identified. The Food Service Manager updated resident 2 and 28's care plan on 4/14/2022 that includes an intervention of consulting with the Registered Dietitian as needed. Any resident identified to have skin issues through the weekly skin assessment will include the appropriate interventions per policy.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 686	Continued From page 6 *She had refused to be repositioned and other cares. *She had been incontinent of bowel and bladder. *Registered nurse (RN) M had a skin observations entry on 11/12/21 at 1:26 p.m. that revealed: -Open areas to bilateral gluteal folds measuring 4 centimeters (cm) by 1 cm to the left side and 2 cm by 1 cm to the right side. -Barrier cream was applied. *On 12/9/21 at 2:36 p.m., RN M's skin/wound note revealed: -The upper buttock crease was pink and the skin was fragile. -The right inner buttock measured a 2 cm by 2 cm bruise. "Light purple area." Skin was intact. *On 1/3/22 at 6:27 p.m., RN I's "Communicated to Physician" progress note revealed: -Open "L" shaped area to right buttock that measured 0.6 cm by 0.8 cm. -Resident 2 had a cushion in her wheelchair and recliner. -She had an air mattress on her bed. -Barrier cream was applied. -No response or orders were noted in the progress note from the physician. *On 1/11/22 at 1:26 p.m., RN M's "Communicated to Physician" progress note revealed: -Open area measured 1 cm by 1.5 cm stage 2 pressure ulcer to her right buttock. -Order received from physician to apply duoderm to right buttock every three days and as needed. *On 1/25/22 at 2:14 p.m., RN N's "Communicated to physician" progress note revealed: -Duoderm not effective to open area on buttock. -Order received from physician to discontinue the duoderm. -Barrier cream applied to affected area and encouraged resident to lay on her side.	F 686	The Interdisciplinary Care Team reviews all residents' skin status at the monthly At-Risk Meeting. The Infection Preventionist or designee will monitor weekly that the proper assessments, notifications and documentation was completed for residents identified to have skin issues through the weekly skin assessments. The Infection Preventionist will report the results of this review to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.	5/12/2022

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F 686	Continued From page 7	F 686		

-She refused to lay on her side.
*On 1/25/22 at 2:51 p.m., RN M documented a skin/wound note that revealed:
-A stage 2 pressure ulcer to inner left buttock measured 5 cm by 4 cm and right buttock measured 4.5 cm by 4.0 cm.
-The skin area around the wound was red and wound beds were pink.
-Resident 2 had been incontinent multiple times.
*On 2/28/22 at 11:32 a.m.n RN M documented a skin/wound note that revealed:
-"Open areas to buttock are closed."
-Continued to use a barrier cream.
*On 3/7/22 at 10:32 a.m., RN N documented a skin/wound note that revealed:
-"Very superficial open abrasion to right inner buttock with cleaning resident."
-The resident's quote of, "They wipe me too hard," was in the progress note.
-Normal saline dressing was applied and education was given to resident to continue laying on her side while in bed between meals and during the night.
-Director of Nursing (DON) B aware.
*On 3/22/22 at 3:19 p.m., RN I communicated to the physician the following:
-The area to right buttock was open 1 cm by 0.8 cm.
-Normal saline dressing was used to the affected area.
*On 3/23/22 at 9:40 a.m., the physician evaluated the wound and ordered normal saline dressing three times per day.

Review of resident 2's skin observation documentation between 12/9/21 through 3/23/22, a total of 105 days with 306 separate entries, revealed the number of times per day resident 2 had toileting/incontinence care provided:

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F 686	Continued From page 8 *One day had only one entry. *18 days had two entries. *72 days had three entries. *14 days had four entries. Interview on 3/23/22 at 2:15 p.m. with DON B regarding skin evaluation revealed: *Skin evaluations had been kept in point click care (PCC) and the skin assessment book. *The wound nurse had been documenting in both places with skin measurements. *Measurements in the skin assessment book were not always documented in PCC. *She would expect other nurses to measure and document new skin findings. *The skin observation task was completed by the certified nursing assistant after providing care. Review of resident 2's undated care plan revealed: *"I am at risk for skin breakdown and pressure ulcer related to decreased mobility, incontinence and moisture under my folds." *Interventions include: -"Administer treatments/meds as ordered and monitor for effectiveness." -"Apply protective barrier cream to peri/rectal area following incontinent episodes and as needed." -"Apply lotion to my skin." *The care plan had not identified the following interventions: -Turning and repositioning a minimum of every two hours with inspection of bony prominence's. -No other interventions were identified if the resident refused. -Incontinence care every two hours and as needed. -No intervention was provided by the registered dietitian.	F 686		

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F 686	Continued From page 9	F 686		

Review of the provider's policy dated 3/21 on Prevention of Pressure Ulcers revealed:
*"It is the policy of this facility to prevent the development of pressure ulcers in residents whenever possible. Prevention measures shall include, but not limited to:
-Assessment risk upon admission to the facility and quarterly with each MDS or significant change.
--Resident had scored at risk for Braden assessments.
-Appropriate skin and incontinence care.
-Identification of disease and comorbid conditions which, increase skin risk.
-Relief and reduction of pressure as needed.
-Continued education of residents, families, and staff relative to the prevention of injury to the skin.
*"Nursing care shall include":
-Turning and repositioning at a minimum of every two hours with inspection of bony prominence's.
-Incontinent care every two hours and as needed.
-Assessment of nutrition and hydration with referrals as needed.
-Institution of measures to reduce the effects of pressure, friction, and shear.
Surveyor: 06365
2. Observation and interview with resident 28 on 3/21/22 at 3:00 p.m. revealed:
*She was in bed with the head of the bed raised at 75 degrees.
*Her physician said her "motor neurons are shutting down her motor skills."
*She did not have much pain "except my tailbone" due to an open area on it.
*She got it from sitting in her reclining chair too long, and had it for about a month.

Review of resident 28's electronic medical record

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F 686	Continued From page 10	F 686		

revealed inconsistencies in documentation between different portions of the record that included:
*A 2/10/22 quarterly Minimum Data Set (MDS) that noted several areas of decline when compared to the 8/26/21 quarterly MDS and the 11/18/21 significant change in status MDS, including:
-Increased staff assistance needed for transferring and eating.
-Use of a catheter.
-Increased incontinence of bowel.
-Increased symptoms of a swallowing disorder.
-A severe weight loss of greater than 10% in 6 months.
-Stage 2 pressure ulcer.
*The care plan noted a focus initiated on 5/31/20 and revised on 3/7/22 for "potential for altered skin integrity/pressure ulcer development" with notations of a pressure ulcer to her tailbone on 2/8/22 "healed" and on 3/1/22.
*The point of care (POC) task documentation for skin observation on each day from February 1, 2022 to March 22, 2022 revealed no areas were noted as scratched, red, discolored, torn, or open.
*The "Skin Only Evaluation" noted measurements of the Stage 2 pressure ulcer on coccyx:
-On 3/2/22, 2 centimeters (cm) length by 2 cm width by "superficial" depth, no drainage or odor.
-On 3/9/22, same as 3/2/22 except for 0 depth.
-On 3/15/22, 0.3 cm by 0.3 cm by 0 depth.
-On 3/21/22, 0.8 cm by 0.7 cm by 9 depth.
*Two of the four evaluations (3/2 and 3/9) noted the resident was unable to move without assistance and sat on a bedpan for long periods due to bowel concerns.
*The 3/21/22 evaluation noted she had been "refusing to get up in recliner" and "continues to set on bed pan for extended periods of time."

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F 686	Continued From page 11 *No skin only evaluation was found for the 2/8/22 pressure ulcer noted as healed on the care plan. Interview on 3/23/22 at 10:49 a.m. with DON B revealed: *The certified nursing assistants monitor for skin concerns every day as part of the POC tasks. *She was not aware there was no POC documentation of open areas to correlate with the pressure ulcers on 2/8/22 and 3/1/22 as noted on the care plan. *She would look for documentation related to the 2/8/22 pressure ulcer. Interview on 3/23/22 at 10:54 a.m. with registered nurse/minimum data set coordinator (RN/MDS-C) I revealed: *Resident 28 used to sit up in her recliner and several different cushions had been tried. *She had limited ability to reposition herself and chose to sit on a bedpan due to bowel concerns. *The pressure ulcer noted on the 2/10/22 MDS had closed after that date "for a little while but opened again." Interview on 3/23/22 at 11:57 a.m. with DON B and RN/MDS-C I revealed: *No documentation was found regarding the pressure ulcer noted on 2/8/22 as healed on the carte plan. *A printed copy of a discontinued order on 2/17/22 for "Duoderm to open area on tailbone." was provided by DON B.	F 686		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435133	A. BUILDING ______ B. WING ______	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	608 1ST STREET NE WESSINGTON SPRINGS, SD 57382

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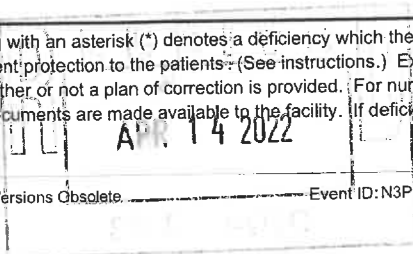
E 000	Initial Comments Surveyor: 45383 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 3/21/22 through 3/23/22. Weskota Manor Inc. was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nikki VonEye
TITLE: Administrator
(X6) DATE: 4/14/2022

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.



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

PRINTED: 04/05/2022
FORM APPROVED
OMB NO. 0938-0391

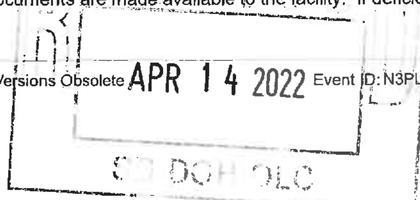
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435133	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	**608 1ST STREET NE** **WESSINGTON SPRINGS, SD 57382**

(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
K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 3/22/22. Weskota Manor Inc. was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 3/23/22. Please mark an F in the completion date column for K271 deficiencies identified as meeting the FSES, in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 271 SS=C	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one of two exits from the basement (the north exit). That exit from the basement had a landing that ended greater than	K 271		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nikki VonEye
TITLE: Administrator
(X6) DATE: 4/14/2022

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.



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435133	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	**608 1ST STREET NE** **WESSINGTON SPRINGS, SD 57382**

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K 271	Continued From page 1 200 feet from the nearest street. Findings include: 1. Observation at 11:00 a.m. on 3/22/22 revealed the north exit from the east basement was not paved to the public way. It had a concrete landing that ended greater than 200 feet from the nearest street. The terrain from the concrete landing to a public way would make the installation of a sidewalk difficult. An interview with the maintenance supervisor at the time of the observation indicated that the basement area was used for storage and laundry. The basement was for staff use only. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 271		

PRINTED: 04/05/2022
FORM APPROVED

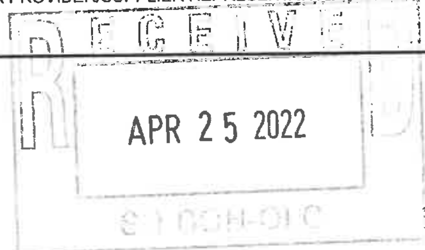
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10707	A. BUILDING: ______ B. WING ______	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	608 1ST ST NE WESSINGTON SPRINGS, SD 57382

(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) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 06365 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 3/21/22 through 3/23/22. Weskota Manor Inc. was found not in compliance with the following requirement: S206.	S 000		
S 206	44:73:04:05 Personnel Training The facility shall have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs shall cover the required subjects annually. These programs shall include the following subjects: (1) Fire prevention and response. The facility shall conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills shall be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) Resident rights; (7) Confidentiality of resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of residents with unique needs; (10) Dining assistance, nutritional risks, and hydration needs of residents; and. (11) Abuse, neglect, misappropriation of resident property and funds, and mistreatment. Any personnel whom the facility determines will have no contact with residents are exempt from training required by subdivisions (5), (9), and (10) of this section.	S 206	The Administrator developed a Personnel Training policy on the mandatory training topics for all employees on 4/12/2022. Mandatory staff education will be completed through the Avera Learning Center online system. The Administrator reviewed the mandatory education list and verified the required education is included in new hire training and annual training for all staff. The Administrator will educate department managers on the required training for new hires and annual training for all staff on 4/26/2022. The Food Service Manager developed a Syringe Feeding policy on 4/7/2022 based on resident 28's unique need for nutrition. The Food Service Manager and Director of Nursing will educate nursing staff on 5/3/2022 on the policy and provide formal training on the syringe feeding process specific for resident 28. The Director of Nursing or designee will educate new hires of the policy and procedure. All staff will be educated at the time when unique needs for any resident occurs. The Administrator or designee will monitor all new hires personnel files and education records to verify the required training was complete. The Administrator will report the results of this review to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue. The Administrator or designee will monitor all current employees education records through Avera Learning Center that required annual training is complete by the designated due date. The Administrator will report the results of this review to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue. NV 4/25/2022	5/12/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nikki VonEye	Administrator	4/14/2022



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10707	A. BUILDING: ______ B. WING ______	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESKOTA MANOR INC	**608 1ST ST NE WESSINGTON SPRINGS, SD 57382**

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S 206	Continued From page 1 Additional personnel education shall be based on facility identified needs. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 43021 Based on record review and interview, the provider failed to ensure: *Five of five recently hired sampled employees (C, D, E, F, and G) had received orientation training for three of twelve mandated topics (Proper use of restraints, resident rights, and care of residents with unique needs). *Documented staff education and training on the care for one of one sampled resident (28) with unique feeding needs. Findings include: 1. Review of employees C, D, E, F, and G's personnel files and orientation records revealed: *The employees had been hired on the following dates: -Dietary Assistant C on 12/13/21. -Licensed Practical Nurse (LPN) D on 10/28/21. -Housekeeping/Laundry Aide E on 10/28/21. -Certified Nursing Assistant (CNA) F on 12/13/21. -CNA G on 10/21/21. *There had been no documentation of orientation training on the proper use of restraints, resident rights, and care of residents with unique needs. Interview on 3/23/22 at 5:02 p.m. with administrator A regarding new employee orientation revealed: *She confirmed employees C, D, E, F, and G had not complete the mandated topics. *The provider had no policy on the mandated training topics for all employees. *She expected the provider's orientation training program to cover all the mandated topics.	S 206		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10707	A. BUILDING: ____ B. WING ____	03/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S 206	Continued From page 2	S 206		

Surveyor: 06365
2. Observation and interview with resident 28 on 3/21/22 at 3:00 p.m. revealed:
*She was in bed with the head of the bed raised at 75 degrees.
*An overbed tray table angled off to the side in front of her had four syringes filled with various colors of contents that she reported included Pedialyte, tater tots and beef, green beans, and water.
*Her physician said her "motor neurons are shutting down her motor skills."
*She decided to use the syringes when she started having trouble swallowing her food.
*Staff now assisted her with pushing the syringes of food into her mouth because she no longer had the strength to do that.
*She had gained weight since the staff began assisting her to eat using the syringes.

Observation on 3/22/22 at 8:30 a.m. revealed:
*Activity assistant/certified nursing assistant (AA/CNA) J filled an empty syringe by pulling up on the syringe plunger while the tip was in each of three separate bowls filled with thin pureed food including hot cereal, eggs, and prunes.
*AA/CNA J slowly pushed on the plunger moving the food into resident 28's mouth while the resident held onto the front of the syringe to hold the tip in her mouth.

Interview on 3/22/22 at 10:21 a.m. with AA/CNA J revealed she knew when to push more food through the syringe by watching for resident 28's swallowing movement or when she raised her finger to indicate she was ready for more.

Interview on 3/22/22 at 3:42 p.m. with social service/activity manager H revealed:
*The resident chose to stop eating in the dining

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S 206	Continued From page 3 room when her motor skills declined. *The physician educated her on the risks and benefits of tube feeding but she decided to feed herself using the syringes. *She fed herself until she needed staff to help her with the syringes. Interview on 3/23/22 at 10:15 a.m. with director of nursing B revealed: *There was no provider policy and procedure regarding syringe feeding and no training program specific to that feeding technique. *Resident 28 "taught us how to use the syringes." Interview on 3/23/22 at 1:53 p.m. with the dietary manager K revealed: *No training had been provided to dietary staff when resident 28 started using the syringes to feed herself. *They "played with the food to get it the right consistency."	S 206		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 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 3/21/21 through 3/23/21. Weskota Manor Inc. was found in compliance.	S 000		