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 _____	C 08/14/2024

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F 000	INITIAL COMMENTS A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/12/24 through 8/14/24. Weskota Manor Inc was found not in compliance with the following requirements: F699, F761, and F812. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/12/24 through 8/14/24. Areas surveyed included quality of care/treatment as it pertained to elopement. Weskota Manor Inc. was found in compliance.	F 000		
F 699 SS=E	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and policy review, the provider failed to ensure fourteen of fifteen sampled residents (1,2,5,7,10,11,12,16,17,19,21,23,26 and 33) had been screened for post-traumatic stress disorder (PTSD) upon admission. Finding include: 1. Interview on 8/12/24 at 12:58 p.m. with resident 10 while seated in her recliner revealed: *She did not know why she was there. She had been "a good girl."	F 699		

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

Nikki VonEye | Administrator | 9/6/2024

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 699	Continued From page 1 *She had thought she was living there because her mother died. Interview on 8/12/24 at 4:00 p.m. with licensed practical nurse (LPN) E regarding the above interview with resident 10 revealed: *She knew that resident 10 had been sent to a juvenile detention center when she was a teenager because she had a boyfriend. *Resident 10 would often tell staff she had been a good girl and did not know why she was there. Interview on 8/12/24 at 4:44 p.m. with social service manager (SSM) D regarding PTSD screening of residents revealed: *She did not screen all new residents for PTSD. *She had screened resident 34 for PTSD due to her having a diagnosis of the disorder upon admission. *She had contacted her social services consultant G regarding screening new residents for PTSD. -She had been informed a screening needed to be completed upon admission and annually on all residents. Interview on 8/13/24 at 10:07 a.m. with SSM D regarding PTSD screening on resident 10 revealed: *She had screened resident 10 today (8/13/24) and had spoken to the resident's son. -The resident's son had verified that resident 10 had been in a juvenile detention center when she was a teenager. --He added that resident 10 would reference she had been a good girl and did not know why she was there. *SSM D had offered counseling to resident 10 but she declined and her family also declined.	F 699	The Social Service Designee developed a PTSD Screening policy on 8/14/2024. The Social Service Designee and Social Service Consultant reviewed and revised the PTSD policy on 9/3/2024. Social Services and/or designee will complete a PTSD screen within 10 days of a resident's admission. The PTSD assessment will be completed on residents annually, PRN, or with a physician's order. PTSD assessment were completed on residents 1,2,5,7,11,16,17,19,21,23,26 by 9/6/2024. A PTSD assessment was completed on resident 10 on 8/13/2024. Resident 33 passed away on 6/4/2024. The Social Service Designee will monitor monthly that all new residents and those residents due for their annual assessment have a PTSD assessment completed. The Social Service 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.	9/28/2024

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F 699	Continued From page 2 Interview on 8/14/24 at 9:55 a.m. with social services consultant G regarding screening residents for PTSD revealed she had informed SSM D all residents needed a screening upon admission and then annually. Interview on 8/14/24 at 10:30 a.m. with director of nursing B regarding screening residents for PTSD revealed she had not been aware that all residents required a screening upon admission and annually. Review of the provider's August 2024 PTSD Screening policy revealed: *"Nursing assess the day of admit with clinical assessment." *"Social Services to evaluate each resident at admit and then during the annual assessment using the PTSD screening tool for DSM-5."	F 699		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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	F 761		

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F 761	Continued From page 3 personnel to have access to the keys. §483.45(h)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure that 17 of 17 expired Influenza vaccine injections were removed from the medication refrigerator prior to the expiration date. Findings include: 1. Observation and interview on 8/13/24 at 5:00 p.m. with licensed practical nurse (LPN) E in the medication storage room revealed: *There were two boxes of Influenza vaccines totaling 17 doses with an expiration date of 06/2024 found in the medication refrigerator. *LPN E agreed that these influenza vaccines were expired and should not have been in the medication refrigerator. *The vaccines were removed from the refrigerator and LPN E said she would find out what needed to be done with them. 2. Interview on 8/14/24 at 07:54 a.m. with director of nursing (DON) B revealed: *DON B agreed that the 17 influenza vaccines were expired. *When asked what happened to the vaccines and she said, "we got rid of them." She later said that	F 761	The Administrator and Director of Nursing reviewed and revised the Medication Destruction policy on 9/4/2024, adding that expired medications waiting to be destroyed will be stored in a bin in the cupboard in the medication room. A log was implemented on 9/4/2024 for Stock Medication Destruction. The Pharmaceutical Supplies Inspection Guide form was reviewed, revised and implemented on 9/4/2024 by the Administrator and Director of Nursing, adding that expired medications have been removed and destroyed. The Director of Nursing will educate all charge nurses on 9/17/2024 on the Medication Destruction policy and Pharmaceutical Supplies Inspection Guide. The Pharmaceutical Supplies Inspection Guide will be completed on a rotation by charge nurses. The Director of Nursing will schedule when this guide is completed. The Director of Nursing or Infection Preventionist will monitor monthly that the Pharmaceutical Supplies Inspection Guide is completed each month and that any expired medications are disposed of per protocol. 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 advised to discontinue.	9/28/2024

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F 761	Continued From page 4 they were destroyed the previous night after the vaccines were discovered. *I asked if she knew what the expiration date was on the vaccines, and she said 06/2024. 3. Interview and record review on 8/14/24 at 1105 a.m. with DON B regarding the provider's Pharmaceutical Supplies Inspection Guide revealed: *The "Pharmaceutical Supplies Inspection Guide" was a tool used to check for outdated medications and pharmaceutical supplies. *This guide was to be completed monthly. *The last time this guide was documented as completed was on 6/4/2024 by LPN E. *That guide was not completed during the month of July, 2024. 4. Review of the provider's Medication Destruction policy revealed: *" When medications are discontinued by the physician order, expired or in the of patient's death or discharge, the medications are destroyed in the facility."	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		

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F 812	Continued From page 5 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and manufacturer's instructions review the provider failed to ensure food items for resident consumption were appropriately labeled, stored, and served in a safe and sanitary manner for the following: *Three of three commercial and one of one resident refrigerators that contained food items that were not labeled, dated, or discarded by the use-by date. *Two of two dry food storage areas that contained dry food items that were not labeled or dated. *One of one commercial freezer that contained food items that were not labeled, dated, or appropriately stored. *One of one food service manager (C) did not properly sanitize the food thermometer while temping the food items before serving them to the residents. *The kitchen and food service equipment was not maintained in a clean condition. Findings include: 1. Observation during the initial tour of the kitchen and food storage areas on 8/12/24 at 12:40 p.m. revealed: *In the reach-in refrigerator: -There were two out of five Activia yogurts with a use-by date of 7/28/24.	F 812	All the expired food items and food items not properly labeled or stored that were noted in this survey report and the expired hydron chlorine tests strips were disposed of by 8/29/2024. The cleaning items that were improperly stored were placed with in another room other cleaning items away from food items. Expiration dates of all food items and chemicals were checked by the Administrator and Dietary Manager on 8/29/2024. All items in refrigerators, freezers, and dry storage areas were checked by the Administrator and Dietary Manager on 8/29/2024 for expirations, proper labeling and storage. The clothing jacket on the shelf in the dry baking goods storage room was removed on 8/12/2024. The top of the oven was cleaned on 8/12/2024. New hydron chlorine test strips were ordered. The rusty cans used for food waste were disposed of and replaced with new ones. Plastic buckets for food waste will be purchased and used for food waste. The Administrator and Dietary Manager are reviewing the following policies: General Food Preparation and Handling, Dry Food Storage, Temperatures of Hot and Cold Food, Food from Outside Sources, and Use of Leftovers. These policies will be updated by 9/12/2024 and reviewed with dietary staff on 9/16/2024. A Thermometer Sanitizing policy and Kitchen & Equipment Cleaning policy are being developed by 9/12/2024 by the Administrator, Dietician Consultant,	

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F 812	Continued From page 6 -There was a can of V8 juice dated 7/29/24. -There was a mason jar containing an unidentified red liquid dated 8/7/24. -There was an opened tube of whipped topping that did not have an opened date or use-by date. *Another refrigerator which staff referred to as the "salad fridge" contained: -An opened bag of mozzarella cheese dated 3/24. -A container of sour cream with an opened date of 8/7 and a use-by date of 7/16/24. -An egg carton contained ten eggs with a use-by date of 5/31/24. -An opened package of deli fresh roast beef that did not have an opened date. -A container of beef paste that did not have an opened date or a use by date. -An unopened package of oven roasted turkey with a use-by date of 8/5/24. -An opened package of oven roasted turkey that did not have an opened date and had a use-by date of 8/5/24. -An opened jug of creamer that did not have an opened date. -A jug of orchard splash juice with an opened date of 8/12/24 and a use by date of 7/26/24. *In the dry baking goods storage room: -A clothing jacket was on the metal wire shelf that had oyster crackers stored on it. -An opened bag of marshmallows that did not have an opened date on it. -A container of pink lemonade powder with an expiration date of 6/7/23 with an opened date of 6/21. -An unsealed bag of Oreo cookie pieces that had a use-by date 6/17/24. -An opened container of white vanilla frosting that	F 812	and Dietary Manager and will be reviewed with dietary staff on 9/16/2024. The Dietary Manager was educated by the Dietician Consultant on 9/3/2024 on the proper sanitizing of food thermometers. Residents and family members will be educated by 9/28/2024 on the proper storage of resident food items in the resident refrigerator/freezer including that items must be labeled with resident name, date and properly stored. Dietary staff were provided written education on 9/4/2024 and will have a follow-up meeting on 9/16/2024 regarding the following topics: labeling, storing, serving food items in a safe and sanitary manner, discarding food items by the use-by date, rotating food, food thermometer sanitizing, equipment cleaning and documention, process for testing chlorine levels, and storage of personal items. The Dietary Manager or designee will check for outdated food and proper labeling and storage of food items when doing the weekly food order. Dietary staff will check the cleaning sheets daily and complete the cleaning tasks assigned for that shift and sign off on the cleaning sheet. Daily reminders to dietary staff on cleaning and documention was implemented on 9/4/2024 through our timeclock messaging system. Additional education will be held at the dietary department meeting on 9/16/2024. The Administrator or designee will monitor	

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F 812	Continued From page 7 did not have an opened date. *The freezer in the dry baking goods storage room contained: -A light weight zipped bag of brats that appeared to have freezer burn dated 7/24. -An opened bag of sausage dated 6/18. -An opened bag of rhubarb with best by date of 4/10/24. -An opened bag of potatoes that did not have a use-by date. -A light weight zipped bag of French fries that did not have a use-by date. -A light weight zipped bag of ham which appeared to be freezer burnt that did not have an opened by date. -A ripped open brown paper sack with French fries that did not have an opened by date. -An opened ice cream container that was labeled, "6/24 chicken pot pie." -Three bags of opened chicken patties that did not have an opened by date. *The weekly cleaning schedule hung up on a cabinet revealed: -Two out of 19 tasks were marked as completed for week 1. -One out of 19 tasks were marked as completed for week 2. *The cabinet above the sink contained: -A cottage cheese tub that contained lemon jello dated 1/30. -A bag open to air that contained vanilla pudding and pie mix that had not open or best by date. -A box of orange gelatin mix that was labeled, "8/16." *The top of the oven appeared dusty with food	F 812	weekly for three months and monthly thereafter, that food is labeled and stored properly, that there are no expired food items or supplies, conduct observations of food thermometer use and sanitizing, and review cleaning schedules. 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 advised to discontinue.	9/28/2024

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F 812	Continued From page 8 particles and had a baking rack set on it. *The canned dry storage area contained: -Cleaning supplies including Comet, Dawn Hillyard Sanitizer, and Stera Sheen on the bottom rack of a food shelving unit. *In the walk-in freezer: -There were three unopened boxes on the floor. -An opened bag of sausage patties that did not have an opened by date. -A light weight zipped bag of blueberry muffins that did not have an opened or use-by date. *In the walk-in fridge: -There were six unopened packages of roasted turkey that was dated use or freeze by 8/5. -A case of cottage cheese that had a use-by date of 8/6. -Three activia yogurts that had a use-by date of 7/28. -A case of lite and fit yogurt that had a use-by date of 8/9. -There were four cucumbers that were uncovered on the shelving unit and visibly spoiled with mold spots. -There were six 4-packs of lemon lime jello that had a use-by date of 4/14. -There were two 4-packs of strawberry jello that had a use-by date of 5/1. -A case of unpasteurized eggs. *In the dining room fridge/freezer: -There was an undated, zipped bag in freezer with pumpkin bread labeled, "a resident's name on it." -There were two undated jars of pickles labeled, "a resident's name on it." -An undated Walmart bag with strawberries,	F 812		

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F 812	Continued From page 9 melon, and tomatoes labeled, "a resident's name on it." -A tub with blue lid with watermelon in it labeled, "8/11 a resident's name on it." -An undated container with a blue lid with grapes in it labeled, "a resident's name on it." -An opened, unfinished can of root beer with resident's initials that was not dated. 2. Observation and interview on 8/13/24 at 11:38 a.m. through 12:10 p.m. with food service manager C during the noon meal prep revealed: *The desserts (carrot cake and pudding) for the noon meal in the reach-in fridge were not covered. *Food service manager C: -Dipped the thermometer in a red bucket which she stated was filled with sanitizer. -Inserted that thermometer in a chicken breast, waited a few seconds, and read the temperature of 165 degrees Fahrenheit (F). -Placed the thermometer in a green bucket which she stated was detergent. -Wiped off the food particles into the green bucket and then dipped the thermometer into the red bucket. -Continued to obtain the temperatures of the food items and used this cleaning process ten additional times. *She stated the sanitizer is the same that is used for the dishes. 3. Observation on 8/13/24 at 12:15 p.m. in the dishwasher room revealed: *Expired hydron chlorine test strips dated 12/1/16. *There were rusty cans that staff put leftover food in after meals and would then wash them in the dishwasher.	F 812		

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F 812	Continued From page 10 4. Interview on 8/13/24 at 3:36 p.m. with food services manager C about the above observations revealed: *She was not aware there were expired items in any of the fridges. *It was her expectation that staff throw away expired food times and label them correctly when opened. *The staff were supposed to keep personal items in their locker and not with food items. *She stated things in the freezer should be wrapped in saran wrap and put in gallon zipped bags. *She was not aware that her zipped bags were not freezer bags, and the food was getting freezer burnt. *If food was brought in for residents, it needed to be labeled correctly with their name, date, and could be kept for seven days. *She confirmed that the eggs were not pasteurized. *She stated the egg container in the kitchen fridge has been refilled since she has been there but should have the correct date from the original egg container marked on it. *She agreed that the cleaning schedule was not complete and that everything on that list should be cleaned weekly and marked when done. *Staff were supposed to put the hydron chlorine test strips on the silverwear before every meal to test the chlorine level. *She stated she was not aware the test strips were expired. *She explained dishes must completely air dry after they were removed from the dishwasher per the sanitizer instructions. *When asked if she allowed the thermometer to dry before temping foods, she stated she had not and that it was a problem.	F 812		

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F 812	Continued From page 11 5. Interview on 8/13/24 at 4:34 p.m. with administrator A revealed there was no policy on the cleaning schedule, and she expected staff to fill the cleaning schedule out accordingly. 6. Review of the providers April 2023 reviewed General Food Preparation and Handling policy revealed: *Procedure: -"The kitchen and equipment are clean." -"Foods are received, checked, and stored properly as soon as they are delivered." -"Food is covered for storage." 7. Review of the providers August 2008 Dry Food Storage policy revealed: * "Food is stored, prepared, and transported at appropriate temperatures and by methods designed to prevent contamination." *Procedure: -"All containers must be legible and accurately labeled." -"Chemicals must be clearly labeled, kept in original containers when possible, and kept in a locked area away from food." -"All stock must be rotated with each new order received." 8. Review of the provider's April 2023 reviewed Temperatures of Hot and Cold Food policy revealed: *Procedure: -"To take temperatures, a clean, sanitized and air-dried thermometer is needed..." -"The thermometer must be sanitized between uses in different foods. Thermometers can be sanitized using alcohol swabs in between taking the temperature of the food."	F 812		

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 _____	C 08/14/2024

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F 812	Continued From page 12 9. Review of the provider's April 2023 reviewed Food from Outside Sources policy revealed: *Procedure: -"It must be placed in a plastic container with tight fitting lid." -"Food brought in should be labeled with the individuals name. If the item is to be stored, it must be dated and placed in the resident's refrigerator. After 3 days the perishable item will be discarded." 10. Review of the Hillyard Sanitizer manufacturer's instructions for use revealed: *For sanitizing food contact surfaces: -" ...must be sanitized by emersion." -"Thoroughly wet all surfaces." -"Drain thoroughly and air dry." -"Do not rinse."	F 812		

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	10707	A. BUILDING: _____ B. WING _____	08/14/2024

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S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/12/24 through 8/14/24. Weskota Manor Inc was found not in compliance with the following requirement: S290.	S 000		
S 290	44:73:07:05 Food Supply The facility shall maintain an on-site supply of perishable and nonperishable foods adequate to meet the planned menus for three days. A facility shall maintain an additional supply of nonperishable foods as part of their emergency preparedness plan. Military meals ready to eat (MRE) are not a substitute for the nonperishable food supply for residents, but may be used to address other emergency food supply needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and policy review the provider failed to maintain an additional three-day supply of nonperishable foods as part of their emergency preparedness plan. Findings include: 1. Observation and interview on 8/13/24 at 3:35 p.m. with food service manager C in the canned dry food storage area revealed: *She had been in her current position since September 2023 and would finish her degree in November 2024. *She confirmed she did not have the required 26 loaves of bread. *She stated they removed corned beef hash from the emergency menu. *There were no cans of beef stew from the	S 290	The Emergency Policy for Nutrition Services during a Disaster policy was reviewed and revised by the Administrator and Dietary Manager on 9/4/2024 to adequately designate the emergency food supply needs for 3 days. The 3-Day Emergency Menu was reviewed and updated on 9/4/2024 by the Administrator, Dietician Consultant, and Dietary Manager. The Registered Dietician approved and signed the 3-Day Emergency Menu on 9/5/2024. All food items on the 3-Day Emergency Menu will be ordered on 9/9/2024 and received on 9/11/2024. The Dietary Manager or Administrator will monitor monthly that adequate supply for the food items on the emergency 3 day menu are in stock. The Dietary Manager will report the results of this review to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advised to discontinue.	9/28/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nikki VonEye	Administrator	9/6/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S 290	Continued From page 1 required menu. *There were only six 2-pound (lb) packages of tuna out of the required thirteen 4lb packages. *There were only four out of seven cans of beans that was required. *The emergency food supply on hand had not: -Been sufficient in quantity to have provided meals for three days and an additional food supply in case of an emergency. -Been signed off by a registered dietician when it was changed. 2. Review of the provider's undated Emergency Policy for Nutrition Services during a Disaster policy revealed: *Purpose: -"A. To provide adequate food and fluids during the event of a disaster." * "The storeroom is stocked with a 1-week supply of various items that can be used in preparing a simplified menu." * "The food in the freezer (meats, frozen, vegetables) would also supply needs for at least 3 days." 3. Review of the provider's April 2018 3-Day Emergency Menu revealed: *The corned beef hash was still on the menu, and they had not replaced it. *There were blank spaces for the following nutritional food options: -Day one dinner starch. -Day two dinner starch and supper bread. -Day three dinner starch and supper vegetable and bread.	S 290		
S 000	Compliance/Noncompliance Statement A licensure survey for compliance with the	S 000		

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S 000	Continued From page 2 Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 8/12/24 through 8/14/24. Weskota Manor Inc was found in compliance.	S 000		