

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

PRINTED: 09/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2014
NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073		
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F 176	Continued From page 1 Review of resident 12's current medication administration record and care plan revealed he was unable to administer his own medication. Review of resident 12's physician's orders revealed he had no order to self-administer his medications. Interview on 8/27/14 at 10:00 a.m. with the Minimum Data Set coordinator revealed resident 12 should not have been self-administering his medications. Interview on 8/28/14 at 10:30 a.m. with the director of nursing revealed she: *Had spoken to LPN A before about leaving medications with residents who were unable to self-administer them. *Agreed resident 12 should not have been giving himself medications. Review of the provider's 8/1/13 policy and procedure on self-administration of medication by a resident revealed "Residents have the right to self-administer their own medications with nursing supervision, but only after evaluation by the Registered Nurse determines that the resident may safely and effectively administer the medication (s) and a physician order is secured that allows the resident to self-administer medication (s)."	F 176			
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221			

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F 221	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on observation, interview, and record review, the provider failed to assess and care plan for positioning/grab bars for three of three sampled residents (1, 6, and 9) with positioning devices. Findings include:</p> <p>1. Random observations from 8/26/14 through 8/28/14 revealed resident 1's bed had positioning bars attached to both sides at the head of his bed.</p> <p>Interview on 8/27/14 at 3:35 p.m. with resident 1 revealed he used the positioning bars to assist with turning from side-to-side in bed.</p> <p>Review of resident 1's medical record revealed: *No assessment for the use of the positioning bars. *A 6/25/14 hospice plan of care had indicated "May use hospital bed with rails as needed." *His 7/11/14 care plan had not mentioned the use of the positioning bars.</p> <p>Surveyor: 32331</p> <p>2. Observation on 8/27/14 at 1:50 p.m. of resident 9's room revealed she had one positioning bar up on the top half of her bed.</p> <p>Review of resident 9's medical record revealed: *She had been admitted on 7/21/14. *She had diagnoses that included tobacco use disorder and multiple sclerosis (disease that affects the brain and the spinal cord). *No assessment had been completed for the use</p>	F 221	<p><i>*which includes residents 1, 6, and 9 PEISDOCHIME</i></p> <p>A policy is in place addressing the proper assessment for the appropriate use of positioning grab bars. Assessments have been completed on nine facility residents currently using positioning grab bars including four residents from the Resident Identifier List. In-service education to all staff responsible for direct care and assessment of positioning grab bars will be completed by 9.25.14.</p> <p>The Director of Nursing or designee will assess all residents using positioning grab bars for appropriateness of use monthly x3 then quarterly for one year thereafter and report findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p><i>* [REDACTED] PEISDOCHIME</i></p> <p><i>x 9/25/14 PEISDOCHIME</i></p>

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F 221	<p>Continued From page 3 of the positioning bar. *There was no physician's order for the positioning bar.</p> <p>Review of resident 9's revised 8/26/14 care plan revealed she had a grab bar on her bed to assist with bed mobility.</p> <p>Interview on 8/27/14 at 2:00 p.m. with resident 9 revealed she used the positioning bar for lifting herself up in bed.</p> <p>Interview on 8/27/14 at 2:50 p.m. with the director of nursing (DON) regarding positioning bars on residents' beds revealed: *Positioning bars were not being assessed, because she had not considered them a restraint. *No assessments were being done on positioning bars. *She was not aware all positioning bars needed to be assessed.</p> <p>Surveyor: 34030 Preceptor: 32332 3. Random observation from 8/26/14 through 8/28/14 revealed resident 6's bed had positioning bars attached to both sides at the head of his bed.</p> <p>Review of resident 6's medical record revealed: *A diagnosis of dementia (a loss of mental ability). *The positioning bars had not been assessed for appropriateness of use nor mentioned in his plan of care.</p> <p>Interview on 8/26/14 at 3:30 p.m. with the Minimum Data Set coordinator revealed: *No assessment on positioning bars for resident 6 existed.</p>	F 221			

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F 221	Continued From page 4 *She had not thought an assessment was necessary as it "was not a restraint and resident 6 could reposition herself with them."	F 221		
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: 34030 Preceptor: 32332 Based on record review, interview, and policy review, the provider failed to investigate bruises of unknown origin for one of one sampled resident (6) with bruises. Findings include: 1. Review of resident 6's medical record and incident reports revealed: *An admission date of 8/9/12. *A diagnosis of dementia (a loss of mental ability). *A Bruise ACP (acute care plan) report dated 4/23/14 describing multiple bruises on the resident's left forearm and hand, and documenting their progress as they resolved.	F 226	A policy regarding Abuse Prohibition and Incident Reporting are both in place at the facility. The incident report for resident #6 dated 4/23/14 has been completed, however the investigation portion of the report is missing. Inservice education will be provided to all staff regarding proper completion of incident reports by 9.22.14. Proper completion of incident reports will be [redacted] by the Director of Nursing or designee monthly x3 months then quarterly x3 and report findings to the QAPI Committee monthly for review and appropriate recommendations. * [redacted] PE/SDD/HMF	x9/28/14 PE/SDD/HMF

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F 226	Continued From page 5 *No mention of how the bruises occurred or any investigation was found. Interview on 8/28/14 at 8:45 a.m. with the social services designee who handled incident reports revealed no documentation for the 4/23/14 incident existed. Interview on 8/28/14 at 10:30 a.m. with the director of nursing revealed: *The bath aide documented any skin changes during the resident's bath and reported them to the charge nurse. *The charge nurse documented the skin changes and started the investigation. *She agreed the bruises should have been investigated.	F 226		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation and interview, the provider failed to:	F 253		

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F 253	<p>Continued From page 6</p> <p>*Clean vents and floors, repair holes in the ceiling, and maintain non-slip adhesive strips in one of one tub room (Maple Street) used by all residents.</p> <p>*Maintain baseboards and prevent rust build-up on floors and registers in two of two public restrooms located outside of the dining room used by residents.</p> <p>*Clean black marks off the floor throughout one of one dining room used by all residents.</p> <p>*Have a preventative maintenance schedule for one of one building.</p> <p>Findings include:</p> <p>1. Random observations from 8/26/14 through 8/28/14 revealed the following issues:</p> <p>*In the tub room located on Maple Street:</p> <ul style="list-style-type: none"> -Multiple water spots and stains on the floor under the water hook-ups for the tub and in the corner of the room (photo 3). -Non-slip adhesive strips on the floor by the tub door that were worn through to the floor (photo 4). -Large holes in the ceiling above the tub (photos 5 and 6). -A ceiling vent covered in dust particles (photo 7). -A wall heater covered in dust particles and rust (photo 8). <p>*In the two restrooms across from the dining room:</p> <ul style="list-style-type: none"> -Baseboards were not fully secured to the wall, and there were dark orange rust spots on the floor and registers (photos 1, 2, and 9). <p>*In the dining room several black marks from wheelchairs on the floor.</p> <p>Interview on 8/28/14 at 8:45 a.m. with the maintenance man revealed:</p> <p>*He had no preventative maintenance schedule for the building and the items mentioned above.</p>	F 253	<p>Vents and floor in tub room have been cleaned and will be maintained by the facility housekeeping department. The dent in ceiling has been repaired by maintenance supervisor and we will ensure that staff giving baths know the proper procedure for lowering tub to ensure the upswinging door does not lead to another dent. Baseboards in the identified area will be repaired and maintained to ensure no rust build-up occurs. The black marks on the floor will be treated and removed from the dining room. The cause of the black marks will be identified and measures put in place to ensure they do not reappear. A preventive maintenance program will be put in place by 9.25.14. Department managers of both Housekeeping and Maintenance will be using checklists to ensure completion.</p> <p>The Administrator or designee will audit compliance with cleaning of vents and floor of the tub room monthly x3 months then quarterly for one year thereafter and report findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p><i>* using preventative maintenance checklist</i></p>	<p><i>x 10/3/14</i> <i>DE/SDDCH/MF</i></p> <p><i>DE/SDDCH/MF</i></p>	

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F 253	Continued From page 7 *He had a preventative maintenance schedule, but he had "stopped completing it about a year ago." *He agreed the items mentioned above were in need of repair. *Housekeeping was responsible for cleaning the vents and floors in the tub room. *Maintenance and housekeeping had attempted to remove the black markings from the floor but were unsuccessful. They needed to bring in a professional floor cleaner but had not. Interview and observation on 8/28/14 at 9:45 a.m. with the administrator revealed: *He was unaware the preventative maintenance schedule had been stopped. *They should have been using a preventative maintenance schedule for the above mentioned issues.	F 253		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on interview, observation, record review, and policy review, the provider failed to: *Ensure smoking assessments were being completed for three of three sampled residents	F 323	<p>* All residents who smoke will have smoking addressed on their care plans. PEJSDDH/MF</p> <p>* including residents 1, 5, and 9 PEJSDDH/MF</p> <p>The facility Smoking policy has been updated to specifically mention the scope and frequency of assessments. Smoking assessments have been completed on all current residents who smoke. Smoking assessments will be completed for all new residents who smoke upon admission and change of resident condition. Professional nursing staff will be in-serviced regarding the updated smoking assessment by 9.22.14.</p> <p>The Director of Nursing or designee will observe compliance with this policy for all residents who smoke monthly x3 months then quarterly for one year thereafter and report findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>X [REDACTED] PEJSDDH/MF</p>	* 9/10/14 PEJSDDH/MF

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F 323	<p>Continued From page 8</p> <p>(1, 5, and 9) who smoked cigarettes. *Ensure care plans had been completed for two of three sampled residents (1 and 5) who smoked cigarettes. Findings include:</p> <p>1. Review of resident 9's medical record revealed she: *Was admitted on 7/21/14. *Had diagnoses that included tobacco use disorder and multiple sclerosis (disease that affects the brain and the spinal cord).</p> <p>Observation and interview on 8/27/14 at 2:00 p.m. with resident 9 on the patio outside the dining room revealed she: *Was smoking a cigarette and putting the ashes in a large, aluminum can on a table. *Had a partial package of cigarettes and a lighter in her pocket. *Stated she smoked three times per day at scheduled hours.</p> <p>Review of resident 9's 8/9/14 care plan revealed she *Used cigarettes and a lighter safely. *Was to have been monitored PRN (whenever necessary). *Was encouraged to use a receptacle for cigarette garbage. *Was encouraged not to give her cigarettes to other residents. *Was to keep her cigarettes and lighter in the medication room when not in use.</p> <p>Interview on 8/27/14 with the Minimum Data Set (MDS) coordinator revealed there had been no smoking assessments completed on resident 9.</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>Interview on 8/27/14 at 2:50 p.m. with the director of nursing ((DON) regarding resident 9's smoking revealed she:</p> <ul style="list-style-type: none"> *Confirmed they had not completed smoking assessments on her or any resident that smoked cigarettes. *Agreed there should have been periodic smoking assessments completed to determine safety for her and all residents that smoked. <p>Surveyor: 32332</p> <p>2. Random observations from 8/26/14 through 8/28/14 of resident 1 revealed he went outdoors to smoke cigarettes.</p> <p>Review of resident 1's medical record revealed:</p> <ul style="list-style-type: none"> *He had a diagnosis of: <ul style="list-style-type: none"> - Paraplegia causing weakness to his lower extremities. -Cancer. *He was receiving narcotic (for severe pain) medication routinely. *No initial or current smoking assessment had been located in the record. *The 7/11/14 care plan had not included: <ul style="list-style-type: none"> -The resident smoked. -If he had been allowed to smoke independently. -Where he was to smoke. -If safety measures were used to prevent injury. <p>Interview on 8/27/14 at 1:45 p.m. with licensed practical nurse A revealed:</p> <ul style="list-style-type: none"> *Resident 1 smoked one or two times per day. *Sometimes he was supervised by family members or by hospice workers if they were visiting. *He was not always supervised. *He was safe with his smoking when he was 	F 323			

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F 323	Continued From page 10 "awake", but he was often sleepy because of his medication. *He would not go to the appointed smoking area to smoke, and chose to smoke at the front entrance instead. Interview on 8/28/14 at 10:40 a.m. with the DON revealed: *Residents had not been assessed for their ability to smoke safely. *The provider's smoking policy had not addressed safety concerns with smoking. *She was not aware resident 1 had been smoking at times without supervision. *Resident 1 should have been supervised with all smoking. *Smoking should have been addressed on the care plan. Surveyor: 32335 3. Review of resident 5's medical record revealed he smoked. There had been no safety assessments completed. 4. Interview on 8/27/14 at 10:30 a.m. with the DON revealed: *They had not completed any smoking safety assessments for the five residents that smoked. *Nursing staff stored the cigarettes and lighters for the residents but had not supervised any of them. Review of the provider's February 2014 Smoking Policy revealed no procedure for assessing residents who smoked for safety.	F 323			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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F 371	<p>Continued From page 11</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to maintain sanitation in the kitchen with the potential of cross-contamination (bacteria transferred from one area to another) in the following areas: *One exhaust vent located above one of two food production counters. *Four of five cupboards used to store clean dishes, food, and food service supplies in the dining room with a cleanable surface. *The shelf used to store pots and pans under one of two food production tables with a cleanable surface. Findings include:</p> <p>1. Observation on 8/26/14 from 9:00 a.m. through 9:15 a.m. in the kitchen above a stainless steel food production table revealed: *One exhaust vent approximately twelve inches by eighteen inches contained multiple dust spots. *The vent was attached to the ceiling's drywall with four screws. *The vent had started to separate from the drywall in four locations. -One side of the vent had a separation from the</p>	F 371	<p>The exhaust vent above the food production table has been cleaned, repaired and properly fastened to the ceiling to ensure that it is sanitary. The vent will be cleaned at least once per month or as needed by the Maintenance Supervisor.</p> <p>The galvanized steel shelf under the food production area has been cleaned. We are replacing the existing shelf with a stainless steel replacement to create a more sanitary surface. The shelf will be placed on a written, comprehensive cleaning schedule and will be cleaned weekly or as needed by the kitchen staff. Kitchen staff will be in-serviced on the new cleaning schedule, monitoring of vents and kitchen shelving cleaning to maintain a sanitary surface.</p> <p>The Maintenance supervisor covered the unfinished particle board shelving with a smooth, cleanable surface on 9.13.14.</p> <p>The Dietary Manager will audit compliance with cleaning of vents and steel shelves monthly x3 months then quarterly x3 and report her findings to the QAPI Committee monthly for review and appropriate recommendations.</p> <p>X [REDACTED] DE/SDD/HME</p>	* 10/10/14 DE/SDD/HME

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F 371	<p>Continued From page 12</p> <p>drywall in the ceiling of approximately one inch (photo 10).</p> <p>*Food consisting of lettuce and other cut fresh vegetables were being prepared by cook B on the table directly below the vent.</p> <p>Interview on 8/26/14 at 4:25 p.m. with the maintenance supervisor regarding the above exhaust vent revealed he:</p> <p>*Had known the vent had been starting to separate from the ceiling's drywall each time he had cleaned the vent.</p> <p>*Cleaned the vent whenever it "needed to be cleaned."</p> <p>*Had not had a cleaning schedule for the vent.</p> <p>*Agreed the vent was dusty.</p> <p>*Agreed the vent needed to have been rebuilt into the ceiling.</p> <p>*Confirmed the vent could have allowed possible contaminants from the ceiling into the foods prepared and stored below on that table.</p> <p>Interview on 8/26/14 at 5:40 p.m. with the administrator regarding the above exhaust vent confirmed:</p> <p>*The vent needed to have been cleaned.</p> <p>*The vent needed to have been repaired to prevent possible contamination of the food items located there.</p> <p>Interview on 8/27/14 at 8:30 a.m. with the maintenance supervisor revealed there was no policy on cleaning and maintenance of the vents.</p> <p>Review of the provider's 2013 Food Storage policy revealed food was to have been stored and prepared by methods designed to prevent contamination or cross-contamination.</p>	F 371			

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

PRINTED: 09/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2014
NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073		
(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 371	<p>Continued From page 13</p> <p>2. Observation and interview on 8/26/14 from 9:00 a.m. through 9:15 a.m. with cook C in the kitchen regarding a shelf below a stainless steel food production table revealed:</p> <p>*There was a galvanized steel shelf that had multiple white, tan, and brown spots below the food production table that contained inverted (turned over) pots and pans.</p> <p>*The shelf had been cleaned about every two months.</p> <p>*He agreed the shelf had significant build-up of debris, and it was no longer a cleanable surface.</p> <p>*He stated the shelf had so much build-up of debris that it was uncleanable.</p> <p>Interview on 8/26/14 at 4:25 p.m. with the maintenance supervisor regarding the above galvanized steel shelf revealed he:</p> <p>*Agreed there was significant build-up of debris on the shelf.</p> <p>*Agreed the shelf needed to have been cleaned.</p> <p>*Confirmed it was no longer a cleanable surface.</p> <p>Interview on 8/26/14 at 5:45 p.m. with the administrator regarding the above galvanized steel shelf revealed he:</p> <p>*Confirmed the shelf had a significant build-up of debris.</p> <p>*Agreed the shelf was not a clean surface for the storage of the pots and pans.</p> <p>Interview on 8/28/14 at 8:30 a.m. with the certified dietary manager regarding the above galvanized steel shelf revealed it had not been on a cleaning schedule.</p> <p>Review of the provider's 2013 Cleaning and Sanitation of Dining and Food Service Areas policy revealed:</p>	F 371			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 371	<p>Continued From page 14</p> <p>*The food service staff would have maintained the cleanliness and sanitation of food service areas. -Through compliance with a written, comprehensive cleaning schedule.</p> <p>Review of the provider's 2013 Handling Clean Equipment and Utensils policy revealed: *Clean equipment would have been handled to prevent contamination. *Clean equipment would have been stored in a clean, dry location that protected them from splashes, dust, or other contamination. *Stationary equipment would also be protected from contamination.</p> <p>3. Observation on 8/26/14 from 9:00 a.m. through 9:15 a.m. in the dining room revealed: *Unfinished particle board located inside four of five cupboards located next to the refrigerator. *The cupboards shelves contained: -Clean dishes. -Tea. -Creamer and sweeteners. -Canned soup. -Bread. -Napkins, disposable aprons, and straws. -Plastic gloves and bouffant caps (used as a hair covering). *The shelves were an uncleanable surface.</p> <p>Interview on 8/26/14 at 4:25 p.m. with the maintenance supervisor and at 5:45 p.m. with the administrator in the dining room regarding the above cupboards revealed they: *Agreed the shelves were an uncleanable surface. *Agreed the shelves needed to have been finished to a smooth, cleanable surface.</p>	F 371			

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F 371	Continued From page 15 *The clean dishes, food, and food service supplies that had been stored there were exposed to an uncleanable surface that had a potential for cross-contamination. Review of the provider's 2013 Food Storage policy revealed food was to have been stored in areas that were clean, dry, and free from contaminants. Review of the provider's 2013 Handling Clean Equipment and Utensils policy revealed glasses and cups would be stored in an inverted position on a clean sanitary surface.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441	Advocare 120 Sanitizing Sour is currently being used in the laundry to ensure that laundry is being appropriately sanitized. A disinfecting cleaner is being used by the Housekeeping staff on daily basis to clean resident areas and resident use items. Policies are in place regarding the proper use of products used for disinfecting resident rooms and resident use items. All environmental staff will be in-serviced on the proper use and application of the Advocare 120 Sanitizing Sour and housekeeping chemicals and proper monitoring of compliance. The Administrator or designee will audit compliance with cleaning of resident areas and resident use items monthly x3 months then quarterly x3 and report findings to the QAPI Committee monthly for review and appropriate recommendations. * [REDACTED] PE/SDDH/MF	*9/25/14 PE/SDDH/MF

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

PRINTED: 09/10/2014
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OMB NO. 0938-0391

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F 441	<p>Continued From page 16</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32335 Based on observation, interview, product label review, and e-mail review, the provider failed to use: *A sanitizer when using low water temperatures for proper cleaning of laundry for one of one building. *Proper chemicals for general housekeeping in one of one building. Findings include:</p> <p>1. Observation on 8/27/14 at 1:10 p.m. in the laundry room revealed the provider used a detergent, a destainer, and a Solid Navisour (softener) in their laundry process. There were no other chemicals used.</p> <p>Interview and product review on 8/27/14 at 1:30 p.m. with the laundry and housekeeping supervisor revealed: *She had not known if they used a chemical or</p>	F 441		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 17</p> <p>hot water temperatures to sanitize the laundry. *They had not been taking the temperature of the water in the washing machine. *The detergent and destainer were not sanitizing agents. *She had not known if the Navisour was a sanitizer. *She contacted her representative, and he informed her they used a chemical with low water temperatures. *She was unable to confirm what that chemical had been.</p> <p>Interview and e-mail review on 8/28/14 at 8:30 a.m. with the administrator revealed his chemical representative had responded "Solid Navisour does not have a sanitizing agent built into it." He confirmed they had not been using a sanitizer for approximately one year since they had switched chemicals.</p> <p>Surveyor: 32332 2. Interview on 8/27/14 at 1:40 p.m. with housekeeper D regarding cleaning and disinfecting residents' rooms and the general living areas revealed she: *Used Ecolab Disinfectant for cleaning floors. *Sometimes used a one to ten mixture of bleach water, but only if the resident had been ill. *Normally used Betco Green Earth Push Drain Maintainer Floor Cleaner and Spotter for cleaning and disinfecting the sinks, toilets, walls, furniture, and any other surfaces.</p> <p>Interview on 8/27/14 at 2:00 p.m. with the housekeeping supervisor revealed: *There were three housekeepers. *All housekeepers had used the Green Earth Push product to do their normal housekeeping</p>	F 441		

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

PRINTED: 09/10/2014
FORM APPROVED
OMB NO. 0938-0391

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F 441	<p>Continued From page 18 cleaning and disinfecting daily. *That was what they had been instructed to use. *There was no policy for which product they were to have used for disinfection.</p> <p>Interview on 8/28/14 at 10:40 a.m. with the director of nursing revealed her expectation was the nursing and housekeeping departments would use a disinfectant to clean resident areas and resident use items.</p> <p>Review of Betco Green Earth PUSH Drain Maintainer Floor Cleaner & Spotter description revealed: *It had no disinfectant claim. *It had no claim to kill bacteria. *It was an enzyme agent and was to have been used to eliminate odors and keep drains clean.</p>	F 441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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K 000 INITIAL COMMENTS

Surveyor: 14180
A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 8/27/14. Wakonda Heritage Manor Avera Health 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 upon correction of deficiencies identified at K011, K062, and K069 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

K 011 NFPA 101 LIFE SAFETY CODE STANDARD
SS=D

If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2

This STANDARD is not met as evidenced by:
Surveyor: 14180
Based on observation, testing, and interview, the provider failed to maintain 90 minute horizontal exit doors in operating condition. One randomly observed horizontal exit door at the entrance to the apartments did not latch when closed with the closer. The door was in the two hour fire-resistive wall between the nursing home and senior living apartments. Findings include:

K 000

Addendums noted with an asterisk per 10/14 telephone to facility administrator. JB/SDD/HMF

K 011

Fire door operations will be added to the facility preventive maintenance program. JB/SDD/HMF

The Maintenance supervisor will replace the current door closure to ensure that the [redacted] door at the entrance to the senior living apartments closes properly and the latch to the door engages. Other critical facility doors used to limit [redacted] will be monitored to ensure appropriate closure. All staff will be in-serviced regarding identification and reporting of doors that are not properly closed.

The Administrator or designee will audit proper door closure weekly x4 then monthly x3 and report findings to the QAPI Committee monthly for review and appropriate recommendations.

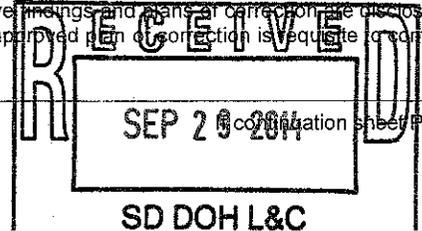
* [redacted] JB/SDD/HMF

* Fire
* the spread of fire
JB/SDD/HMF

* 9/23/14
JB/SDD/HMF

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Clayton Robert Bushnell</i>	TITLE Administrator	(X6) DATE 9/23/14
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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.



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

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FORM APPROVED
OMB NO. 0938-0391

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K 011	Continued From page 1 1. Observation and testing at 10:30 a.m. on 8/27/14 revealed the 90 minute fire rated door separating the nursing home from the senior living apartments did not latch when closed with the closer. The door was in the two hour fire-resistive wall between the nursing home and the apartments. Testing the door several times with the administrator revealed the door pulled into the frame, but the latch would not engage. Interview with the administrator at the time of the observation and testing confirmed that finding. He further stated the door hardware would be adjusted or repaired as soon as possible. This deficiency could affect the safety of all residents due to smoke and fire.	K 011		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on record review and interview, the provider failed to ensure the automatic sprinkler system had the five year internal inspection completed in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection, testing, and maintenance</p>	K 062	<p>Building Sprinkler Company has committed to providing a five year internal inspection before 10.3.14. Administrator or designee will review new inspection reports when available from Building Sprinkler Company to ensure proper follow-up is completed based on professional recommendations.</p> <p>* [REDACTED] JDS/SD/CH/MF * Administrator or designee will report findings to the monthly DAPI committee for review and appropriate recommendations. JDS/SD/CH/MF</p>	<p>* 10/3/14 JDS/SD/CH/MF</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2014
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K 062 Continued From page 2 reports at 11:00 a.m. on 8/27/14 revealed an annual inspection had been completed by Building Sprinkler Company. In the comments section of the 11/30/11 report a required five year internal inspection of the system was recommended. None of the annual sprinkler system reports following the 11/30/11 report indicated that inspection had been completed. Interview with the administrator at the time of the record review revealed he could not confirm that test had ever been completed. This deficiency could affect the safety of all residents due to fire and smoke.

K 062

K 069 SS=D NFPA 101 LIFE SAFETY CODE STANDARD
Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96

This STANDARD is not met as evidenced by:
Surveyor: 14180
Based on document review and interview, the provider failed to ensure the kitchen hood fire suppression system was connected to the building fire alarm signaling system for one of one kitchen hood. Findings include:

1. Document review at 11:00 a.m. on 8/27/14 of the commercial kitchen equipment inspection report for the March 2014 inspection, identified the kitchen hood fire suppression system was not connected to the building fire alarm system. Interview with the administrator at the time of the document review revealed he was unaware of the requirement. He stated he wished the inspection company would have identified the deficiency when noted. This deficiency could affect the safety to staff and residents due to fire and

K 069

Automatic Building Controls will connect our kitchen hood with our building fire alarm system before 10.10.14. Administrator or designee will new review inspection reports when available from Automatic Building Controls to ensure proper follow-up is completed based on professional recommendations.

*10/10/14
JBISD/DMF

x [REDACTED] JBISD/DMF
*Administrator or designee will report findings to the monthly ADPI committee for review and appropriate recommendations. JBISD/DMF

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

PRINTED: 09/09/2014
FORM APPROVED
OMB NO. 0938-0391

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K 069	Continued From page 3 smoke.	K 069		

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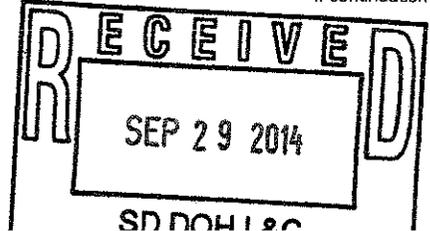
South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/28/2014
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S 000	Initial Comments 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 8/26/14 through 8/28/14. Wakonda Heritage Manor was found not in compliance with the following requirement: S206.	S 000	Addendums noted with an asterisk per 10/16/14 telephone to facility administrator. PE/SDDH/ME	
S 206	44:04:04:05 PERSONNEL-TRAINING The facility must have a formal orientation program and an ongoing education program for all personnel. Ongoing education programs must cover the required subjects annually. These programs must include the following subjects: (1) Fire prevention and response. The facility must conduct fire drills quarterly for each shift. If the facility is not operating with three shifts, monthly fire drills must be conducted to provide training for all staff; (2) Emergency procedures and preparedness; (3) Infection control and prevention; (4) Accident prevention and safety procedures; (5) Proper use of restraints; (6) ...Resident rights; (7) Confidentiality of...resident information; (8) Incidents and diseases subject to mandatory reporting and the facility's reporting mechanisms; (9) Care of...residents with unique needs; and (10) Dining assistance, nutritional risks, and hydration needs of...residents. ...Additional personnel education shall be based on facility identified needs.	S 206	Staff were educated regarding resident's pressure ulcer. PE/SDDH/ME Avera Education and Staffing will be providing education identifying, assessing and monitoring pressure ulcers to all professional nurses on 9.25.14. # The Director of Nursing or designee will monitor for appropriate pressure ulcer documentation and orders monthly x3 months then quarterly for one year thereafter and report findings to the QAPI Committee monthly for review and appropriate recommendations. * [REDACTED] PE/SDDH/ME * residents charts/acute care plans PE/SDDH/ME	* 9/25/14 PE/SDDH/ME

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Clay Michael Bestaluk</i>	TITLE Administrator	(X6) DATE 9/23/14
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South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10701	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/28/2014
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NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073
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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) COMPLETE DATE
S 206	<p>Continued From page 1</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32335</p> <p>Based on record review and interview, the provider failed to educate the nursing staff on identifying, accessing, and monitoring pressure ulcers (a sore caused by unrelieved pressure that resulted in damage to skin) for one of one sampled resident (5) with an open area. Findings include.</p> <p>1. Review of resident 5's 8/16/14 acute care plan revealed he had two open areas and a reddened area that had been noticed that day. The licensed practical nurse (LPN) had begun the treatment of Silvadene covered by a large island dressing (a dressing to cover a wound). She had not received a physician's order and had not followed the provider's standing order procedure for wound care.</p> <p>Review of resident 5's medical record revealed a fax dated 8/21/14 to the physician stating the resident had open areas on his bottom. They had asked if they could start Silvadene and an island dressing daily. That had been five days after the open areas had been discovered.</p> <p>Review of resident 5's 11/23/13 admission orders with the standing facility order form revealed wound care would have been initiated by the nurse on duty to include "dressing with bacitracin" not Silvadene.</p> <p>Interview on 8/26/14 at 5:00 p.m. with LPN A and the director of nursing (DON) revealed: *The DON had been unaware of any open areas to resident 5's bottom. *LPN A stated resident 5 had two stage I pressure ulcers and one stage II pressure ulcer.</p>	S 206		

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S 206	<p>Continued From page 2</p> <p>Interview on 8/26/14 at 5:15 p.m. with the DON and the Minimum Data Set (MDS) assessment nurse revealed: *They were unsure if resident 5 had any pressure ulcers. *They had not seen the areas. *The nurse on duty was supposed to identify areas caused by pressure and begin the appropriate documentation. *On 8/21/14 the MDS nurse had noticed treatment had been started on 8/16/14 without physician notification. She had faxed the physician at that time.</p> <p>Interview on 8/26/14 at 5:45 p.m. with LPN A revealed she had not known what tools or documentation to utilize regarding stage II pressure ulcers. She had not received training on identifying, accessing, or monitoring pressure ulcers from the provider.</p> <p>On 8/27/14 at 10:00 a.m. resident 5 refused to have surveyor 32332 look at the open areas on his bottom.</p> <p>On 8/27/14 at 10:50 a.m. the DON reported to this surveyor there were no red areas on resident 5's bottom. He had a small open slit, but it was not from pressure. It appeared to have been from moisture. The DON could not locate any documentation of the nursing staff having been trained on identifying, accessing, and monitoring pressure ulcers. She agreed education was needed in that area.</p>	S 206		