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
	435119	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST WILMOT, SD 57279

(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 000	INITIAL COMMENTS An extended recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/27/24 through 2/29/24. Wilmot Care Center Inc was found not in compliance with the following requirements: F656, F658, F684, F689, F760, F802, F803, F812, and F909. A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 2/27/24 through 2/29/24. The areas surveyed included physical environment, adequate supervision to prevent unwitnessed elopement, and medication administration. Wilmot Care Center Inc was found not in compliance with the following requirements: F658, F689, and F760. On 2/28/24: *At 9:36 a.m., immediate jeopardy was identified related to the physical environment and adequate supervision to prevent an unwitnessed elopement at F689. *At 12:46 p.m., administrator A provided their plan for the removal of the immediate jeopardy. *At 12:55 p.m., the provider's removal plan was accepted by the survey team. *At 2:30 p.m., the survey team determined the immediacy was removed. The resident census was 26.	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	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek
TITLE: Administrator
(X6) DATE: 3-21-2024

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 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. (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	F 656	F 656 1. Care plans for resident 22's was reviewed and revised by 3/22/24 to reflect current changes. Resident 22' s care plan has been updated to include her interventions, preventative measures and wander guard for elopement risk/wandering. Resident 24's care plan was reviewed and revised 3/20/24 to reflect current needs for mood, pain, and adjustment difficulties. Resident 3 is no longer a resident at the facility. All residents are at risk of having care plans that are not up to date and do not reflect current care needs and changes in resident conditions. 2. All resident care plans will be reviewed and updated by 3/27/24 to reflect the individualized care needs of each resident. 3. The DON or designee will educate all staff on the importance of the care plan to be accurate and include personal preferences, as well as, following the care plan interventions and reporting any resident changes or voiced preferences. All resident care plans will be reviewed quarterly and with any significant change. Care Plan education will occur no later than March 26, 2024, and those not in attendance at the education session	3-28-2024

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F 656	Continued From page 2 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: Based on observation, interview, and record review, the provider failed to revise individualized care plans as resident changes occurred for 3 of 13 sampled residents (22, 3, and 24). Findings include: 1. Observation and interview on 2/27/24 at 1:13 p.m. with resident 22 revealed she: *Walked about independently without assistive devices in the hallway from her room to the television lounge area outside of the dining room and to the seating area in the lobby between the front entrance door and the nurse's desk. *Responded with incomplete phrases and mixed thoughts when asked questions about how her day was going or about her interactions with staff and other residents. Review of the electronic medical record (EMR) for resident 22 revealed: *A physician diagnosis dated 9/15/23 of "unspecified dementia, unspecified severity, with anxiety." *A care plan focus initiated on 10/11/23 for "elopement risk/wanderer r/t [related to] cognition and mobility," with the interventions initiated on 10/11/23 to: -"Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate." -"WANDER ALERT: left wrist." Review of resident 22's progress notes in the	F 656	F656 cont. due to vacation, illness or casual work status will be educated upon return of their next shift worked. 4. The DON/designee will audit 6 random residents to ensure their care plans are up to date for resident care needs/preferences and the interventions are being followed. Audits will be weekly for four weeks, and then monthly for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	

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F 656	Continued From page 3 EMR revealed a pattern of attempted and actual elopements on the following dates and times: *12/31/23 at 4:01 p.m., "Headed straight to the door and held emergency exit and went outside." *12/31/23 at 10:38 p.m., "Said goodbye and headed down the hall towards her room. Moments later alarm went of [sic] at west hall emergency exit." *1/1/24 at 2:56 p.m., "Walked out the front door, staff redirected her back in the facility." *1/1/24 at 6:40 p.m., "Left the table before being served. She started walking fast toward the front exit." *2/1/24 at 6:01 p.m., "Night nurse arriving to work and seen resident walking at the end of the parking lot." *2/5/24 at 5:39 p.m., "Attempted to leave out the front door and set alarm off." *2/13/24 at 3:30 p.m., "AL [assisted living] resident hollered out that she walked out the door. No alarm sounded as res [resident] had cut off her wander guard again." *2/19/24 at 5:07 p.m., "Staff were getting residents into dining room and noticed resident was not in her room. Writer sent CNA to go out and look for resident." *2/19/24 at 5:20 p.m., "CNA located resident near the school and brought her back to WCC [Wilmot Care Center]." Review of the provider's Missing Resident/Elopement Policy revealed the policy had not been followed by staff for: *Prevention: "1. Interventions that may be used for residents identified as high risk for elopement include: a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g., every one-half hour checks)." *"4. Prevention strategies are listed on each	F 656		

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F 656	Continued From page 4 resident's plan of care and reviewed...on at least a quarterly basis or with a change of condition." *Resident 22's care plan had not been updated since 10/11/23 and did not specify a frequency for monitoring her location or any specific interventions or strategies. Interview on 2/28/24 at 7:53 a.m. with director of nursing (DON) B revealed: *When asked about resident 22's care plan regarding the frequency of monitoring her location, she responded, "She is usually hanging around out here. She tends to watch for groups of people by the front door and attempts to go out with them." *"Staff check placement of wander alert bracelet once a day," and it was "recorded on TAR [treatment administration record]." Refer to F 689, finding A. 2. 2. Observation and interview on 2/27/24 at 3:10 p.m. with resident 3 revealed: *She was seated in a wheelchair in her room next to her bed and facing the window. *The bed was at a lower level than the standard height. *The wheelchair had anti-roll back brakes over the back wheels. *She did not provide responses to how much assistance she needed to complete her activities of daily living (ADLs). Review of the EMR for resident 3 revealed: *A "Plan of Care" progress note on 2/1/24 at 4:03 p.m. stated she "had been in the hospital and went to her son's home where she was having multiple falls." *Physician orders started on 2/2/24 for:	F 656		

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F 656	Continued From page 5 -"Antiroll back bars to be placed on wheelchair." -"Fall alarm to be placed on bed and wheelchair at all times." Review of progress notes in resident 3's EMR revealed multiple unwitnessed falls on the following dates and times: *2/1/24 at 7:00 p.m., "resident sitting on her bottom on the floor in front of the bathroom. Resident was knocking on the door for help." *2/2/24 at 3:57 p.m., "Found resident on the bathroom floor." *2/3/24 at 9:57 p.m., "Alarms are in place and going off...found sitting on her buttocks right inside her room door." *2/20/24 at 9:52 p.m., "Found her on the floor in the BR [bathroom]." *2/22/24 at 4:53 p.m., "Fell on right side off bed onto floor mat. Bed low position. Fall in room. Bed alarm sounding." Review of resident 3's care plan revealed: *A focus initiated on 2/27/24, "The resident has had an actual fall with no injury. Poor communication/comprehension unknown origin." *The interventions for that focus included: "bed/chair alarm, room close to nurses station, video monitor, bed in low position with fall matt on floor while resident in bed." *A focus initiated on 2/28/24, "The resident is High, risk for falls r/t dementia." *The interventions for that focus included: -"Anticipate and meet The [sic] resident's needs." -"Be sure The [sic] resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Interview on 2/29/24 at 11:32 p.m. with Minimum	F 656		

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F 656	Continued From page 6 Data Set (MDS) coordinator C regarding the intervention to "anticipate and meet" resident needs revealed he agreed the intervention should be more specific to address the potential risks related to falls. Interview on 2/29/24 at 3:54 p.m. with DON B revealed: *The care plan to "anticipate and meet" the resident's needs were vague. *The documentation of the fall investigations did not correlate meeting the resident needs to the timing of the falls. *The provider's policy did not address investigating that factor. Refer to F 689, finding B. 1. 3. Observation and interview on 2/27/24 at 12:02 p.m. with resident 24 revealed he: *Was seated in his wheelchair in his room and his left foot was wrapped and positioned on a foot pedal. *Had gotten some pins removed and needed to manually lift his left arm into position due to a stroke. *Cried while talking about having an appointed guardian, having to be at the facility rather than living on his own. *Said sometimes staff walk away when he asks for a pain pill, maybe they don't hear me. Review of resident 24's EMR revealed: *An admission summary progress note on 1/23/24 noted he was admitted "after an occlusion in the left lower extremity." *A plan of care progress note on 1/23/24 noted the court-appointed guardian completed the admission paperwork and his admission would be	F 656		

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F 656	Continued From page 7 a "long term placement." *The 1/30/24 admission MDS noted he was cognitively intact, reported no mood difficulties, had functional impairment of the upper and lower extremities on one side, was independent or needed supervision for his activities of daily living (ADLs), and had not had any pain. *Two plan of care notes on 2/12/24 and 2/14/24 noted his desire to not live at the facility. *An incident note and a plan of care note on 2/15/24 noted he left the facility and was "going to get a ride to [another county]" or "wanting to go to jail, to a homeless shelter in [another city] or to [his home location]." *An appointment/return progress note on 2/20/24 noted he "returned from surgery...metal implants were removed from left ankle." Review of resident 24's physician orders revealed: *On 1/23/24: "Document pain level per resident verbal pain rating every day and night shift." *On 2/6/24: Tylenol 325 mg [milligrams] two tablets every four hours as needed for pain and fever. *On 2/20/24: -"Cam boot on during the day, off at night." -Tramadol HCl [opioid pain medication] 1 tablet every 8 hours as needed for pain management for 20 days. *On 2/21/24, "Wound care: Change mepilex dressings every other day, keep clean and dry. Elevate extremity above heart level" to happen in the morning every other day. Review of documented pain levels reported in resident 24's EMR between his admission date of 1/23/24 and 2/28/24 revealed: *He had not reported a pain level above 0 [zero]	F 656		

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F 656	Continued From page 8 before 2/21/24 *Every day from 2/21/24 to 2/28/24, his pain levels were reported between a rating of 3 [three] and 7 [seven]. Review of the February 2024 TAR in resident 24's EMR revealed he had received: *Tramadol: -Two times on 2/21/24, 2/23/24, and 2/24/24 -One time on 2/22/24, 2/25/24, 2/26/24, and 2/27/24. *Tylenol: -One time on 2/22/24, 2/24/24, and 2/26/24. -Two times on 2/23/24. Review of resident 24's care plan initiated on 2/5/24 revealed: *A focus of "ADL self-care performance deficit r/t left hemiplegia from stroke" with a goal to "maintain current level of function." *A focus of "pressure ulcer lt [left] ankle" with interventions to "administer medication as ordered" and administer treatments as ordered." *There was no focus or interventions to address his: -Adjustment difficulties related to placement at this facility. -Increased pain levels related to the surgical procedure. Interview on 2/27/24 at 1:59 p.m. with social service designee (SSD) D revealed: *She had multiple conversations with resident 24 regarding his guardianship, the history of being homeless and in prison, his desire to live elsewhere, and his personal care "oddities" such as using wipes for a bath and the garbage can for a urinal. *Resident 24 is "not real good at relating" to the	F 656		

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F 656	Continued From page 9 reality of his situation. *She had conversations with his sister and the guardian regarding alternate placement options. *Resident 24 had broken his ankle and the pins were not set correctly so they were sticking out and those had been removed last week. Interview on 2/28/24 at 1:17 p.m. with SSD D revealed resident 24: *Had unreasonable expectations and manipulative tendencies. *Would easily get emotional when talking with her about his situation. *Could benefit from some mental health services. Interview on 2/28/24 at 1:27 p.m. with MDS coordinator C revealed: *The mood section of the 1/30/24 MDS was coded with no difficulties based on resident 24's "No" responses during the mood interview. *Resident 24 had displayed unrealistic and manipulative mood and that should be addressed on the care plan. *It was not originally addressed because it did not trigger from the MDS at that time but should have been added as his behaviors began happening. Interview on 2/29/24 at 11:15 a.m. with MDS coordinator C revealed he: *Learned about changes in resident conditions by reviewing the progress notes for the previous day. *Would have expected a care plan related to resident 24's increased pain should have been added. Interview on 2/29/24 at 3:56 p.m. with DON B revealed: *A care plan focus and interventions should have been added to address resident 24's mood and	F 656		

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F 656	Continued From page 10 pain difficulties. *There was a need to "implement care plan meetings."	F 656	F 658 1. Medication error for Resident 28 final report was submitted and accepted by Department of Health (DOH) on 2/29/2024. No further medication errors have occurred involving Resident 28's warfarin dosing. There have been no adverse effects related to the medication error and routine lab draws per provider have been within normal limits. All residents are at risk for receiving medications that have not been verified by the five rights of administration, and/or not comparing medication package/bottle to the Physician's order and the MAR prior to administering new admission medications or scheduled daily medications during medication pass times. The five rights of medication administration, comparing medication package/bottle to the Physician's order and the Medications Administration Record (MAR) prior to administering new admission medications has been educated to Licensed Practical Nurse (LPN) L on 2/27/2024 during interview and Certified Nursing Assistant/unlicensed medication assistant (CNA/UMA) J on 2/29/2024 during interview.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health facility reported event, interview, record review, and policy review, the provider failed to follow the five rights of medication administration and to compare the medication package with the physician's orders received from the pharmacy was correct before administering the medication to one of one sampled resident (28). Findings include: 1. Interview and review of the South Dakota Department of Health facility reported event form on 2/29/24 at 8:02 a.m. with director of nursing (DON) B revealed: *Resident 28 was discharged from the hospital on 2/26/24 at 11:00 a.m. and received his warfarin 5 milligram (mg) tab before his discharge. The hospital had the resident's warfarin scheduled for noon. *Licensed practical nurse (LPN) L received the resident's warfarin delivery from the pharmacy at approximately 6:20 p.m. on 2/26/24. *LPN L placed the resident's medication bubble cards in the medication cart without reviewing the medication bubble card with the current	F 658		3-28-2024

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F 658	Continued From page 11 physician's orders. *The resident's warfarin was labeled with a p.m. sticker from the pharmacy because the provider normally administered warfarin in the evening. *The medication administration record (MAR) had the warfarin scheduled to be administered at noon. The warfarin 7.5 mg dose was to be given on Tuesdays and Saturdays. The warfarin 5mg dose was to be given on Mondays, Wednesdays, Thursdays, Fridays, and Sundays. *LPN L administered the warfarin 7.5 mg on the evening of Monday 2/26/24 that was scheduled to have been administered on 2/27/24 at noon. *The administration of the warfarin 7.5 mg dose was not documented on the residents MAR. *DON B stated that when LPN L was interviewed, she admitted that she had not followed the "five rights" of medication administration (The "five rights" of medication administration include the right patient, the right medication, the right time, the right dose, and the right route). *The DON's expected that the nurse should have followed the "five rights" of medication administration. *All medications for new admissions should have been checked against the MAR for accuracy. *On 2/27/24 during the noon medication pass, certified nursing assistant/unlicensed medication assistant CNA/UMA J noticed that the scheduled dose of warfarin 7.5 mg for 2/27/24 was missing. CNA/UMA J then administered the dose scheduled for Saturday 3/2/24 without consulting the nurse and resident 28 received an additional dose of warfarin 7.5 mg. *After CNA/UMA J administered the warfarin 7.5 mg dose, she went to question if she should have given the dose with the charge nurse. *The charge nurse reported the medication discrepancy to DON B, and upon further	F 658	F 658 cont. CNA/UMA J was educated on the importance of the five rights of medication administration, comparing medication package/bottle to the Physician's order and the Medications Administration Record(MAR) prior to administering new admission medications and/or scheduled daily medications during medication pass times, along with the importance of verifying/asking questions of the charge nurse or DON prior to giving a medication when a potential error has been discovered on 3/22/2024. All nurses and medications aides received the education regarding the Five Rights of Medication and The New Medication Administration Policy by 3/28/2024, and those not on the schedule or in attendance at the education session due to vacation, illness or casual work status will be educated upon their return of their next shift worked. 2. All residents are at risk of medications being administered without following the Five Rights of medications and/or not comparing the medication package/bottle to the physician's order and the MAR prior to giving the medication.	

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F 658	Continued From page 12 investigation, discovered that resident 28 had received two doses of the warfarin 7.5 mg. *DON B notified the resident's physician who ordered to immediately draw a protime (PT) and international normalized ratio (INR). (A blood test that tells you how long it would take for your blood to clot). *The blood work was obtained, and Resident 28 was monitored for bleeding for the next "24-48" hours. *Results received on 2/27/24 at approximately 3:00 p.m. the PT was 30.8 and the INR was 3.0. (The therapeutic range for people taking warfarin was INR of 2.0 to 3.0) *Resident 28's physician was notified of the laboratory results and the physician ordered the resident's next scheduled warfarin 5mg dose was to be given on 2/28/24. Interview on 2/29/24 at 10:32 a.m. with CNA/UMA J and DON B revealed: *She admitted that she should have questioned the missing dose of warfarin with the nurse before she administered that dose. *DON B was able to provide training documentation for CNA/UMA J. Review of the provider's undated Administration General Guidelines policy revealed: *Medication administration staff should always consider the rights of medication administration to include the right resident, the right medication, the right dose, the right route, and the right time. Compare the MAR with the label packaging for accuracy check. *The authorized personnel who prepared and administered the medication were then responsible for recording the administration of the medication on the appropriate record.	F 658	F 658 cont. 3. The DON/designee will educate all nurses and medication aides on the importance of the five rights of medication administration and the importance and the need of comparing the medication package to the physicians order and the medication administration record and EMAR (electronic medication administration record) prior to administering any medications to a new admission or when it is a new medication or cycle fill. The education will occur no later than March 28, 2024 and those not in attendance at the education session due to vacation, illness or casual work status will be educated upon their return of their next shift worked. 4. The DON/designee will audit new admissions medications within 24 hours of admission, new orders within 48 hours of new order and receiving medication and monthly cycle fill. Audits will be weekly for four weeks, and then monthly for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	

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F 658	Continued From page 13 *If a medication aide was administering medications, he/she must discuss differences with the licensed nurse on duty before administration of that medication to ensure the medication was correct.	F 658	F 684 1. Resident 3 is no longer a resident. Resident 16 has had a thorough skin assessment completed and documented in the progress note section under Skin/Wound Note. Resident 16's care plan has been updated to reflect care plan focus of anticoagulation therapy goals to current resident needs. 2. All residents have the potential to have skin issues/concerns not reported or documented by nursing staff or other entities working with residents. 3. Gentell wound nurse has conducted a skin sweep with the director of nursing to identify any areas of concern with skin/wounds for all residents residing in the facility as of 3/20/2024. Residents that did not agree to the skin assessment have had a complete skin assessment conducted by the Director of Nursing or charge nurse by 3/27/24 to reflect any current bruising or edema. Education provided to nurses and CNA's present on 3/20/24 by Gentell wound nurse, and those not on the schedule or in attendance at the education session due to vacation, illness or casual work status will be educated upon their return of their next shift worked.	3-28-2024
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, the provider failed to ensure staff followed the policy to identify and evaluate skin conditions for 2 of 3 sampled residents (3 and 16). Findings include: 1. Observation and interview on 2/27/24 at 3:10 p.m. with resident 3 revealed: *She was seated in a wheelchair in her room next to her bed and facing the window. *The back of her hands and some fingers were swollen. *She did not know when that started but stated it was not painful. Review of resident 3's the electronic medical record (EMR) revealed: *An admission diagnosis on 2/1/24 of "acute	F 684		

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F 684	Continued From page 14 diastolic (congestive) heart failure." *Physician orders started on: -2/5/24 for Lasix oral tablet 40 mg (diuretic or fluid pill). -2/20/24 for "apply edema wear stockinette's [sic] on in am [morning] and off at HS [night] per OT [occupational therapy]." *The progress notes from admission on 2/1/24 to 2/28/24 did not include a type related to skin observations. Review of the user defined assessment (UDA) list in the EMR for resident 3 revealed: *The "cardiovascular" section of the "skilled charting" assessments noted: -On 2/26/24 and 2/27/24, "moderate pitting" edema [swelling] was present on the "LE" [lower extremity]. -On 2/28/24, the same level of edema was present on the "RLE" [right lower extremity]. -There was no documentation related to the edema in resident 3's hands. *There were no assessments in the UDA list with a description related to those skin conditions. Observation and interview on 2/28/24 at 4:35 p.m. with registered nurse O revealed: *She confirmed resident 3's hands looked like they had edema. *She had "not noticed it in the morning" when she took care of resident 3's right lower leg. *The edema in her hands had "not been reported during the morning shift report." *She would alert director of nursing (DON) B so she can "take a look". Review of the provider's "Pressure Injury Prevention Policy" effective 5/1/22, revealed: *"When a CNA [certified nursing assistant] is	F 684	F684 cont. 4. The DON or designee will randomly audit skin assessments for 6 residents. Audits will be weekly for four weeks, biweekly for 2 weeks and then monthly for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, and revision of audits based on findings.	

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F 684	Continued From page 15 providing routine care, they will monitor the skin conditions of the resident." *"If an abnormal condition is found, they will notify the charge nurse immediately." *"Each resident will receive a full body skin inspection upon admission within 8 [eight] hours, once a week by the charge nurse." *"Findings will be documented in the progress note section of the medical record." *"Weekly wound assessment will be documented using the "WOUND - WEEKLY OBSERVATION TOOL in PCC [point click care - an EMR software program]." Interview on 2/29/24 at 9:13 a.m. with DON B revealed: *The "Pressure Injury Prevention Policy" was the only policy that had procedures related to skin inspections. *The "Skin/Wound" progress note was what the staff should have used to document observations during skin inspections. Interview on 2/29/24 at 3:38 p.m. with DON B revealed: *Edema should be addressed in the "skilled charting" UDAs. *After the skilled stay had ended, edema should be noted in weekly skin/wound progress notes. *Nurses should reference the previous week's skin/wound progress note to address the status of previous skin observations. 2. Observation and interview on 2/27/24 at 3:39 p.m. with resident 16 revealed she: *Was seated in her room in a reclining chair with her feet up. *Had various colors of bruising on both forearms and the right side of her face.	F 684		

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F 684	Continued From page 16 *Knew that some of the bruising on her forearms was when staff "attempted to draw blood." *Was not sure of the reason she had other bruises on her arms but she had not fallen. *Did not know she had bruising on her face. Review of resident 16's EMR revealed: *The 12/30/23 Minimum Data Set (MDS) assessment noted the Brief Interview for Mental Status score was 15, meaning her cognition was intact. *A physician order on 2/14/24 for warfarin sodium 3 milligrams [anticoagulant, a blood thinner]. *A care plan focus initiated on 2/3/21 for anticoagulant therapy with a goal to be free from adverse reactions and interventions also initiated on 2/3/21 that included: -"Daily skin inspection. Report abnormalities to nurse." -"Monitor/document/report PRN [as needed] adverse reactions of anticoagulant therapy:...bruising." *Progress notes included Skin/Wound Notes that documented bruising on: -2/19/24, "Bruising noted to bilateral forearms/hands. -2/24/24, "Bruise to right hand patient says was from blood draw." *Those two notes were the only Skin/Wound Notes in February 2024. The two Skin/Wound notes in January 2024 did not document any bruising. Interview on 2/29/24 at 3:34 p.m. with DON B revealed: *The Skin/Wound Note should have been written every week on the same day as the resident's bath, even if there were no new concerns. *She acknowledged there were some gaps in	F 684		

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F 684	Continued From page 17 weekly documentation. *She confirmed the nurse writing the note should look at the previous note to address the status of all previously documented skin concerns.	F 684	F 689 Elopement - Immediate Jeopardy 1. Immediate Jeopardy was removed on 2/28/24. Resident 22's care plan and Treatment Administration record has been updated to reflect current interventions regarding keeping resident in a secure physical environment with adequate supervision to minimize the risk of an unwitnessed elopement. Wander Risk assessment was completed on 3/21/2024. 2. All residents have the potential to elope. 3. Residents will have a wandering risk assessment completed upon admission to identify if they are an elopement risk or if have a known history of elopement. If assessment identifies risk the resident will be assessed quarterly and with any significant change of condition. If a resident has an elopement a wandering risk assessment will be completed with each event. Any resident identified to be a risk will have care plan interventions that have been identified as high risk to reflect monitoring, triggers, redirection, etc. Care plans will be reviewed if an incident occurs, quarterly and with any significant changes.	3-28-2024
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on review of a South Dakota Department of Health (SD DOH) Required Healthcare Facility Event Reporting, record review, observation, interview, and policy review, the provider failed to provide a secure physical environment and adequate supervision to minimize the risk of an unwitnessed elopement by one of one sampled resident (22). Findings include: 1. IMMEDIATE JEOPARDY NOTICE Notice of immediate jeopardy was given verbally and in writing on 2/28/24 at 9:36 a.m. to administrator A for F 689 Accidents related to physical environment and adequate supervision to prevent unwitnessed elopement: *On 2/21/24 at 4:24 p.m., the provider submitted a SD DOH Required Healthcare Facility Event Reporting, that reported resident 22 had left the	F 689		

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F 689	Continued From page 18 building unwitnessed on 2/19/24 while staff were getting other residents into the dining room for the evening meal. Resident 22 was last seen by staff at 4:15 p.m. A visitor reported having seen a female "with exact description of what resident is wearing...near the grocery store up town." At 5:20 p.m., a certified nursing assistant (CNA) located resident 22 "near the school and brought her back." The provider's conclusion noted: -"Resident will not keep wanderguard on." -"Front door is locked and needs code/magnet to open door." -"FRONT DOOR WAS NOT LOCKED PRIOR TO THIS ELOPEMENT AS RESIDENT WAS UTILIZING WANDERGUARD. WANDERGUARD BECAME INEFFECTIVE AS RESIDENT CUT IT OFF BETWEEN STAFF CHECK." *Review of resident 22's electronic medical record revealed two additional elopements occurred on 2/1/24 and 2/13/24. Her care plan was revised on 10/11/23 stated, "Identify pattern of wandering. Intervene as appropriate." There were no specific interventions for the frequency of supervision. The care plan was not updated to address a change in the location of the WanderGuard bracelet from resident 22's left wrist to the left ankle. The only Kardex intervention stated, "WanderGuard bracelet left wrist." *Interview with director of nursing (DON) B revealed the only intervention change that was implemented since the incident on 2/19/24 was to keep the front door locked. However, observation on the afternoon of 2/27/24 and the morning of 2/28/24, and a further interview with DON B revealed the front door was not always locked.	F 689	F 689 Elopement cont. Initial elopement education was completed to all staff on 2/28/2024 that were present during survey all remaining staff that have worked a scheduled shift have been educated as of 3/4/2024. Missing person/elopement policy has been reviewed and revised in collaboration with the medical director, administrator, DON, and interdisciplinary team that includes roles and responsibility for all staff about ensuring resident safety when identified as an elopement risk. The revised policy has been circulated to all staff via payroll on 3/27/2024 for in-house staff and put in the travel binder with sign in sheet for travel staff. Those not on the schedule to receive a paycheck due to vacation, illness or casual work status will be educated upon their return of their next shift worked. 4. DON or designee will audit residents that are high risk for elopement to ensure that no elopement has occurred, wander risk assessment completed per facility requirement, and to ensure interventions, monitoring, triggers, and redirection tactics are included in the care plan. Audits will be weekly for four weeks, biweekly for 2 weeks and then monthly for three months.	

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F 689	Continued From page 19 *Interview with buildings manager (BMgr) F revealed the exit doors at the end of the North and West resident hallways had door alarms when the doors were opened, but they did not have the magnetic lock system for WanderGuard bracelets. All of the other exit doors, including the front door, had the wander alert magnetic lock system but would only function when there was the presence of a WanderGuard bracelet. He checked the functioning of the door alarms weekly. He also checked the functioning of resident 22's WanderGuard bracelet when he accompanied resident 22 out the east service exit for smoke breaks. *The provider's undated Missing Resident/Elopement Policy had not been followed for the following: -Assessment: "1. A Wandering Risk Scale assessment is completed on admission, quarterly, and upon change of condition." The previous assessment completed for resident 22 was quarterly on 12/14/23. No assessment had been completed since her elopement on 2/19/24. -Prevention: "1. Interventions that may be used for residents identified as high risk for elopement include: a. Frequent monitoring of the resident's whereabouts to assure he or she remains in the facility (e.g., every one-half hour checks)." -"g. Environmental controls: "The facility is secured to minimize the risk of elopement through: (a) functional alarm system, (b) safety locks or key-pad entry." - "4. Prevention strategies are listed on each resident's plan of care and reviewed...on at least a quarterly basis or with a change of condition." Resident 22's care plan did not specify a frequency for monitoring her location or any specific interventions or strategies.	F 689	F689 Elopement cont. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings. F 689 Falls 1. Resident 3 is no longer a resident. 2. All residents have the potential to have falls that are not thoroughly investigated to find a correlation between meeting the resident needs and timing of the falls. 3. Fall investigations will be completed with every fall that is documented in Risk Management to identify correlations with falls related to resident needs. The Position Change Monitor policy and the Fall policy have been reviewed and revised in collaboration with the medical director, administrator, DON, and interdisciplinary team that includes roles and staff responsibility, the required documentation needed to accompany a fall and fall investigation. This will be provided to all staff by 3/28/2024.	3-28-2024

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F 689	Continued From page 20 IMMEDIATE JEOPARDY REMOVAL PLAN On 2/28/24 at 12:46 p.m., administrator A provided the survey team with a written plan for the removal of the immediate jeopardy. The removal plan was approved by the survey team at 12:55 p.m. *"Resident 22 has not left the facility unattended since 2/1/24. WanderGuard has been placed on left ankle. The nurse will confirm location of WanderGuard 4 [four] times a day. If the WanderGuard is not on person, WanderGuard will be found and placed on the person if [sic] unable to find then a new one will be put on the person immediately. Interventions have been updated and nursing will have to verify resident location in the facility every 2 [two] hours for 2 weeks and then every 4 hours for the entirety of Resident 22's stay at the facility. The care plan has been updated regarding the WanderGuard but does not specify location as the nurse is required to specify 4 times per day where the WanderGuard is located on Resident 22's body. The Kardex intervention will not state the location of WanderGuard as above." *"Specific interventions have been established to include nurse to verify where abouts [sic] of Resident 22 every 2 hours for 2 weeks than [sic] every 4 hours. WanderGuard placement will be verified by the nurse 4 times per day. The front door will remain locked at all times until resident 22 is no longer ambulatory or alternative placement has been established. Magnetic locks have been ordered for the West and North exit doors to ensure that Resident 22 cannot leave the facility unattended. Until magnetic locks are in operation of the West and North doors staff [sic]	F 689	F689 Falls cont. Those not on the schedule to receive a paycheck due to vacation, illness or casual work status will be educated upon their return of their next shift worked. 4. The DON or designee will audit fall investigations for 5 random residents a month. Audits will be weekly for four weeks, biweekly for 2 weeks and then monthly for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	

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F 689	Continued From page 21 will respond to any and all alarms by going to the door, verifying if a resident is out of the facility while another staff completes resident head count to verify all residents are in the facility. The elopement policy will be followed if a resident leaves the facility." *"Facility interventions will be 1. Weekly door alarm checks that are monitored by maintenance personnel or designee and documented, results will be reviewed monthly at QAPI [quality assurance performance improvement] for 6 [six] months then quarterly. 2. Elopement drills will be completed monthly by maintenance or designee to ensure staff know the process. The Elopements drills will alternate shifts to ensure that all staff have been through a drill. Education will be conducted after each drill to verify understanding and discuss things that could have gone better. Elopement drill results will be brought to QAPI by maintenance personnel or designee monthly for 6 months then quarterly. 3. Director of Nursing or designee will report education of staff, verification of resident and wander guard to QAPI Monthly for 6 months then quarterly. Director of Nursing or designee will perform audits to ensure wander guard is on Res [resident] 22 and that charge nurse if [sic] verifying location of resident weekly X4 [times 4] weeks, biweekly for 1 month, monthly for 6 months. All staff working 2/28/24 will be educated regarding elopement policy, Exit door alarm policy, new interventions of Resident 22 to keep her safe, and that the front door will remain locked at all times as above. All staff will be educated upon next shift worked by DON or administrator. All new staff will be educated during orientation by HR [human resources] personnel or designee. Agency staff will be	F 689		

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F 689	Continued From page 22 educated by initialing the education provided in the Travel Agency Education Binder and verified by Director of Nursing or designee. " *"All audits , drills, and door alarm checks will be evaluated after 6 months by the QAPI committee to determine if audits will need to continue, cease or change in frequency." Administrator A also provided a copy of a quotation received on 2/28/24 for 2 units of a "Dynalock Maglock" system. Administrator A stated that was for installation on the north and west doors. On 2/28/24 at 2:30 p.m., the survey team determined the immediacy was removed. After removal of the immediacy, the severity and scope was a level D. 2. Observation and interview on 2/27/24 at 1:13 p.m. with resident 22 revealed she: *Walked about independently without assistive devices in the hallway from her room to the television lounge area outside of the dining room and then to the seating area in the lobby between the front entrance door and the nurse's desk. *Provided incomplete phrases and mixed thoughts when asked questions about how her day was going or about her interactions with staff and other residents. *Had a pleasant look on her face and periodically reacted to the surroundings with laughter and a partial statement. *Did not respond when asked what she had found funny. Review of resident 22's the electronic medical record (EMR) revealed:	F 689		

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F 689	Continued From page 23 *A physician diagnosis dated 9/15/23 of "unspecified dementia, unspecified severity, with anxiety." *A care plan focus was initiated on 10/11/23 for "elopement risk/wanderer r/t [related to] cognition and mobility," with the interventions initiated on 10/11/23 to: -"Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate." -"WANDER ALERT: left wrist." *The 12/9/23 quarterly Minimum Data Set (MDS) assessment coded her mental status was moderately impaired, wandering had occurred one to three days, and a "wander/elopement alarm" had been used daily. *A 12/13/23 "Wandering Risk Scale" assessment coded her as "high risk to wander" with a mental status as "can follow instructions" and communicate, a history of wandering, and "had no reported episodes of wandering in the past 3 months." Review of resident 22's progress notes in the EMR revealed: *On 12/14/23, a "Plan of Care Note" stated she will "state that she is leaving, when asked where she is going states 'to Wilmot.' She goes out with the group to smoke at each smoke break. She spends much of the time in the lobby daily visiting with the other residents. Much of her conversation is very difficult to understand and often makes little sense." *On 12/16/23 at 10:34 a.m., a "Behavior Note" stated she had been "wandering around and calling sister and brother over and over to pick her up." *On 12/21/23 at 12:09 p.m., a "Health Status	F 689		

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F 689	Continued From page 24 Note" stated she was "missing her wander guard. Device was found in her room." *On 12/31/23 at 4:01 p.m., a "Behavior Note" stated she "wrote a note to 'boss man' about loving her two sons, the rest was unable to interpret. After she handed it to the nurse she headed straight to the door and held emergency exit and went outside. Staff followed her and convinced her to come back. She came back in tears." *On 12/31/23 at 10:38 p.m., an "Incident Note" stated she "had been sitting up at the nurse's station visiting with other resident's [sic]. She said goodbye and headed down the hall towards her room. Moments later alarm went of [sic] at west hall emergency exit. Resident found walking across the parking lot towards the road." *On 1/1/24 at 2:56 p.m., a "Behavior Note" stated she "walked out the front door, staff redirected her back in the facility." *On 1/1/24 at 6:40 p.m., a "Behavior Note" stated she "left the table before being served. She starting walking fast toward the front exit. Nurse stopped her...She wanted to walk to her brothers house." *On 2/1/24 at 6:01 p.m., a late entry "Alert Note" stated "Night nurse arriving to work and seen resident walking at the end of the parking lot. Nurse escorted her back to the facility. Wanderguard alarm did not sound when she had left. CNA found wanderguard alarm in her room. Unable to locate device in which resident had used to cut off." *On 2/5/24 at 5:39 p.m., a "Behavior Note" stated she "attempted to leave out the front door and set alarm off. Staff redirected her. She said, 'I want to go out!'" *On 2/13/24 at 3:30 p.m., a late entry "Behavior Note" stated she "was seen exiting the building	F 689		

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F 689	Continued From page 25 when family of another resident was leaving. AL [assisted living] resident hollered out that she walked out the door. No alarm sounded as res [resident] had cut off her wander guard again. Writer went out to get resident and walked with her to the end of the block and back." *On 2/19/24 at 5:07 p.m., an "Alert Note" stated "staff were getting residents into dining room and noticed resident was not in her room. Residents [sic] neighbors [sic] daughter came to writer stating she seen a lady that looks like her moms [sic] neighbor with exact description of what resident is wearing near the grocery store up town. Writer sent CNA to go out and look for resident." *On 2/19/24 at 5:20 p.m., an "Alert Note stated "CNA located resident near the school and brought her back to WCC [Wilmot Care Center]." Resident stated, "I was looking for my folks." Interview on 2/27/24 at 1:59 p.m. with social service designee (SSD) D revealed: *Resident 22 had walked out the front door with someone and that had happened a couple of times. *She "cuts here WanderGuard off." *SSD D had been trying to figure out how to incorporate a chain so that resident 22 would not be able to cut the WanderGuard bracelet. *Resident 22 was "usually looking for her brother" and "had some awareness of where he lives. It is pretty hard to get lost in Wilmot without someone noticing." *She had "never tried to go out any other door than the front door." *Staff "check placement" and the presence of resident 22 "frequently. We almost cannot let her out of sight." *The "front door is locked now all the time. It was not locked before because we are not a locked	F 689		

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F 689	Continued From page 26 facility." Interview on 2/27/24 at 2:20 p.m. with licensed practical nurse (LPN) I revealed: *She had worked for the provider full-time for about a year, and on and off for about 10 years. *When asked what an elopement risk factor for a resident would be, she replied that MDS coordinator C completed the elopement risk assessments. *When asked how she or others would know what interventions or assistance a resident needed, she stated that it was "a small facility, we report together." *She further explained verbal reports were provided when staff members started their shift, that included ADL support and wandering risk. *When asked if there were certain residents as risk for unsafe wandering or elopement, she asked if she could "look at my list of residents." She then reported there were seven residents with unsafe wandering and three of those resident's would go out of the building. When asked about the door alarms, she explained a "wanderguard will alarm the back door. The front door will lock if a wanderguard is close to it and if the door is open it will alarm. The front door is always locked." *She explained that resident 22's Wanderguard "was in place before the elopement," but she "cut off her wanderguard." It was replaced and positioned "in a different spot" than the last location. *It was a "busy time" of the day. We "investigated after being informed that she was seen downtown." *"Every shift is checking placement of the wanderguard," and "the doors are now locked."	F 689		

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F 689	Continued From page 27 Interview on 2/27/24 at 2:38 p.m. with BMgr F revealed: *All of the exit doors have an alarm when the door was opened. *All of the doors, except the north and west resident hallway exit doors, have a "mag lock" that will alarm if a Wanderguard comes close to it. *When a door alarm goes off, the location would come up on the call light system at the nurse's desk. That included the front door. *The north door and west doors do not have "mag lock" on them, but they do have an alarm that would go off if the doors were opened. *The doors without a mag lock were locked from the outside. *He tested the functioning of the wander alert bracelets once a month. *Resident 22 must have "walked out with some other people." *Cleaning staff have found resident 22's wander alert bracelets in various places. One of them was now completely missing. *He verified resident 22's bracelet was working and in place when she came close to the smoking exit door on the east service wing. Interview on 2/27/24 at 2:52 p.m. with CNA H revealed: *She was a traveling CNA and had only worked for the provider twice. *She would learn about the needs of residents during a report at the start of her shift and by looking in the computer. *Two residents would set-off an alarm when they were close to the door, including resident 22. *There was a code for entering the building by east service door and a different code for turning off a door alarm when a resident would set it off.	F 689		

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F 689	Continued From page 28 Interview on 2/27/24 at 3:20 p.m. with LPN I revealed that the front door was "locked at all times," the north door and the west door were not locked but would alarm if the doors were opened. Observation and interview on 2/27/24 at 5:30 p.m. when testing staff response to the alarm at the west exit door revealed: *CNA G responded in less than one minute after the alarm sounded when the west door was opened. *He reported that he had been in a resident's room at the other end of the west hallway. *He received an alert on the call light phone he carried with him while working. *LPN I then arrived. She explained she had come to "check if someone had responded to the door alarm." Observation on 2/27/24 at 6:11 p.m. revealed: *Resident 22 was sitting on a bench in the lobby located between the front entrance door and the nurse's desk. *Two staff were sitting and conversing with each other at the nurse's desk. *A green light was displayed on the door locking system above the door. *Upon testing if the alarm would sound when the door was opened, the alarm did not go off. *The staff at the desk did not respond to the door that was being opened. *Resident 22 watched but did not move towards the door. Interview on 2/28/24 at 7:53 a.m. with DON B revealed: *Since resident 22's elopement on 2/19/24, the only different intervention was that they "keep the	F 689		

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F 689	Continued From page 29 front door locked." *When asked about the care plan regarding the frequency of monitoring her location, she responded, "She is usually hanging around out here. She tends to watch for groups of people by the front door and attempts to go out with them." *"The last time she went out she had been in isolation for COVID." *"Staff check placement of wander alert bracelet once a day," and it was "recorded on TAR [treatment administration record]." *"Maintenance checks the functioning of the door alarms weekly." *The "front door is unlocked now because of the door malfunction," but resident 22 "cannot push the door open herself because it is too heavy." Review of the January and February 2024 TARs revealed "WanderGuard for wandering check daily for flashing light, every shift left ankle" had been documented every shift as completed. Interview on 2/28/24 8:06 a.m. with DON B revealed: *When the light on the door locking system above the front door was red it is "locked" and "green is unlocked." *"We usually lock them at 6:00 p.m." *When asked "When are they unlocked and by whom?" she responded, "We lock them at night just for safety" and referred to the "crazy things that could go on in Wilmot" at night. Review of the resident 22's care plan on 2/28/24 revealed the focus of "elopement risk/wanderer r/t cognition and mobility" had been revised with additional interventions: *"Distract resident from wandering by offering pleasant diversions, structured activities, food,	F 689		

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F 689	Continued From page 30 conversation, television, book. Resident prefers: going out to smoke, calling her brother or sister, drinking coffee or capacino [sic] and going outside for a walk." *Monitor location every 2 hours for 2 weeks than [sic] every 4 hours while she resides in the facility. Document wandering behavior and attempted diversional interventions in behavior log." *"Provide structured activities: toileting, walking inside and outside, reorientation strategies such as smoking, sitting in common areas, visiting with staff, activities. *"The resident's triggers for wandering/eloping are not specific, she has random and frequent thoughts of wanting to go home or travel. The resident's behaviors is [sic] de-escalated by redirecting, telling her the weather is not suitable to leave right now, calling her brother and sister, going to activity or getting her a cup of coffee/capacino [sic]." *"WANDER ALERT: wander guard will be worn at all times. If [resident 22] removes wander guard it will be immediately replaced." Review of the provider's undated policy, "Exit Doors Alarm System," revealed: *"Procedure: The alarm sounds each time a door that has been equipped with the system is opening, thus serving to notify staff that someone has made an exit." *"Six doors have been equipped with alarms: - a. North outside exit door - b. West outside exit door - c. clinic door - d. east inside service door - e. front outside door - f. dining room emergency exit." *"Presently, there are three different systems in use:	F 689		

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F 689	Continued From page 31 - 1. North door, the West door, and the Clinic doors -- a. The alarm is controlled from the Nurse's station -- c. When one of these doors is opened, the buzzer at the Nurse's Station sounds and a light on the monitor indicates which door has been opened. - 2. On the East door and the Front door (faces South) -- a. The alarm is controlled from the computer at the Nurse's station. Alarms are connected to the Android pager system. --b. There is also an alarm that sounds at the door when the door is opened. --d. The East and Front doors are also equipped with the Accu-Tech Wander Guard system. --- i. This system is also connected to the Android pager system through the computer at the Nurse's station. --- ii. A notification will be sent to all staff Androids and an alarm will sound at the door when a resident equipped with a wander guard bracelet enters or exits." B. Based on observation, interview, record review, and policy review, the provider failed to investigate the correlation between meeting the needs of the resident and the timing of the fall incidents for one of two sampled residents (3) who were new admissions. Findings include: 1. Observation and interview on 2/27/24 at 3:10 p.m. with resident 3 revealed : *She was seated in a wheelchair in her room next to her bed and facing the window. *The room light was turned off and no music or	F 689		

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F 689	Continued From page 32 television playing in her room. *The bed was at a lower level than the standard height. *The wheelchair had anti-roll back brakes over the back wheels. *She responded clearly to the questions asked. *She did not respond to how much assistance she needed to complete her activities of daily living (ADLs). Review of resident 3's the EMR revealed: *An admission diagnosis on 2/1/24 of "dementia in other diseases classified elsewhere, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety." *A "Plan of Care" progress note on 2/1/24 at 4:03 p.m., the first one in resident 3's record, that stated she "had been in the hospital and went to her son's home where she was having multiple falls. Son was working and unable to care for her during the day." *Physician orders started on 2/2/24 for: -"Antiroll back bars to be placed on wheelchair." -"Fall alarm to be placed on bed and wheelchair at all times." *The list of user-defined assessments completed since resident 3's admission: -Did not include a physical restraint assessment. -A Morse Fall Scale assessment was completed on 2/8/24 that noted a history of falling, impaired gait, and she "overestimates or forgets limits." *The 2/8/24 admission MDS C coded: -Moderately impaired for her mental status. -Dependent on staff for toileting and substantial/maximal assistance to transfer. -Always incontinent of urine and occasionally incontinent of bowel. -Two or more falls since admission with no	F 689		

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F 689	Continued From page 33 injuries. Review of resident 3's progress notes in the EMR revealed on: *2/1/24 at 7:00 p.m., "resident sitting on her bottom on the floor in front of the bathroom. Resident was knocking on the door for help...new admit this day and is noted to be mildly confused....reoriented to call light system... Writer cannot confirm understanding." *2/2/24 at 3:57 p.m., "Found resident on the bathroom floor." *2/3/24 at 1:04 p.m., "Refused personal cares this morning. She denies needing help with task." *2/3/24 at 9:57 p.m., "Another resident came and got this writer...alarms are in place and going off...found sitting on her buttocks right inside her room door...resident states 'I fell.'" *2/4/24 at 3:11 a.m., "Does not use call light, has a pressure alarm in bed and in w/c [wheelchair]." *2/4/24 at 11:44 a.m., "Reminded resident that she needs to call for help when standing or transferring, resident is upset with that." *2/5/24 at 11:44 a.m., "Caught her self transferring herself to the toilet." *2/6/24 at 6:06 a.m., "Sitting on the edge of the bed trying to get up several times since 0230 [2:30 a.m.], bed alarm has alerted staff to this." *2/8/24 at 2:38 a.m., "Has covid [sic] and is in isolation for this...using video monitoring in her room at present, she is able to let staff know what she needs, toileting, a drink..." *2/9/24 at 4:28 a.m. and 2/10/24 at 4:49 a.m., "Is not able to make wants and needs known...Does not use call light for assistance. Check/[and] change Q2H [every two hours] and as needed." *2/11/24 at 1:03 a.m., "Is able to make needs known...does not use call light." *2/12/24 at 12:52 a.m., "awake and sitting on the	F 689		

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F 689	Continued From page 34 edge of her bed so far tonight." *2/16/24 at 2:40 a.m. and 2/19/24 at 3:57 a.m., "able to communicate her wants and needs...does not use call light." *2/20/24 at 9:52 p.m., "Found her on the floor in the BR [bathroom]. Plan: Will try to keep resident in the lobby until staff can assist her with cares." *2/22/24 at 4:53 p.m., "Fell on right side off bed onto floor mat. Bed low position. Fall in room. Bed alarm sounding." Review of the "Fall" incident investigations on 2/1/24, 2/2/24, 2/3/24, 2/4/24, 2/20/24, and 2/22/24 revealed: *All of the falls were unwitnessed. *None of the "predisposing situation factors" section documented the last time staff had contact with the resident and what wants or needs were addressed. Review of ADL documentation on the days for the falls noted above revealed only one-time entry was documented each day for the activities of "Chair/Bed-to-Chair Transfer," "Toilet Transfer," and "Toilet Hygiene." Review of resident 3's care plan revealed: *A focus initiated on 2/27/24, "The resident has had an actual fall with no injury. Poor communication/comprehension unknown origin." *The interventions for that focus included: "bed/chair alarm, room close to nurses station, video monitor, bed in low position with fall matt on floor while resident in bed." *A focus initiated on 2/28/24, "The resident is High, risk for falls r/t dementia." *The interventions for that focus included: -"Anticipate and meet The [sic] resident's needs." -"Be sure The [sic] resident's call light is within	F 689		

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F 689	Continued From page 35 reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." Interview on 2/29/24 at 11:32 p.m. with MDS coordinator C regarding the intervention to "anticipate and meet" resident needs revealed he agreed the intervention should be more specific to address the potential risks related to falls. Interview on 2/29/24 at 1:32 p.m. with CNA/UMA J, who was also an unlicensed medication assistant and restorative therapy assistant, revealed: *The chair and bed alarms used for resident 3 were audible. *Resident 3 did not "seem to even be aware it is sounding." *"Usually [the chair alarm sounded] when she is attempting to use the bathroom." *She "doesn't recognize the need for help." *The CNAs are "supposed to document each time toileting occurs, but the first time someone documents, the button turns green." *CNA J knew there was another resident that the computer displayed the need to document every two hours, and "that could be done" for resident 3. Interview on 2/29/24 at 3:54 p.m. with DON B revealed: *The care plan to "anticipate and meet" the resident's needs was vague. *The documentation on the fall incident investigations did not correlate the provision of ADLs to meet the resident needs related to the timing of the falls. *The provider's fall policy did not address investigating that factor.	F 689		

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F 689	Continued From page 36 *The provider's position changing monitors policy was not followed. Review of the provider's "Fall Policy," updated on 12/17/20, revealed: *"13. The Charge Nurse will review and update the Care Plan as needed." *"14. The resident's fall will be discussed with the interdisciplinary team to gather information and implement necessary interventions to prevent falls." *"15. The online PCC [point click care - a software program] incident report and investigation follow-up form will be reviewed and signed by the Administrator and Director of Nursing." *"18. The nurse is to chart in PCC under RISK MANAGEMENT." -"d. Factors: Check all that apply." Review of the provider's "Position Changing Monitors Use Policy," updated on 7/3/20, revealed: *"Policy: Position changing monitors are used to notify staff when a resident has exited his/her chair or bed." *"Guidelines: A Positioning Changing Monitor is considered a physical restraint if/when the resident is afraid to move to avoid setting off the position changing audible alarm." *Procedure: -"1. Resident will be assessed for falls risk." -"2. When using audible position changing alarms a [sic] Physical Restraint Assessment will be completed." -"Position changing monitor may be initiated by nurse --"After completed falls assessment and physical restraint assessment (for audible alarms) show	F 689		

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F 689	Continued From page 37 monitor to be an appropriate intervention AND --"After care plan has been revised to include position changing monitor."	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on the South Dakota Department of Health facility reported event, interview, record review, and policy review, the provider failed to correctly administer medication according to the physician's order and per facility policy for one of one sampled resident (28). Findings include: 1. Interview and review of the South Dakota Department of Health facility reported event form on 2/29/24 at 8:02 a.m. with director of nursing (DON) B revealed: *Resident 28 was discharged from the hospital on 2/26/24 at 11:00 a.m. and received his warfarin 5 milligram (mg) tab before his discharge. The hospital had the resident's warfarin scheduled for noon. *Licensed practical nurse (LPN) L received the resident's warfarin delivery from the pharmacy at approximately 6:20 p.m. on 2/26/24. *LPN L placed the resident's medication bubble cards in the medication cart without reviewing the medication bubble card with the current physician's orders. *The resident's warfarin was labeled with a p.m. sticker from the pharmacy because the provider normally administered warfarin in the evening. *The medication administration record (MAR) had	F 760	F 760 1. No new medication errors have been identified for resident 28. 2. All residents have a right to be free from significant medication errors. 3. Medication error policy will be reviewed with nurses and UMA's prior to 3/28/2024. Those not on the schedule due to vacation, illness or casual work status will be educated upon their return of their next shift worked. 4. The DON or designee will randomly audit 5 residents per month to ensure a medication error has not occurred by comparing the MAR to the Medications in the cart. Audits will be weekly for four weeks, biweekly for 2 weeks and then monthly for three months. Results of these audits will be discussed by the DON/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	3-28-2024

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F 760	Continued From page 38 the warfarin scheduled to be administered at noon. The warfarin 7.5 mg dose was to be given on Tuesdays and Saturdays. The warfarin 5mg dose was to be given on Mondays, Wednesdays, Thursdays, Fridays, and Sundays. *LPN L administered the warfarin 7.5 mg on the evening of Monday 2/26/24 that was scheduled to have been administered on 2/27/24 at noon. *The administration of the warfarin 7.5 mg dose was not documented on the residents MAR. *DON B stated that when LPN L was interviewed, she admitted that she had not followed the "five rights" of medication administration (The "five rights" of medication administration include the right patient, the right medication, the right time, the right dose, and the right route). *The DON's expected that the nurse should have followed the "five rights" of medication administration. *All medications for new admissions should have been checked against the MAR for accuracy. *On 2/27/24 during the noon medication pass, certified nursing assistant/unlicensed medication assistant CNA/UMA J noticed that the scheduled dose of warfarin 7.5 mg for 2/27/24 was missing. CNA/UMA J then administered the dose scheduled for Saturday 3/2/24 without consulting the nurse and resident 28 received an additional dose of warfarin 7.5 mg. *After CNA/UMA J administered the warfarin 7.5 mg dose, she went to question if she should have given the dose with the charge nurse. *The charge nurse reported the medication discrepancy to DON B, and upon further investigation, discovered that resident 28 had received two doses of the warfarin 7.5 mg. *DON B notified the resident's physician who ordered to immediately draw a protime (PT) and international normalized ratio (INR). (A blood test	F 760		

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F 760	Continued From page 39 that tells you how long it would take for your blood to clot). *The blood work was obtained, and Resident 28 was monitored for bleeding for the next "24-48" hours. *Results received on 2/27/24 at approximately 3:00 p.m. the PT was 30.8 and the INR was 3.0. (The therapeutic range for people taking warfarin was INR of 2.0 to 3.0) *Resident 28's physician was notified of the laboratory results and the physician ordered the resident's next scheduled warfarin 5mg dose was to be given on 2/28/24. Interview on 2/29/24 at 10:32 a.m. with CNA/UMA J and DON B revealed: *She admitted that she should have questioned the missing dose of warfarin with the nurse before she administered that dose. *DON B was able to provide training documentation for CNA/UMA J. Review of the provider's undated Administration General Guidelines policy revealed: *Medication administration staff should always consider the rights of medication administration to include the right resident, the right medication, the right dose, the right route, and the right time. Compare the MAR with the label packaging for accuracy check. *The authorized personnel who prepared and administered the medication were then responsible for recording the administration of the medication on the appropriate record. *If a medication aide was administering medications, he/she must discuss differences with the licensed nurse on duty before administration of that medication to ensure the medication was correct.	F 760		

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

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F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure sufficient dietary training for four of five sampled dietary services employees' (P, R, S, T). Findings include: 1. Observation and interview on 2/27/24 at 11:16 a.m. with cook P revealed: *She was working in the kitchen alone with no supervision. *She stated that she had not completed any dietary training. *She had only been working at the facility since 1/9/24. *She stated she only observed other cooks in the kitchen before cooking by herself.	F 802	F802 1.Dietary employees G, H, and I will be trained on the required dietary subjects including food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation requirements by 3-15-2024. Employee J no longer works for the facility. 2. All current dietary employees completed annual required dietary subjects by 3-15-2024 with an in-person training and they will also be encouraged to take an on-line food-handlers course. Certified Dietary Manager (CDM) will update Dietary Department Orientation policy to include the nine (9) required subjects to be completed within thirty (30) days of hire and then annually. 3. Human Resource (HR) manager will audit Orientation dietary department education to ensure completion within thirty (30) days of hire and CDM will audit annual education completion on a monthly basis. HR manager and CDM will report initial findings at the March QAPI meeting and then quarterly for 1 year or until committee recommends completeness.	3-28-2024

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F 802	Continued From page 41 Review of employee P, R, S, and T training files revealed there was no documentation of dietary training for the following topics: food safety, handwashing, food handling/prep, foodborne illness, serving/distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation. Interview on 02/29/24 at 1:34 p.m. with certified dietary manager (CDM) E revealed: *Training for dietary staff included a few days with the dietary manager and observation of kitchen tasks, then new dietary staff would assist the other dietary staff for a few days, and then they would start completing their job with supervision. *They have had some staffing issues including a head cook who was off work for medical reasons. *When asked about specific required dietary training she was unable to provide proof of training for any of the above-mentioned. Interview on 2/29/24 at 3:14 p.m. with administrator A revealed: *Explained that dietary manager E was unable to provide dietary training documentation for the dietary staff. Administrator A stated, "Because she hasn't done it." *Training and orientation had been an issue facility wide. Staff will say to her "I haven't been trained to do this." *She had conducted kitchen audits and had concerns. During one audit she asked why the steam table was cool during mealtime, and when she assisted in the kitchen in the past, she made the observation that she was the only one who had washed her hands. *Agreed that training should have been completed and documented.	F 802		

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F 802	Continued From page 42 *Her expectation would have been that every department should complete their own orientation and training and document it appropriately. *She stated that there was no policy for orientation or training of new staff.	F 802	F 803 1. Cook P was in-serviced on correct serving portions and using correct measuring utensils on 3-15-2024.	3-28-2024
F 803 SS=D	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to have a policy in place for the dietary staff	F 803	2. All cooks will be in-serviced on correct serving portions and using correct measuring utensils by 3-15-2024. CDM will update dietary policy regarding correct serving portions and utensils. 3. CDM or designee will audit in-service training, correct serving portions and use of correct measuring utensils at lunch and supper daily for 1 weeks, ensuring every cook is audited; then 1 random meal daily for 2 weeks; 3 random meals a week for 4 weeks; then 1 random meal a week for 4 weeks and then monthly for 1 year; ensuring all cooks are audited. Results will be discussed at the March Quality Assurance Performance Improvement (QAPI) meeting by the CDM and then quarterly for 1 year or until committee recommends completeness.	

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F 803	Continued From page 43 to follow to ensure the correct serving portions had been used by one of one cook (P) when she prepared the meals for the residents. Findings include: Findings include: 1. Observation and interview on 2/27/24 at 11:16 a.m. with cook P in the kitchen revealed: *There was a menu binder located in the kitchen. -The lunch meal included: one Salisbury steak , one-half cup mashed potatoes, one-half cup of stewed tomatoes, one-half fresh fruit and one dinner roll. *She was performing the duties of the kitchen and cooking by herself. *She stated she had not completed any dietary training. *She had only been working at the facility since 1/9/24. *She had observed other cooks before cooking by herself. *She used a blue-handled scoop to place the mashed potatoes onto a resident's plate. *She was not aware of what size scoop the blue handled scoop was. *The blue handled scoop was a ¼ cup. *She used a perforated serving spoon to serve the stewed tomatoes. *She stated that she did not know the measurement of the perforated spoon, but she tries to fill only half of the spoon to serve the residents. *She stated the dietary manager and registered dietitian were on vacation. 2. Observation and interview on 2/27/24 at 4:29 p.m. during the supper meal with cook Q revealed: *The menu binder was located in the kitchen. -The supper meal included the following: one	F 803		

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F 803	Continued From page 44 hotdog on a bun, a half cup of baked beans, one-half cup of macaroni salad, and one-half cup fresh fruit. *She had been a cook at the facility for six years. *She stated that new cooks observed other cooks for three days before cooking on their own. *She pointed out a poster on the wall in the kitchen that provided the sizes and color of each type of utensil used in serving the resident's their meals. Interview on 2/29/24 at 1:20 p.m. with registered dietitian E about the overall function of the dietary department revealed: *The facility's kitchen prepared food for the residents. *She stated that cook P was a new employee. *She stated that she had not provided any training for cook P besides the 3 days observing other cooks in the kitchen.. *She stated that each new kitchen staff "observe one then do one." *She stated that she would expect that the correct measuring utensils should have been used to serve the resident's meals. Interview on 2/29/24 at 1:27 a.m. with administrator A about the dietary department revealed: *She was aware that no training had been conducted with the newly hired dietary staff. *Her expectation would have been that each resident gets the proper amount of food and the correct measuring utensils were used to serve the resident's food. The provider had no policy or process in place for the dietary staff to use to ensure the correct measuring utensils were used when serving the	F 803		

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F 803	Continued From page 45 residents their food.	F 803		
F 812 SS=D	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 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, and policy review, provider failed to ensure the food storage policy was followed by dating opened food packages in one of one kitchen. Findings include: 1. Observation between 2/27/24 at 9:40 a.m. and 2/28/24 at 3:50 p.m. of the kitchen walk-in refrigerator revealed: *Three blue mugs with water were sitting uncovered. *Four larger mugs under the blue mugs were uncovered and appeared to contain water. *One opened clear bag of a head of lettuce that	F 812	F812 1. All uncovered mugs were emptied and washed before being used again. All undated and spoiled food was thrown away immediately. 2. CDM will in-service all dietary staff on dating all food in the refrigerators/coolers/freezers and procedure for any non-dated, outdated or spoiled food by 3-27-2024. 3. CDM or designee will audit refrigerator and coolers on a daily basis for 2 weeks, then 2x a week for 2 weeks and then weekly for 1 year. CDM will report audit findings of undated and spoiled items at the next QAPI meeting and then quarterly for 1 year or until QAPI committee recommends completeness.	3-28-2024

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F 812	Continued From page 46 appeared to be browning, and had no date on the bag. *Three bags of opened undated celery on the second shelf that had brown leaves. *An opened bag of coleslaw with no date. *A box of onions sitting on the third shelf that appeared to be rotten. *Two twist-tied undated bags of shredded cheese. *A taped undated bag of parmesan cheese. *One-gallon bottle of Kikkoman Soy Sauce with a date of 12/12/22 written at top of bottle and what appeared to be a black mold-like substance on the side of the bottle. *An opened undated bottle of "Best Yet" Cesar salad dressing. *A cracked egg in the brown egg carton. Interview on 2/27/24 at 4:29 p.m. and again on 2/28/24 at 1:30 p.m. with cook Q revealed: *She checked the walk-in in freezer every day for spoiled food. *She stated: -That the onions had been in there for about two months. -The food items that were out of date and spoiled should have been thrown away. -That food items should have been dated when opened. Interview on 2/28/24 2:03 p.m. with dietitian E revealed she: *Stated it was difficult to get food supplies and some of those supplies had come to the facility spoiled. *Would expect that all food items were dated when they were opened and after three days should have been thrown out.	F 812		

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	435119	A. BUILDING _____ B. WING _____	C 02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH ST WILMOT, SD 57279

(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 812	Continued From page 47 Review of the providers September 2021 Food Storage policy revealed "all food should be dated with the date that it was open and expires 3 days later unless it was frozen packaged meat then it expires in 10 days."	F 812		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess for need, obtain a physician order, follow facility policy, and properly install a bedrail for one of one sampled resident (11) to ensure the resident's safety. Findings include: 1. Observation on 2/27/24 at 2:08 p.m. of resident 11's bedrail revealed: *The bedrail that consisted of a base frame that slide under the mattress with support legs that did not touch the floor and was loosely fastened to the bed, so it appeared to wobble while resident was sitting on her bed. *When asked about the bedrail, Resident 11 stated she attached it to her bed by herself and used it to reposition herself and get out of bed. Interview on 2/28/24 at 3:05 p.m. with certified occupational therapist assistant (COTA) M	F 909	F909 1. The bed rail for resident 11 has been removed as it was not intended for her bed that is in the nursing home setting. Resident 11 currently does not have any assist rails on her bed. 2. All residents have a potential for having a bed rail placed on their bed that has not been assessed for need, without physician order, against facility policy, or properly installed to ensure resident safety. 3. Bed rail policy and procedure have been reviewed and revised in collaboration with the medical director, administrator, DON, and interdisciplinary team to ensure the above process is in place for all residents requiring bed rails on their bed. Education will be provided to the nursing staff, therapy staff, maintenance staff by 3-28-2024 to ensure the process and policy are followed. Those not on the schedule due to vacation, illness or casual work status will be educated upon their return of their next shift worked.	3-28-2024

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F 909	Continued From page 48 revealed: *The process for the installation of bedrails was that occupational therapy (OT) or physical therapy (PT) would complete an assessment and they would communicate with the nursing staff to let them know their recommendations. Nursing would then get the physician's order for the bedrail. *OT was unaware that the resident had a bedrail on her bed. *She was not sure if the resident's bedrail was assessed or if there was a current physician's order for the bedrail. Interview on 2/28/24 at 3:10 p.m. with administrator A revealed: *Resident 11 was admitted to the nursing home from the assisted living and used the bedrail while she was in assisted living. *Administrator A stated she was not aware that the bedrail was used by the resident. *She thought that the resident's daughter had put the bedrail on the bed when the bed was moved on 2/25/24. *Administrator A stated that PT was providing therapy five days a week and OT provided therapy three days a week. She was surprised that it was not assessed. Interview on 2/29/24 at 9:34 a.m. with physical therapist assistant (PTA)/director of rehabilitation N revealed: *When residents brought their own bedrails into the facility, nursing would notify PT and they would evaluate the resident's bedrail use and make their recommendations. *Nursing would contact the resident's physician and get an order for the bedrail, then maintenance would install the bedrail, and PT	F 909	F 909 cont. 4. Maintenance will conduct regular inspection of all bed frames, mattresses, and bed rails as part of the regular maintenance program to identify possible areas of entrapment. When bed rails and mattresses are purchased separately from the bed frame the facility must ensure that the bed rails, mattress, and bed frame are compatible. The Administrator or designee will randomly audit 6 resident rooms to ensure that bed rails are or are not in place on the resident bed. If a bed rail is in place, has an assessment been completed, is there a physician's order, the facility policy has been followed, and has the bed rail been properly installed. Results of these audits will be discussed by the Administrator/designee at the QAPI meetings with the IDT and medical director for analysis and recommendations for continuation, discontinuation, or revision of audits based on findings.	

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	435119	A. BUILDING _____ B. WING _____	C 02/29/2024

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WILMOT CARE CENTER INC	501 4TH ST WILMOT, SD 57279

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F 909	Continued From page 49 would evaluate to ensure the resident could use it safely. *She stated that she should have questioned the nursing staff when she noticed the bedrail. Interview on 2/29/24 at 11:00 a.m. with registered nurse (RN) H regarding the process and procedure when a resident brought in their own bedrail. She stated that she would have called the resident's physician to get an order. Interview on 2/29/24 3:00 p.m. with buildings manager F revealed: *When a bedrail would need to be installed, he would receive a request from the nursing staff to install the bedrail. *He stated that he would not install a bedrail without an order from the physician. Review of resident 11's electronic medical record (EMR) revealed: *There was no physician order for a bedrail. *The use of a bedrail was not in resident's care plan. Review of the provider's undated Side Rail policy revealed: *An initial assessment would have been made to determine the resident's symptoms or the reason for using the bedrail. The assessment would have included a review of the resident's bed mobility and ability to transfer between different positions. *The physician was to have been notified. *The use of bedrails would have been addressed in the resident's individual care plan.	F 909		

South Dakota Department of Health

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	10712	A. BUILDING: _____ B. WING _____	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	501 4TH STREET WILMOT, SD 57279

(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 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/27/24 through 2/29/24. Wilmot Care Center Inc was found not in compliance with the following requirement: S301.	S 000		
S 301	44:73:07:16 Required Dietary Inservice Training The dietary manager or the dietitian shall provide ongoing inservice training for all dietary and food-handling employees. Topics shall include: food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration, and sanitation requirements. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, and record review the provider failed to ensure sufficient dietary training for four of five sampled dietary services employees' (P, R, S, T). Findings include: 1. Observation and interview on 2/27/24 at 11:16 a.m. with cook P revealed: *She was working in the kitchen alone with no supervision. *She stated that she had not completed any dietary training. *She had only been working at the facility since 1/9/24. *She stated she only observed other cooks in the kitchen before cooking by herself. Review of employee P, R, S, and T training files	S 301	S301 1. Dietary employees G, H, and I will be trained on the required dietary subjects including food safety, handwashing, food handling and preparation techniques, food-borne illnesses, serving and distribution procedures, leftover food handling policies, time and temperature controls for food preparation and service, nutrition and hydration and sanitation requirements by 3-15-2024. Employee J no longer works for the facility. 2.0 All current dietary employees completed annual required dietary subjects by 3-15-2024 with an in-person training and they will also be encouraged to take an on-line food-handlers course. Certified Dietary Manager (CDM) will update Dietary Department Orientation policy to include the nine (9) required subjects to be completed within thirty (30) days of hire and then annually.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek

TITLE: Administrator

(X6) DATE: 3-21-2024

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
	10712	A. BUILDING: _____ B. WING _____	02/29/2024

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S 301	Continued From page 1 revealed there was no documentation of dietary training for the following topics: food safety, handwashing, food handling/prep, foodborne illness, serving/distribution, leftovers, time/temperature controls, nutrition/hydration, and sanitation. Interview on 2/29/24 at 1:34 p.m. with certified dietary manager (CDM) E revealed: *Training for dietary staff included a few days with the dietary manager and observation of kitchen tasks, then new dietary staff would assist the other dietary staff for a few days, and then they would start completing their job with supervision. *They have had some staffing issues including a head cook who was off work for medical reasons. *When asked about specific required dietary training she was unable to provide proof of training for any of the above-mentioned. Interview on 2/29/24 at 3:14 p.m. with administrator A revealed: *Explained that dietary manager E was unable to provide dietary training documentation for the dietary staff. Administrator A stated, "Because she hasn't done it." *Training and orientation had been an issue facility wide. Staff will say to her "I haven't been trained to do this." *She had conducted kitchen audits and had concerns. During one audit she asked why the steam table was cool during mealtime, and when she assisted in the kitchen in the past, she made the observation that she was the only one who had washed her hands. *Agreed that training should have been completed and documented. *Her expectation would have been that every department should complete their own orientation and training and document it appropriately.	S 301	S301 cont. 4. HR manager will audit Orientation dietary department education to ensure completion within thirty (30) days of hire and CDM will audit annual education completion on a monthly basis. HR manager and CDM will report initial findings at the March QAPI meeting and then quarterly for 1 year or until committee recommends completeness.	3-26-2024

South Dakota Department of Health

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	10712	A. BUILDING: _____ B. WING _____	02/29/2024

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S 301	Continued From page 2 *She stated that there was no policy for orientation or training of new staff.	S 301		
S 000	Compliance/Noncompliance Statement 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 2/27/24 through 2/29/24. Wilmot Care Center Inc was found in compliance.	S 000		

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

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	435119	A. BUILDING _____ B. WING _____	02/29/2024

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E 000	Initial Comments 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 2/27/24 through 2/29/24. Wilmot Care Center Inc was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek
TITLE: Administrator
(X6) DATE: 3-21-2024

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.

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

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	435119	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/28/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMOT CARE CENTER INC	**501 4TH ST** **WILMOT, SD 57279**

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K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/28/24. Wilmot Care Center Inc was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Van Beek

TITLE: Administrator

(X6) DATE: 3-21-2024

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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