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	68077	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSHIRE HURON	1251 ARIZONA AVE SW HURON, SD 57350

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S 000	Compliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted from 8/1/23 through 8/2/23. The Wellshire Huron was found not in compliance with the following requirements: S200, S337 and S642.	S 000		
S 200	44:70:03:01 General fire safety Each facility must meet applicable fire safety standards in NFPA 101 Life Safety Code, 2012 edition. An automatic sprinkler system is not required in existing facility unless significant renovations or remodeling occurs, provided that any existing automatic sprinkler system must remain in service. An attic heat detection system is not required in an existing facility unless significant renovations or remodeling occurs. This Administrative Rule of South Dakota is not met as evidenced by: Based on document review and interview, the provider failed to connect the Ansul fire suppression system in the kitchen hood to the fire alarm system. Findings include: 1. Document review on 8/1/23 at 3:30 p.m. of the fire alarm system revealed the kitchen fire suppression system was not connected to the fire alarm system. Interview with the maintenance director at the time of the above document review on 8/1/23 revealed he believed the kitchen fire suppression system was connected as required. The administrator contacted the fire alarm contractor and confirmed the kitchen fire suppression system was not connected as	S 200	1. On 8/3/2023 the facility Maintenace Supervisor contacted Automatic Building Controls (ABC) to ask them to connect the Ansul system onto the fire panel. ABC reported to him that we first needed to contact our electrician to have electricity installed in the Ansul area so there would be power for the connection. The electrician was contacted on that same day and has ordered the parts to conduct the electrical installation. The connection to this panel will be completed no later then September 15, 2023. 2. The Fire Panel is already included on the weekly TELS (the facility Preventative Mainteance System) to ensure that checks are conducted on this panel monthly. We will add the Ansul system to these fire panel checks. The Maintenance Supervisor/ designee will be responsible for these monthly checks. ABC conducts a yearly check on the facility fire panel system as well and will check the Ansul system on their yeary checks. 3. The Maintenance Supervisor will report on the weekly fire panel checks for 3 months at the monthly QAPI meetings to ensure the newly installed Ansul system is operating appropriately. The Maintenance Supervisor is responsible for overall compliance.	9/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laurie L. Solem
TITLE: Administrator
(X6) DATE: 08/17/2023

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S 200	Continued From page 1 required. This deficiency affected one of numerous kitchen hood fire suppression system requirements.	S 200		
S 337	44:70:04:11 Care policies Each facility shall establish and maintain policies, procedures, and practices that follow accepted standards of professional practice to govern care, and related medical or other services necessary to meet the residents' needs. This Administrative Rule of South Dakota is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the following: *Hospital discharge instructions had been implemented and followed for the care of an indwelling pleural catheter (tube inserted into the space between the lungs and the chest wall to drain fluid) for one of one sampled resident (2). *Documentation and nursing assessments related monitoring and dressing changes for one of one sampled resident's (2) pleural catheter care had occurred consistently. Findings include: 1. Observation and interview on 8/1/23 at 12:40 p.m. with resident 2 in her room revealed: *She had moved into the facility about three months prior. *She reported having concerns with breathing in the past and indicated she utilized an inhaler and nebulizer treatments regularly. *She also reported having a PleurX drain (indwelling pleural catheter) in her right rib cage area.	S 337	1. Resident 2's care plan was updated on 8/3/23 to include Pleurx Drain instructions including monitoring site for signs & symptoms of infection and for assessing for respiratory distress. 2. All other resident care plans and MARs/TARs will be reviewed by the Director of Nursing (DON) /designee by 8/18/2023 to ensure they are up to date, accurate, and free from missing documentation. 3. The DON will provide education to Wellshire Nurse Manager B. and all other facility nurses by 8/24/2023 on the updated Facility "Resident Care Plan Policy" and the "Charting and Documentation Policy" to ensure that all care plans are reviewed and updated on admission, change of condition, quarterly, and annually, to ensure they include interventions for all medical treatments; on ensuring that documentation is completed on all physician orders - including orders on dressing changes. 4. Audits will be conducted by the DON/designee on resident 2 and 3 random resident care plans and their MARs/TARs weekly for 4 weeks and then monthly for 3 months to ensure care plans are reviewed and updated on admission, change of condition, quarterly, and annually, to ensure they include interventions for all medical treatments and on ensuring that documentation is completed on all physician orders - including dressing changes. All audit findings will be presented by the DON/ designee at monthly QAPI meetings for 4 months for discussion of the effectiveness of the correction plan, reduce frequency of the audits, or to discontinue the audits based on the audit findings. The DON/designee is responsible for overall compliance.	09/12/2023

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S 337	Continued From page 2 -The drain had been placed in April 2023 while she was hospitalized. -She had one liter of fluid drained from her lung at while in the hospital. *She showed the surveyor the drain site which was covered with a gauze and a Tegaderm dressing. -The edges of the Tegaderm dressing were loosened. *She indicated the nurse changed the dressing if it had gotten too loose or wet from her showers. -She thought the dressing got changed approximately every week or two weeks. *She indicated the nurse had used the PleurX drain to drain fluid off her lung since she had been in the facility after her hospitalization. -She was unsure when the last time that had been done. Review of resident 2's care record revealed: *She had been admitted on 4/22/23. *Her diagnoses included: congestive heart failure, chronic obstructive pulmonary disease, right pleural effusion, and emphysema. *Her 4/17/23 Hospital Discharge Instructions included the following: -She had a recurrent right pleural effusion with insertion of an indwelling pleural catheter. -There was a physician's order to drain one to two liters from the PleurX catheter as needed for complaints of shortness of breath. -Home Care instructions for the PleurX pleural catheter included to: --Check the dressing daily to make sure it was clean and dry. --Check the catheter regularly for cracks or kinks in the tubing. --Check the catheter insertion site daily for signs of infection that included: skin breakdown, redness, swelling, pain, fluid or blood, warmth,	S 337		

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pus, or a bad smell.
--Drain your catheter as recommended by your physician.
--Change your dressing at least once a week, or more often if needed to keep the dressing dry and intact.
--Do not take baths, swim, or use a hot tub.

Review of resident 2's last revised 7/24/23 care plan revealed:
*A focus area of shortness of breath related to decreased energy and fatigue and decreased lung expansion.
-Interventions for that focus area included to:
--Monitor, document, and report abnormalities in breathing pattern to the practitioner.
--Pace and schedule activities providing adequate rest periods.
--Monitor and document changes in orientation, increased restlessness, anxiety, and air hunger.
*There was no documentation regarding the resident's indwelling pleural catheter to her right chest or the care of that catheter related to:
-Dressing changes, how often they should have been completed, or who was responsible for the dressing changes.
-Assessments of the site for potential infection.
-Draining fluid from the catheter as recommended by the physician.
-The other home care instructions as indicated in the 4/17/23 hospital discharge orders.

Review of resident 2's 4/22/23 through 8/2/23 progress notes from the nursing staff revealed:
*On 4/22/23 at 12:31 p.m.: "...admitted to Wellshire...has Pleurex [PleurX] catheter present to right chest wall; this site is without redness/drainage; dressing in place of dry gauze and tagaderm [Tegaderm]; per resident she had 1L [liter] of fluid removed on 4/19/23 at [hospital];

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S 337	Continued From page 4 resident denies shortness of breath, cough, chest pain, or dizziness..." *On 4/25/23 at 4:15 p.m.: "...attempted to drain fluid from Pluerex [PleurX] catheter to right chest wall;...right chest wall Pleurex catheter accessed without complications; less 10 cc [cubic centimeters, measurement for liquid] of blood tinged fluid was drained..." *On 4/26/23, 4/27/23, 4/28/23, and 5/1/23 the dressing was dry and intact and no other concerns were noted. *On 5/2/23 at 8:02 a.m.; "...resident reported feeling very short of breath;...denies any [any] chest pain, dizziness, cough, sore throat or runny nose or congestion; lungs are diminished on the right and CTA [clear to auscultation] on the left; call was placed to [emergency contact] regarding [resident's] shortness of breath and that this is possibly anxiety-driven; [emergency contact] agreed and stated that she would come see her this morning and talk to her; [resident] has a f/u [follow-up] appt [appointment] with [practitioner] this morning and will be having a chest xray [x-ray] done to determine if she needs fluid pulled from the PleurX drain;...this nurse will follow-up hourly with [resident]." *On 5/2/23 at 10:55 a.m.: "...obtained PleurX drain system from [hospital] and brought to Wellshire; under sterile conditions, right chest wall PleurX catheter was accessed;...only approximately 10cc of blood-tinged fluid was drained; new dry gauze dressing with tagederm [Tegaderm] was applied to right chest wall without complications..." *On 5/2/23 at 5:02 p.m.: "Resident had appt [appointment] today with [practitioner] for f/u from hospitalization;...[resident] had a chest xray [x-ray] and this looked better than her last; [practitioner] is going to check with Radiology regarding if the PleurX drain could be plugged or	S 337		

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what the process for that is and get back to me; Due to [resident] seeing [seeming] to be more SOB [short of breath] in the AM..."
*On 5/3/23 the dressing was dry and intact with no concerns noted.
*On 5/4/23 the dressing was changed after it became loose from her shower.
*On 5/5/23 the dressing was dry and intact with no concerns noted.
*On 5/6/23 and 5/7/23 there were no notes.
*On 5/8/23, 5/9/23, 5/10/23, 5/11/23, and 5/12/23 the dressing was dry and intact with no concerns noted.
*On 5/13/23 and 5/14/23 there were no notes.
*On 5/15/23 the dressing was changed.
*On 5/16/23 and 5/17/23 there were no notes.
*On 5/18/23 at 2:22 p.m.: "Interdepartmental Care Conference held today; Present for care conference are [resident], [resident's daughter in law], [name] with SS [social services], and [registered nurse (RN)/nurse manager B]...staff assist [resident] with showering twice a week and obtain her weight once a week; There have not been any concerns regarding those two areas in this reporting period; [resident] has a PleurX drain present to her right chest wall due to Pleural Effusion and this dressing is monitored daily by nursing and changed PRN [as needed]; Orders for draining fluid is up to date and active but the supplies to do a drain would have to be obtained from the hospital...[resident's] service plan was reviewed and updated..."
*On 5/19/23, 5/20/23, and 5/21/23 there were no notes about the drain or the dressing.
*On 5/22/23 the dressing was changed due to becoming wet in the shower.
*On 5/23/23 there was no note about the drain or the dressing.
*On 5/24/23 the resident reported feeling short of breath, the practitioner was updated, and the

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S 337	Continued From page 6 orders were changed for a medication dosage. -There was no documentation about the dressing or the drain. *The only note in June was on 6/26/23 at 2:23 p.m. which included: "[Resident] went to the ER [emergency room] with her daughter for low back pain and shortness of breath. At the ER they performed a chest xray [x-ray], lumbar spine xray [x-ray], CBC, CMP, and UA [laboratory tests]; labs were unremarkable; Chest xray [x-ray] showed some fluid in the right lower lung bases but the PleurX catheter is sitting higher than the fluid currently so this was no accessed/drained at the ER...[Resident] returned to the ALF [assisted living facility] with decreased SOB [shortness of breath] and her back pain was improved..." *There was no documentation specific for the PleurX drain, dressing, or assessment of that site in July 2023 or through 8/2/23. -The last documentation of facility staff monitoring or changing the dressing site to the PleurX drain had been on 5/22/23. Review of resident 2's Medication and Treatment Administration Records (MAR/TAR) revealed: *The May 2023 TAR included: -A 5/11/23 entry to monitor the PleurX catheter dressing to her right chest daily and change it as needed. -That entry ended on 5/19/23 and the initials indicated the task was completed only on 5/11/23 through 5/18/23. -A 5/2/23 entry to drain one to two liters from the PleurX catheter PRN shortness of breath. --There were no initials indicating that had been done as it noted in the nurse notes on 5/2/23. *The June 2023 and July 2023 TARs included: -The same entry to drain the catheter as needed with no initials indicating that it had been done. -There were no entries to monitor the drain site or	S 337		

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S 337	Continued From page 7 to document the dressing changes to the site. *The May 2023, June 2023, and July 2023 MARs had no documentation regarding the PleurX drain site or the dressing changes to that site. Interview and record review on 8/2/23 at 5:00 p.m. with RN/nurse manager B regarding resident 2's PleurX drain site care and documentation revealed: *She confirmed the resident had a PleurX drain site on her right chest wall area. -The nurses were the only ones who changed the dressings or assessed that area. *She was the full-time nurse for the assisted living. -Primarily she had done the resident's dressing changes, but at times a nurse from the attached skilled nursing facility assisted with resident care at the assisted living. *She confirmed there was nothing about the PleurX drain site or the care of it on the resident's care plan. -The care plan should have included that information. *She was the nurse responsible for ensuring the care plan was accurate and revised with changes in resident conditions. *She stated she changed the dressing to the resident's drain site at least weekly. -Sometimes the dressing got changed more often if it had become loose or had gotten wet. *She confirmed she had not documented those dressing changes every time it was completed. -The documentation had made it appear as if the dressing had not been changed since 5/22/23. *She confirmed there were no MAR/TAR entries supporting the dressing changes or care of the PleurX drain site other than for those specific dates in May 2023. *The documentation of dressing changes should	S 337		

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S 337	Continued From page 8 have been on the MAR/TAR or in the progress notes to support it had been completed as ordered. *When she changed the dressing to the drain site she indicated she assessed the site for signs of potential infection. -She agreed she should have been documenting those assessments and dressing changes to support what she had done. Interview on 8/3/23 at 5:45 p.m. with administrator A confirmed the above findings. Documentation in the resident's record should have supported the care of the resident's drain site. Review of the provider's undated Day of Admission/Move-In policy revealed: *The Assisted Living Director and/or designee should have ensured the care plan was complete and the MAR was set up on move-in day to ensure appropriate resident care. *"5. The Assisted Living Director and/or designee will orient caregivers about the needs of the newly admitted resident on each shift." Review of the provider's undated Ongoing Resident Assessments policy revealed: *"a. All staff members are encouraged to informally monitor residents on a regular basis throughout the course of normal daily activities, and to report any changes in condition that are identified." *Residents should have been formally assessed on a quarterly basis and the care plan should have been updated as needed. *There was no mention of the process for documentation by the nursing staff regarding the residents' care needs.	S 337		

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S 337	Continued From page 9 Review of the provider's undated Resident Care Plans policy revealed: *The Assisted Living Director and/or designee should have developed a care plan for each resident. *The care plan should have addressed the following: -Medication management and/or assistance required. -Physical needs related to illness or chronic disease management. -Skin integrity issues. -Any need identified by the family or resident. *Formal review of the resident's care plan should have taken place at the following times: -Thirty days after admission. -Quarterly. -Annually. -Upon a significant change in the resident's status or condition. Review of the provider's undated Policy and Procedure Manual table of contents revealed there were no policies specifically related to documentation.	S 337		
S 642	44:70:07:05 Control and accountability of medications Written authorization by the resident's physician, physician assistant, or nurse practitioner shall be secured for the release of any medication to a resident upon discharge, transfer, or temporary leave from the facility. The release of medication must be documented in the resident's record, indicating quantity, drug name, and strength. The facility shall maintain records that account for all medications and drugs from receipt through administration, destruction, or return.	S 642	1. We are unable to correct noncompliance for resident 4 but, Nurse Manger B. did document in nurse's notes that resident 4, family, and PCP were in agreement to discharge planning. Nurse Manager B. did not obtain the official order and was educated by the DON on 8/14/2024 on facility discharge policy. Resident 4 transferred to our attached Skilled Nursing Facility (SNF), and Nurse Manager B. was unaware that a medication reconciliation form needed to be completed since we are the same campus. Nurse Manager B. was educated on 8/14/2023 on the facility policy which includes that medications are to be packaged and counted for transporation. 2. Education will be provided by the DON to Wellshire Nurse Manager B. and all other facility nurses by 8/24/2023, to ensure that a discharge order is obtained from the resident's Primary Care Provider (PCP) at the time of transfer or discharge from the facility. Education was also provided to ensure that a medication reconciliation form is .....Continues on next page	09/12/2023

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S 642	Continued From page 10 This Administrative Rule of South Dakota is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to obtain a practitioner's order and ensure documentation for the release of all medications for one of one sampled discharged resident (4). Findings include: 1. Review of resident 4's closed care record revealed: *She had been admitted on 2/10/22. *She had been transferred to the attached skilled nursing facility (SNF) on 5/24/23. *Her May 2023 Medication Administration Record included the following medications she had been receiving while in the assisted living center: -Aleve 220 milligrams (mg) daily at bedtime for pain. -Aspirin EC 81 mg daily for prophylaxis. -Ezetimibe 10 mg daily at bedtime for hypertension. -Fenfibrate 67 mg two capsules daily at bedtime for hyperlipidemia. -Fish Oil 1000 mg daily at bedtime for a supplement. -Losartan potassium 50 mg daily for hypertension. -Omeprazole 20 mg daily in the morning for indigestion. -Salonpas Patch apply to lower back in the morning and remove in the evening for back pain. -Vitamin D 2000 international units daily for a supplement. -Cyclobenzaprine 5 mg three times daily for muscle spasms in the back. -Tramadol 50 mg every six hours as needed for back pain.	S 642	completed at time of discharge or transfer to ensure medications are counted and that the person receiving the medications signs a receipt acknowledging responsiblity and safe keeping of those medications; and on the updated facility "Discharge Policy" which includes all of this information. 4. Audits will be conducted by the DON/designee on every resident transfer or discharge for the next 4 months to ensure an order is obtained from the resident's PCP for transfer or discharge from the facility and to ensure a medication reconciliation form is completed and includes quantity of medications and recipient name of party responsible for medications to ensure accountability. 3. All audit fingings will be presented by the DON/designee at monthly QAPI meetings for 4 months for discussion of the effectiveness of the correction plan, reduce frequency of audits, or discontinue the audits based on the audit findings. The DON will be responsible for overall compliance.	

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S 642	Continued From page 11 *Her progress notes had no documentation of what had occurred related to her medications at the time of her transfer and discharge. Interview on 8/2/23 at 4:45 p.m. with registered nurse/nurse manager B regarding resident 4 revealed: *The resident had been transferred to the attached SNF on 5/24/23 due to her need for a higher level of care. *All of the resident's medications had been sent to the SNF with her. *There were no practitioner's orders authorizing the release of those medications at the time of her discharge to the SNF. -She was not aware of that state requirement. *She confirmed there was no documentation of the release of the resident's medications to the SNF, which medications were sent, or how many doses had been sent. *She agreed there should have been documentation of what had occurred with all the resident's medications at the time of her discharge. *She confirmed the facility was responsible for the security and accountability of all medications from the time they were received through disposal, return, or appropriate release to another person or entity. Interview on 8/3/23 at 5:45 p.m. with administrator A confirmed the above findings. Review of the provider's undated Move-Out policy revealed: *"The resident's medications are counted and packaged appropriately for transportation. The person receiving the medications upon transfer signs for their receipt, accepting and acknowledging responsibility for safekeeping."	S 642		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	68077	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSHIRE HURON	1251 ARIZONA AVE SW HURON, SD 57350

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S 642	Continued From page 12 *"A resident discharge summary is completed in the resident's record." *There was no documentation in the policy for having a practitioner's order to release the medications. Review of the provider's undated Medications Left Behind by a Resident policy revealed: *"When a resident moves out of the community, all medications, including over-the-counters, should go with resident when possible." *"4. Document on Discharged Medications Record when medication is transferred with the resident. Obtain signature of person accepting the medications (i.e., responsible party) will be obtained, indicating agreement with the quantity of each medication transferred out of the facility."	S 642		

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
	68077	A. BUILDING: _____ B. WING _____	R 09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WELLSHIRE HURON	1251 ARIZONA AVE SW HURON, SD 57350

(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 Statement A revisit survey for compliance with the Administrative Rules of South Dakota, Article 44:70, Assisted Living Centers, requirements for assisted living centers, was conducted on 9/18/23, for all previous deficiencies cited on 8/2/23. All deficiencies have been corrected, and no new noncompliance was found. The Wellshire Huron was found in compliance with all regulations surveyed.	{S 000}		

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