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
	435105	A. BUILDING _____ B. WING _____	C 03/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEATCREST HILLS HEALTHCARE CENTER	1311 VANDER HORCK ST BRITTON, SD 57430

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/27/24 through 3/28/24. The areas surveyed included resident neglect, dietary services and physical environment. Wheatcrest Hills Healthcare Center was found not in compliance with the following requirement: F656.	F 000		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656	1. Unable to correct deficient practice noted during survey for residents 1, 4, 5, 6, 7 and 8. All residents have the potential to be affected. 2. The DNS or designee will educate all nursing staff on the expectations of following the care plan, reviewing the care plan prior to start of shift, bathing expectations for the residents and removal of dentures prior to bedtime by 4/18/2024. All staff not in attendance will be educated prior to their next working shift by the DNS or designee. 3. The DNS or designee will audit all baths in the center weekly times 8 weeks and monthly times two months to ensure bathing is done minimally every 7 days and that the baths/showers are documented appropriately. The DNS or designee will audit 4 residents with dentures weekly times 8 weeks and monthly times two months to ensure dentures are removed prior to bedtime. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and expectations to continue or discontinue the audits.	5/8/2024

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

Stephen Schmitz | Executive Director | 4/19/2024

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 656	Continued From page 1 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: A. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, and interview the provider failed to follow the individualized care plan that reflected the removal of dentures for one of one sampled resident (1), who required evaluation and treatment at the emergency department. provide care as directed in the care plans for the following: Findings include: 1. Review of the 3/2/24 SD DOH FRI involving resident 1 revealed: *He was observed making a whistling noise. *A small portion of his lower partial denture was visible in his mouth, and then was not visible. *The on-call provider was notified and orders were obtained to transfer him to the emergency department (ED) for evaluation.	F 656		

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F 656	Continued From page 2 *The denture was removed in the ED and he returned to the facility. 2. Further review of the provider's FRI investigation and interview with certified nursing assistant (CNA) A revealed: *She had not removed resident 1's dentures that evening. *She stated she was aware his dentures should have been removed, but she had forgotten to remove them. 3. Review of resident 1's medical record revealed: *Was admitted on 10/20/2023. *Had a diagnosis of Alzheimer's disease. *His care plan had been updated to include: -On 10/23/2023 the intervention "the resident requires substantial assist by one staff with oral hygiene. Resident has dentures, staff to use denture adhesive provided by family to put dentures in for meals and take dentures out after meals." had been added to his care plan. -On 3/2/2024 the intervention "Sign in room reminding staff to take dentures out after meals" had been added to his care plan. 4. Interview on 3/28/24 at 9:09 a.m. with the director of nursing (DON) B revealed she : *Expected all staff to follow each resident's individual care plan. *Confirmed the intervention to remove resident 1's dentures after meals was on his care plan prior to the incident on 3/2/2024. *Agreed CNA A had not followed resident 1's care plan. B. Based on interview, record review, and job description review revealed the provider failed to	F 656		

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F 656	Continued From page 3 follow the individualized care plan for bathing for five of sixteen sampled residents (4, 5, 6, 7, and 8). Findings include: 1. Interview on 3/27/24 at 4:20 p.m. with resident 4 revealed she: *Was scheduled to receive a bath weekly. *Stated she did not receive her bath one week, until two or three days later. 2. Review of resident 4's bathing documentation revealed she was bathed on: *1/4/24 and did not get bathed again until 1/12/24, that was 8 days later. *2/16/24 and did not get bathed again until 2/27/24, that was 11 days later. *3/7/24 and did not get bathed again until 3/15/24, that was 8 days later. *There was no documentation of a sponge bath found. 3. Review of resident 5's bathing documentation revealed: *She was bathed on 2/8/24 and did get bathed again until 2/16/24, that was 8 days later. *There was no documentation of a sponge bath found. 4. Review of resident 6's bathing documentation revealed: *He was bathed on 2/12/24 and did not get bathed again until 2/28/24, that was 16 days later. *There was no documentation of a sponge bath found. 5. Review of resident 7's bathing documentation revealed: *She was bathed on 2/12/14 and did not get	F 656		

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F 656	Continued From page 4 bathed again until 2/28/24, that was 16 days later. *There was no documentation of a sponge bath found. 6. Review of resident 8's bathing documentation revealed: *She was bathed on 2/12/24 and did not get bathed again until 2/29/24, that was 17 days later. *There was no documentation of a sponge bath found. 7. Review of the care plans for residents 4, 5, 6, 7, and 8 revealed staff were to "Provide sponge bath when a full bath or shower cannot be tolerated." 8. Interview on 3/28/24 at 12:12 p.m. with DON B regarding bathing revealed she: *Stated there was no bathing policy. *Expected each resident to receive a weekly bath. *Stated staff were to try again or offer a sponge bath when a resident refused bathing. *Stated bathing was not monitored to ensure all residents received a weekly bath or a sponge bath. *Was not aware that some residents had gone more than seven days between bathing. *Stated residents who did not receive a scheduled bath should have been given a sponge bath. *Stated there was no documentation if sponge baths were given. 9. Review of the provider's March 2012 CNA job description revealed a CNA: *"Under general supervision performs a combination of following duties in caring for residents in the Center, consistent with the plan of care."	F 656		

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F 656	Continued From page 5 *"Provides assistance with bathing, dressing, toileting, and oral hygiene activities of daily living (ADLs)." 10. Review of the provider's January 2019 Baseline Plan of Care policy revealed it "includes information regarding care and services sufficient to promote safe delivery of care." A comprehensive care plan policy was requested from the DON multiple times throughout the survey, but was not provided by the end of the survey.	F 656		