

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

ORIGINAL

PRINTED: 12/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/11/2013
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NAME OF PROVIDER OR SUPPLIER WHEATCREST HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430
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(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
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F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/9/13 through 12/11/13. Wheatcrest Hills was found not in compliance with the following requirement: F226.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Preceptor: 26180 Based on interview, record review, and policy review, the provider failed to thoroughly investigate and follow-up on a complaint of missing funds (cash) from one of one sampled resident's (15) wallet. Findings include: 1. Interview on 12/09/13 at 2:41 p.m. with resident 15 revealed he: *Had reported approximately three weeks ago that he had \$150.00 stolen from his wallet. *Had reported it to the "director." *Told the surveyor "No, nothing was done. All they said was don't keep money in your room or with you and to put it in the safe." *Felt he had a right to keep his own money in his	F 226		1-07-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Orlaine Surman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-03-14</i>
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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 226	<p>Continued From page 1 wallet without fear of it being stolen.</p> <p>Review of resident 15's 10/09/13 Brief Interview for Mental Status (BIMS) regarding his cognition (mental ability) revealed a score of 10. Review of the BIMS guidelines stated a score of 8-10 indicated moderate cognitive impairment.</p> <p>Interview and review on 12/11/13 at 9:25 a.m. with the administrator and social service designee (SSD) of the Required Nursing Facility Event Report regarding resident 15's complaint of missing money revealed: *A report dated 11/12/13 had been filled out by the administrator regarding his complaint of missing money. *The report indicated: -He was legally blind. -He had taken his priest out for lunch on 11/12/13 and when he went to pay for the meal he did not have any money in his wallet. -He stated he thought he had \$140.00 to \$180.00 in his wallet. -His family had been there the weekend prior to 11/12/13. *The provider had spoken to the resident's son about the missing funds. He had stated the resident had spent \$40.00 on a meal with his family, filled a vehicle with gas, taken his niece out for lunch, and had given his priest money. -The resident later stated he thought he had \$250.00 in his wallet before the money went missing. *The provider also stated in the report that he should not have kept that much money in his room, but the resident had refused to bring it to the business office. *The provider had not notified local law enforcement.</p>	F 226		

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F 226	<p>Continued From page 2</p> <p>*The provider felt he had spent the money the previous weekend.</p> <p>Further interview at the above time with the SSD revealed she had interviewed the bath aide. The bath aide had reported the resident had no money in his wallet. When asked how the bath aide would have known his wallet was empty, the SSD replied "She looked at the thickness of the resident's wallet." There had been no documentation regarding an interview with the bath aide.</p> <p>Continued interview at the above time with the administrator revealed they felt they had accounted for the missing funds. They failed to give an accurate count for the remainder of the \$150.00 and could only account for \$40.00 reported to be spent on meals. They had not determined how much had been spent on fuel, other lunches, or money to the priest. The administrator stated they had not notified the resident of the investigation.</p> <p>Review of e-mail correspondence between the SSD and the resident's son revealed: *11/12/13- She notified him of the missing money. The resident's son replied his father had spent around \$40.00 on meals. He had not recalled his father spending any more than that, but he was not with him the whole time. *11/12/13- She had searched the resident's drawers with his permission for missing money and had not found any. -11/13/13- The son spoke with his father and family members and concluded the resident had spent some money but had plenty of cash in his wallet. The son had been told there was no money left.</p>	F 226	<p>In regards to res #15, the investigation has been reviewed and updated. This administrator would like to state an inaccuracy on page 3 of 5. It was reported, "The administrator stated they had not notified the resident of the investigation." Res #15 had been notified that an investigation was being started on the same day he reported the alleged loss.</p> <p>Wheatcrest Hills has replaced the current policy and procedure with a Welcov Abuse prevention Plan, which covers misappropriation of property. A copy of same has been distributed to all staff and a verbal inservice will be done on the 20th of January.</p>	

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F 226	<p>Continued From page 3</p> <p>-11/13/13- The son remarked his father would have never used all of his money, and he felt the staff needed to continue their investigation.</p> <p>-11/14/13- The SSD had interviewed staff about the missing money but "had not found anything out though."</p> <p>-11/14/13- The son had been very concerned because his father "used cash for very few things and would never use his last cash without knowing it."</p> <p>-11/19/13- After interviewing staff, the provider planned to put money in another resident's room to see if it would be taken.</p> <p>Surveyor: 26180 Review of the provider's undated Abuse Prevention Plan revealed: *"The administrator, director of nursing services, or Nursing Supervisor, will make sure that a report is made out, that the internal investigation begins immediately, the appropriate reporting takes place and that interventions are implemented to provide the vulnerable adult with a safe living environment." *Reportable incidents included "Misappropriation of property that is not substantial, (i.e. \$1-\$2 or a can of pop)." *How to conduct and document the investigation included: -"Focus on the problem. Clearly identify the problem, stay on message, say it clearly, and say it simply." -"Answer the questions: Who. It is best to get a first person report in writing whenever possible. If interviewing another resident/patient, family member or other visitor, quote as much as possible." *"THE INVESTIGATION REPORT IS SEPARATE FROM THE RESIDENT RECORD."</p>	F 226	<p>A Root Cause Analysis report form has been implemented, covering the investigation of reportable incidents. Documentation for such will be included in the incident log file or the resident file.</p> <p>The administrator will monitor all reportable incidents for compliance to policy at the time they are sent to the DOH. This information will be reported monthly to the QA committee for a period of 3 months by the administrator.</p>	

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F 226	Continued From page 4 -What: Describe the event, use senses, be objective. -When: Document the time. Accuracy is critical. -Where: Document the location, be as descriptive as possible. -How: Description of how event may have occurred with the acquired information from those interviewed if there were no witnesses and/or the individual is not a good historian. -Conclusion: This is a summary statement that indicates an allegation or suspicion of abuse/neglect was either substantiated or not substantiated."	F 226			

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/11/13. Wheatcrest Hills was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 12/12/13 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and document review, the	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Deanne Furman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-03-14</i>
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K 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building. Three of three basement stairways discharged onto the main level and were not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include: 1. Observation beginning at 11:00 a.m. revealed the west basement stairway discharged onto the main level adjacent to the nurses' station. Observation also revealed the north basement stairway discharged onto the main level in the kitchen pantry area. Further observation revealed the east exit from the basement discharged onto the main level in the physical therapy vestibule. A continuous one hour enclosure was not provided to the exterior of the building in those locations. Review of the previous life safety code survey confirmed those findings. The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 033		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to construct a paved path of exit discharge to the public way at three of four exits (west exit	K 038		F

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K 144	Continued From page 3 Surveyor: 18087 Based on observation and interview, the provider failed to maintain the generator battery per NFPA 99 guidelines. A maintenance-free battery had been installed. Specific gravity testing for the generator battery had not been done. Findings include: 1. Observation at 11:00 a.m. on 12/11/13 revealed the generator battery was dated January 2010 (47 months prior to the survey date). Generator batteries should be scheduled for replacement every 24-30 months. The installed battery was a maintenance-free battery (sealed). Interview with the maintenance supervisor at the time of the observation revealed he did not know the maintenance-free (type) battery was not acceptable. He was unaware monthly specific gravity tests had to be performed and logged.	K 144	The battery for the generator was replaced with a deep cycle battery with removable water caps to allow for testing. Gravity testing will be done monthly by maintenance personnel and logged on a monthly maintenance check report. This monthly maintenance check will be monitored by the maintenance director for a period of 3 (three) months and reported to the QA team on a monthly basis for 3 (three) months.	12-19-13

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SOUTH DAKOTA DEPARTMENT OF HEALTH

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S 000	<p>Initial Comments</p> <p>Surveyor: 18560 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 12/9/13 through 12/11/13. Wheatcrest Hills was found in compliance.</p>	S 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Deanne Furman *Administrative* *2013-14*

