

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

ORIGINAL

PRINTED: 06/23/2014
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/11/2014 |
| NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382 | | |
| (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 Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 6/10/14 through 6/11/14. Weskota Manor was found not in compliance with the following requirements: F221, F241, F280, F281, F364, and F441. | F 000 | Addendums noted with an asterisk per 7/17/14 telephone to facility den. CSJSDOH/MF | | |
| 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. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to: *Ensure wheelchair brakes were not applied without the consent of the resident for three of three random observations of unidentified residents in the dining room. *Ensure side rail assessments had been appropriately completed for five of five sampled residents (1, 4, 6, 7 and 9) to ensure proper use and safety. Findings include: 1. Random observation on 6/10/14 at 5:35 p.m. of resident 9 while she had been pushed up to her table by feeding assistant (FA) B revealed: *The resident had been wheeled to the dining room by unidentified staff. | F 221 | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shea Blue* TITLE: Administrator & CEO (X6) DATE: 07/09/2014

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 221 | <p>Continued From page 1</p> <p>*FA B then pushed resident 9 in her wheelchair to her table. *Resident 9 began to back up using her feet in her wheelchair away from the table. *FA B proceeded to again push her back to the table. *Resident 9 stated "You are rough." *FA B replied to resident 9 "Well you need to sit still." She then locked the wheelchair brakes on the resident's wheelchair. *The resident was cognitively impaired (decreased mental status) and unable to unlock her brakes on the wheelchair.</p> <p>Random observations on 6/11/14 during the noon meal service of two unidentified certified nursing assistants (CNA) regarding the application of wheelchair brakes for two unidentified residents in wheelchairs revealed: *Residents had been wheeled into the dining room and brought to their assigned seating. *Brakes had been applied to the wheelchairs of the residents by the CNAs without the residents consent. *It was unknown if the residents would have been able to release the brakes if they desired. *The residents had been observed throughout the course of their meal with the brakes applied on their wheelchairs.</p> <p>2. Observation and interview on 6/10/14 at 2:00 p.m. with resident 6 in her room while she laid in bed revealed: *Her right side of the bed had been along the wall. *The left side had a half upper side rail in the up position. *She stated she "sometimes" used the side rail for assistance in positioning while in bed.</p> | F 221 | <p><i>*any residents including resident 9 CS/SDDH/MF</i></p> <p><i>*2-4 random observations weekly and monthly 8-10 random observations monitoring that wheelchair CS/SDDH/MF</i></p> <p>1. Staff member FA B was counseled and educated to not lock the brakes on ██████████ wheelchairs without the residents consent and ability to unlock them. Staff member FA B was counseled and educated to talk appropriately and respectfully to the residents and treat them with dignity. The Director of Resident Care reviewed and updated the Restraint Use Policy. All staff was educated on July 7, 2014 regarding criteria for locking brakes on residents wheelchairs. The Director of Resident Care will complete ██████████ brakes are not locked without the residents consent and their ability to unlock them. The Director of Resident Care will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Mgmt/QI committee advises to discontinu</p> | 7-31-2014 |
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| F 221 | Continued From page 2 Review of resident 6's medical record revealed: *Her care plan and current Minimum Data Set (MDS) had not included the use of side rails for positioning. *She had no formal assessment documented on side rail use in her chart. Surveyor: 32331 3. Observation on 6/10/14 at 10:30 a.m. of resident 4's room revealed two quarter side rails attached to her bed in the down position. One was on the top half of her bed and one on the bottom half of her bed. Review of resident 4's medical record revealed: *She had a history of falls. *No assessment had been completed for the use of the side rails. *There were no physician's orders for the side rails. Review of resident 4's revised 5/29/14 care plan revealed the upper side rail had been documented on the care plan for positioning. Review of resident 4's 5/22/14 MDS assessment, section P, under physical restraints revealed a side rail was used daily. Observation on 6/11/14 at 7:45 a.m. of resident 4 in her bed revealed a quarter side rail up on the top half of her bed. Interview on 6/11/14 at 10:20 a.m. with the director of nursing (DON) regarding the side rails on resident 4's bed revealed: *She used the upper side rail for positioning. | F 221 | 2. 3. 4. 5. 6. A new Side Rail Use Assessment form was implemented and completed for residents 6,4,1 and 7. Family for all these residents were notified of the risks and benefits of side rail usage. The Care Plans for these residents have been updated to reflect side rail usage. The MDS Assessments will be updated for side rail usage on these residents next assessment period. The Director of Resident Care Services reviewed and updated the Restraint Use Policy. All staff was educated on July 7, 2014 regarding restraints and side rail use. The Side Rail Use Assessment Form will be completed upon resident admit, quarterly MDS assessment and with any significant change of the resident. The risks and benefits will be reviewed with the resident and/or their family and the resident or their family will sign off on the use of side rails. The Director of Resident Care or MDS Coordinator will complete a concurrent QI at care conferences assuring that assessment forms are completed on admits and MDS assessments. The Director of Resident Care Services will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 | |

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| F 221 | <p>Continued From page 3</p> <p>*Side rails were being reviewed quarterly, however, they were not being completed thoroughly.</p> <p>*She agreed side rails needed to have been completely assessed for their continued use.</p> <p>Surveyor: 32332</p> <p>4. Random observation on 6/10/14 and 6/11/14 of resident 1's bed revealed one half side rail on the top half of her bed.</p> <p>Review of resident 1's medical record revealed: *The 5/22/14 care plan indicated she: -Had required extensive assistance of one or two staff for bed mobility. -Used one side rail to the upper half of the bed for positioning. *A 5/14/14 MDS 3.0 Coordinator Assessment had indicated: -Restraints in bed: One side rail every day (QD) for positioning. *A 5/21/14 Annual assessment by the MDS coordinator stating "Uses one upper SR [side rail] every day [QD] for positioning, not as restraint." *No side rail consent form had been located in her medical record.</p> <p>5. Random observations on 6/11/14 of resident 7's bed revealed one half side rail on the top half of her bed. Interview on 6/11/14 at 11:30 a.m. with resident 7 revealed she used the side rail daily to assist with repositioning.</p> <p>Review of resident 7's medical record revealed: *The 5/20/14 care plan indicated she: -Used one side rail to the upper half of her bed to reposition herself. -Used one side rail to stand and transfer onto the</p> | F 221 | | |

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| F 221 | Continued From page 4 commode. *A 4/15/14 MDS Coordinator's admission assessment indicated she used: -One upper side rail for positioning. -Held the side rail to stand for transfers. *No restraint consent form had been located in her medical record. 6. Interview on 6/11/14 at 3:00 p.m. with the MDS coordinator revealed: *The side rails had been discussed at each care conference, however: -Residents or families had not signed consents indicating they had been instructed of possible risks of side rail use. -She had not used the provider's Physical Restraint Elimination Assessment to determine the appropriateness of the side rail. Review of the provider's February 2010 Restraint Use Policy revealed: *Prior to use of a restraint there must have been documentation in the medical record of: -The resident or resident representative notification as to the benefits and risks associated with the use of the restraints. -The resident or resident representative was to have made informed consent for use of the restraint quarterly. -The intended outcome for use of a restraint. | F 221 | | | |
| F 241 SS=E | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. | F 241 | | | |

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| F 241 | Continued From page 5 This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation and interview, and resident rights brochure, the provider failed to ensure the dignity of residents was maintained in the dining room during random observations by: *Locking the breaks on a resident's wheelchair (9) and telling her to "sit still." *Releasing the handles on the wheelchair of resident (11), allowing the resident's wheelchair to move another five feet unassisted. *Pulling a resident (3) in a Geri-chair (special reclining chair on wheels) backwards through the dining room. *Not serving residents meal trays together when seated at the same table. *Not providing or respecting resident's privacy during resident council or group meeting. *Not assisting dependent residents to eat in an appropriate amount of time after setting up their trays. Findings include: 1. Random observation on 6/10/14 at 5:35 p.m. of feeding assistant B with resident 9 revealed: *The resident had been wheeled to the dining room by unidentified staff. *Feeding assistant B then pushed resident 9 in her wheelchair to her table at the opposite end of the dining room from this surveyor. *The resident began to back away from the table in her wheelchair using her feet. *She proceeded to again push the resident back to her table. *The resident stated "You are rough." *Feeding assistant B replied "Well you need to sit still." | F 241 | 1. 2. 3. Staff member FA B was counseled and educated to not lock the brakes on residents wheelchairs without the residents consent and ability to unlock them; to talk appropriately and respectfully to [REDACTED] and treat them with dignity; to be in control of wheelchairs and geri-chairs at all times until the chair is in a stopped position; and that the proper way to push ger-chairs and wheelchairs is in the forward position. The Director of Resident Care Services reviewed and updated the Restraint Use Policy and Residents Rights Policy. All staff was educated on July 7, 2014 regarding proper processes for locking brakes on residents wheelchairs, speaking with respect and dignity to the residents, being in control of wheelchairs and ger-chairs at all times and pushing geri-chairs and wheelchairs in the forward position. The Director of Resident Care will complete [REDACTED] [REDACTED] brakes are not locked without the residents consent and their ability to unlock them, speaking with respect and dignity to the residents, being in control of wheelchairs and geri-chairs at all times and pushing geri-chairs and wheelchairs in the forward position. The Director of Resident Care will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. all residents including 3, 9 & 11 [REDACTED] | 7-31-2014 | |

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| F 241 | <p>Continued From page 6</p> <p>*She then locked the wheelchair brakes on the resident's wheelchair.</p> <p>2. Random observation at 5:40 p.m. on 6/10/14 in the dining room, regarding feeding assistant B and resident 11 revealed: *She wheeled the resident into the dining room towards her table. *She proceeded to release the handles on the wheelchair prior to stopping. *The resident continued to move forward in her wheelchair approximately another five feet before coming to a stop.</p> <p>3. Random observation later that same day at 6:00 p.m. in the dining room regarding resident 3 in her Geri-chair revealed feeding assistant B: *Grabbed the handle on the back of the resident's chair. *Had not turned the resident to face the direction of travel through the dining room. *Proceeded to pull the resident one handed backwards through the dining hall to her spot at the assistive table.</p> <p>4. Random observations on 6/10/14 in the dining room regarding residents that had to wait for their trays to be delivered revealed: *Multiple unidentified residents had to wait to be served their meals while their table mates ate their supper. *Some residents were not served until after their table mates had finished eating. *Random unidentified resident comments were heard by this surveyor about their frustration having not been served at the same time as their table mates.</p> <p>Surveyor: 26180</p> | F 241 | <p>4. All staff was educated on July 7, 2014 that meal trays need to be served to residents when all tablemates are at the table. Nursing and dietary staff will communicate to ensure that all residents at a table are present before meal trays are served. The Food Service Manager will complete [REDACTED] that meal trays are being served when all residents are present at their table. The Food Service Manager will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> <p><i>* (continued from page 6) weekly QI of 3-4 random observations and monthly thereafter 8-10 random observations monitoring that wheelchair CS/SD/DH/MF</i></p> <p><i>* weekly QI of 3-4 random observations and then monthly 8-10 random observations monitoring CS/SD/DH/MF</i></p> | 7-31-2014 |

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| F 241 | Continued From page 7 5. Observation of resident 3 on 6/10/14 during the supper meal service revealed: *She received her covered meal tray at 6:04 p.m. *She was unable to feed herself. *There was not a staff person to assist her with eating until 6:22 p.m., eighteen minutes after she had received her tray. Random observations in the dining room at the above time revealed a table of seven dependent residents were served their meals at 6:05 p.m.. Staff had not started to feed them until 6:25 p.m. 6. Observation and interview on 6/10/14 at 2:00 p.m. with the resident council revealed: *A group of seven residents representing the resident council met with the surveyors in the dining room. *All doors in to the dining room were closed for the meeting. *During the one hour meeting at least ten interruptions occurred with staff walking through the meeting room. Review of the provider's resident rights in long term care facilities brochure which was given to residents in their admission packet revealed "When you enter a long-term care facility, you must be treated as an individual with respect, dignity and consideration." 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. | F 241 | 5. All staff was educated on July 7, 2014 and nursing staff was educated on June 26, 2014 that dependant residents will be served their meal trays when nursing staff is available to assist them. These meal trays will remain in the kitchen area until staff is available to assist the dependant residents with their meal. The charge nurse on duty will make sure that meal trays are not brought out of the kitchen prior to staff assisting the residents are present. The Food Service Manager will complete [redacted] dependant residents are not served until staff is available to assist them. The Food Service Manager will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. <i>*a weekly QI of 3-4 random observations and then monthly 8-10 random observations monitoring that</i> 6. The Resident Council meeting on June 11, 2014 was held in the Manor Family Living Room providing privacy. The Activity Coordinator reviewed and updated the Resident/Family Council policy to reflect resident council meetings will be held in the Family Living Room for privacy. All staff was educated on July 7, 2014 on the location change to the Family Living Room for Resident Council meetings for more privacy. The hallway double doors will be closed | 7-31-2014 | |
| F 280 SS=D | | F 280 | | | |

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| F 280 | Continued From page 8 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure the care plan had been revised with a complete and accurate guideline for one of one sampled resident (6) with regard to repositioning and Ace wrap application. Findings include: 1. Observation and interview on 6/10/14 at 12:30 p.m. with resident 6 revealed she: *Had been lying in bed on her side. *Stated she would be repositioned in bed only when she asked. *Had an Ace wrap applied to her right arm to "help keep the swelling down" from a recent infection in her arm. *Stated "sometimes they put my Ace wrap on, sometimes they don't. Depends on if they remember." | F 280 | F241 #6 continued: and notices will be posted when Resident Council is in session so there are no interruptions. The Activity Coordinator will report the number of Resident Council meetings and location of the meetings to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 | |

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| F 280 | <p>Continued From page 9</p> <p>Observation of resident 6 at supper time that same day revealed her Ace wrap had large gaps in the wrapping and most of the Ace had moved towards her wrist.</p> <p>Observation and interview on 6/11/14 at 12:15 p.m. of resident 6 revealed she had no Ace wrap applied that day.</p> <p>Review of the medical record for resident 6 revealed: *She was non ambulatory (does not walk). *She had an open pressure ulcer in the crease between her buttocks. *"Reposition per protocol" had not been check marked on the care plan. *"Try to avoid her sitting up for more than two hours at a time" had been hand written on 6/3/14 on the care plan. *Her care plan made no mention of the Ace wrap, how long it would remain on or off, or nursing interventions to check for circulation in her arm when the Ace had been applied. *The treatment record dated 6/5/14 had "Ace wrap to right arm if she can tolerate it" written in. *No documentation had been found in the medical record that assessed the resident to see if the Ace had been tolerable.</p> <p>Interview with the director of nursing (DON) regarding resident 6 revealed: *The resident was on a turn schedule that she had "created for repositioning" that noted when the resident was in bed or out of bed. *Staff were to note the time when the resident's location had been changed [from bed to chair]. *She agreed: -Proper repositioning should be more than "time up or time down."</p> | F 280 | <p>Resident 6's Care Plan was updated July 8, 2014 to include the repositioning schedule, ace wrap is applied to the right arm and addresses open sore area. A notice has been given to all nurses that they must document all cares and treatments on the residents Care Plan. This information will be reviewed again at the nurses meeting by July 31, 2014. The night charge nurse will follow up and ensure cares are documented on the Care Plan per the Daily Resident Change form. The Director of Resident Care or other designated staff will monitor weekly to ensure all new orders, falls and skin conditions are on the residents Care Plan. The Director of Resident Care Services will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> | 7-31-2014 | |

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| F 280 | Continued From page 10 -If the resident remained in the same position for more than an hour [with an open pressure ulcer] she needed to be repositioned in her current location [bed or chair]. -The care plan had no interventions or goals related to the Ace wrap. -Staff would have no way to know how to correctly care for the resident without an accurate or complete care plan. | F 280 | | | |
| F 281 SS=D | Review of the provider's July 2013 Resident Care Plan Policy revealed a care plan would identify areas that needed to be addressed, contain a goal, and specific interventions. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 32332 Based on record review, interview, and policy review, the provider failed to ensure fluids were monitored for two of two sampled residents (1 and 7) with fluid restrictions. Findings include: 1. Review of resident 1's medical record revealed a 1/10/14 physician's order for 1800 cubic centimeter [cc] fluid/24 hour restriction. Review of resident 1's food services diet card (used by the dietary department to prepare her food trays) revealed she was to have received 450 cc at every meal for a total of 1350 cc in twenty-four hours. | F 281 | | | |

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| F 281 | <p>Continued From page 11</p> <p>Review of a breakdown of her fluids developed by the dietary manager for the dietary staff had revealed she was to have received: *Breakfast 450 cc. *Dinner 350 cc. *Supper 350 cc. *The twenty-four hour total for the dietary department was to have equaled 1150 cc without her afternoon or bedtime snack.</p> <p>Review of the dietitian's 5/8/14 Medical Nutrition Therapy Assessment revealed resident 1 was to have received an 1800 cc fluid restriction. The assessment had stated the resident's meal intake had been 50 to 100 percent. It had not indicated how much fluid the resident had been taking.</p> <p>Review of her medical record revealed a 5/15/14 note from the dietary manager stating "Nursing gives 550 cc and dietary 450 cc per twenty-four hours. We allow the rest of the fluids at lunch time and other intakes."</p> <p>Review of resident 1's 5/22/14 care plan revealed she was to have been given: *With every meal 450 cc. *By the nursing department 550 cc of fluids every 24 hours.</p> <p>Review of resident 1's 6/7/14 through 6/10/14 intake record revealed: *Breakfast and lunch intakes had been documented. *The supper intake had been documented one of four days. *Extra fluids given by nursing staff from 6:00 a.m. through 6:00 p.m. had been documented. *Extra fluids given by nursing staff from 6:00 p.m.</p> | F 281 | <p><i>* see page 15 (S/S/D/D/H) MF</i></p> <p>Dietary staff will monitor and document the fluid intake in cc's for residents with fluid restriction after each meal of breakfast, dinner and supper. The dietary staff will submit this information to the night charge nurse who will then document it in the Treatment Medication Record. Nursing staff will document intake on the Intake form that is placed in the residents room. The charge nurse will document the nursing total from a 24 hour period in the Treatment Medication Record. The night charge nurse will then document the total of dietary and nursing cc's on the Treatment Medication Record at the end of the 24 hour period to ensure fluid restriction is met. Documentation will be on the residents Care Plan as to how much fluid each department is allowed to give the resident. This process was communicated to dietary and nursing staff by July 8, 2014. The Fluid Restriction policies were reviewed and updated. The Food Service Manager or designee will monitor and document daily for two weeks then weekly for two months and monthly thereafter that dietary staff reported intake to nursing for each meal. The Director of Resident Care or designee will monitor and document daily for two weeks then weekly for two months and monthly thereafter that daily totals were documented in the Treatment Medication Record. The Food Service Manager and Director of Resident Care will each report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> | 7-31-2014 |

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| F 281 | <p>Continued From page 12 through 6:00 a.m. had not been documented. *Twenty-four hour totals had not been done to ensure the required restrictions were being met.</p> <p>2. Review of resident 7's medical record revealed a 5/27/14 physician's order for 2000 cc fluid restriction.</p> <p>Review of her diet card revealed she was to have received 490 cc per meal for a total of 1470 cc in twenty-four hours.</p> <p>Review of a breakdown of her fluids developed by the dietary manager for the dietary staff revealed: *Breakfast 475 cc. *Dinner 500 cc. *Supper 500 cc. *The twenty-four hour total for the dietary department was to have equaled 1475 cc without her afternoon or evening snack.</p> <p>Review of the dietitian's 5/8/14 Medical Nutrition Therapy Assessment revealed resident 7's meal intake was between 50 to 100 percent. It had not included the resident's fluid intake.</p> <p>Review of resident 7's 5/28/14 care plan revealed she was to have been given 2000 cc. It did not state who was to have given the fluid.</p> <p>Review of resident 7's 6/6/14 through 6/10/14 fluid intake record revealed: *Breakfast and lunch intakes had been documented. *The supper intake had not been documented three of five days. *Extra fluids given by nursing staff from 6:00 a.m. through 6:00 p.m. had been documented. *Extra fluids given by nursing staff from 6:00 p.m.</p> | F 281 | <p><i>*A new policy has been established to ensure accurate fluid intake monitoring for all residents including residents 1 and 7.</i> <i>CS/SDDDH/MF</i></p> | |

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| F 281 | <p>Continued From page 13 through 6:00 a.m. had not been documented. *Twenty-four hour totals had not been done.</p> <p>Interview on 6/11/14 at 2:15 p.m. with certified nursing assistant (CNA) A revealed when asked how much fluid she was to have given each resident she stated: *She was not sure how much fluid residents 1 and 7 were to have received during her shift. *One nurse would place a glass of water at each resident's bedside. She was to have let that nurse know when that fluid was gone. *She was not sure what the other nurses did to measure the residents' fluid intakes.</p> <p>Interview on 6/11/14 at 2:20 p.m. with CNA D revealed: *She would have given residents 1 and 7 fluids in little glasses and then charted how much they drank. *The nurse documented the fluid intake. *She could document the intake but she did not think they kept intake records in the residents' rooms.</p> <p>Interview on 6/11/14 at 3:00 p.m. with CNA C revealed: *She was not sure of the amount of fluid the above residents received. *She told the nurse when the resident wanted a drink. *The nurse filled the glass.</p> <p>Interview on 6/11/14 at 2:45 p.m. with registered nurse (RN) G revealed: *The nursing department was responsible for documenting fluid intakes. *The intake totals had not been done at the end of each day.</p> | F 281 | | |

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| F 281 | Continued From page 14 Interview on 6/11/14 at 4:00 p.m. with the dietary manager revealed: *Nursing was to have documented all fluid intake for residents 1 and 7. *There had been no total fluid intakes documented for the residents. *Neither she nor the dietitian would have been able to know how much fluid the residents had been taking in. Interview on 6/11/14 at 3:15 p.m. with the director of nursing revealed the nursing department had not documented residents 1 and 7's fluid intake totals. Review of the provider's July 2009 Fluid Restriction policy revealed: *Nursing was responsible for recording the intake of fluid each shift. *Dietary would follow the provider's medical centers policy on fluid restriction. Review of the provider's medical centers June 2000 Fluid Restriction policy revealed: *"Post 'fluid restriction' on patient information board in (patient's) room." *If the restriction had been 1200 cc or less dietary would take 480 cc of the total amount. *If the restriction had been more than 1200 cc dietary would take 600 cc of the total amount. *Nursing would take the remainder and divide it between both shifts. | F 281 | | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive | F 364 | | | |

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| F 364 | <p>Continued From page 15 value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure nutritional value was maintained for one of three meal preparations for five of five sampled resident (8, 12, 13, 14, and 15) on pureed diets. Findings include:</p> <p>1. Observation on 6/10/14 at 11:50 a.m. with cook I revealed: *She placed five servings of the broccoli and cauliflower vegetables from a half-sized steam table pan located in the steam table into a blender container. *She then placed the blender containing the vegetables under the faucet on the two-compartment sink and placed tap water into the blender. *She placed the blender container on the blender's base to puree the vegetables. *She removed the pureed vegetables from the blender with a spatula into a quarter-sized steam table pan. *She placed the pureed vegetables into the steam table next to the pureed au gratin potatoes.</p> <p>Interview on 6/11/14 at 11:51 a.m. with cook I revealed: *She had pureed the au gratin potatoes using hot tap water from the sink. *There were five residents 8, 12, 13, 14, and 15 on pureed diets.</p> | F 364 | <p>The Food Service Manager reviewed and updated the Food Preparation Policy* All dietary staff was educated on June 30, 2014 on the proper process to puree foods. The Food Service Manager will monitor weekly for one month and monthly thereafter to ensure dietary staff are following proper process when pureeing foods. The Food Service Manager will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> <p><i>affecting all residents on pureed diets including residents 8, 12, 13, 14 and 15. CSDDDHMF</i></p> | 7-31-2014 | |

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| F 364 | Continued From page 16 Observation on 6/11/14 from 11:53 a.m. through 12:25 p.m. in the kitchen revealed cook I served the meals to the residents in the dining room including residents 8, 12, 13, 14, and 15 on pureed diets. Interview on 6/11/14 at 3:00 p.m. with the certified dietary manager revealed: *Pureed foods needed to have been prepared with extra nutritious foods such as broth, gravies, milk, and juices in the pureed process as appropriate for the food item. *Adding tap water to the blending process of the pureed foods was inappropriate. *The nutritive content of the vegetables and the au gratin potatoes had been compromised by using tap water for blending into a pureed consistency. Review of the provider's August 2013 Food Preparation policy revealed: *Cooks used food preparation and cooking techniques that provided quality food in appearance, taste, and nutrients. *Pureed foods were to have been blended with liquids that added further nutrients (vegetable juices, fruit juices, and milk) rather than water. *In all areas of food preparation a maximum effort was made to have retained the nutrient value of the food. | F 364 | | | |
| F 441 SS=E | 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 | F 441 | | | |

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| F 441 | Continued From page 17 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. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure appropriate infection control practices were | F 441 | Staff member CNA A was educated on July 8, 2014 on the proper cleaning and disinfecting process of the whirlpool tub. Instructions for cleaning and disinfecting of the whirlpool tubs were updated and reviewed with staff who bathe residents. The updated instructions were placed in each whirlpool room for easy reference. All staff was educated on July 7, 2014. The Director of Resident Care or charge nurse will complete weekly observations on the days baths are given for one month. Then monthly, 8-10 random observations will be made to ensure proper cleaning and disinfecting if completed. The Director of Resident Care will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 |

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| F 441 | <p>Continued From page 18</p> <p>followed for:</p> <ul style="list-style-type: none"> *The cleaning and sanitizing one of one observed whirlpool tub (north hall). *The cleaning and disinfecting of multi-use curlers between residents' use in the beauty shop. *Hand washing and glove use during the care of two of nine sampled residents (6 and 3). *Proper hand hygiene and appropriate handling of food between residents for one of one unidentified resident and one of one sampled resident (2). <p>Findings include:</p> <ol style="list-style-type: none"> 1. Observation and interview on 6/10/14 at 10:20 a.m. of certified nursing assistant (CNA) A while she cleaned the whirlpool tub without gloves revealed she: <ul style="list-style-type: none"> *Started the water in the whirlpool tub. *Pressed the disinfectant button, held it for five seconds, then released it. *Filled the tub about "half way" and scrubbed the tub with a brush. *Was not sure how long to press the disinfectant button to get the appropriate amount of disinfectant in the tub jets. *Agreed she should have worn gloves when touching contaminated equipment. <p>Interview on 6:10 p.m. at 2:45 p.m. with the maintenance supervisor regarding the cleaning of the north hall whirlpool tub revealed he agreed:</p> <ul style="list-style-type: none"> *Not enough sanitizer had been used in the whirlpool tub to disinfect it. *The provider's instructions needed to be updated to match manufacturer's guidelines. <p>Review of the May 2008 whirlpool cleaning instructions revealed:</p> | F 441 | | |

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| F 441 | <p>Continued From page 19</p> <p>**"Release the button [disinfectant] after you see the solution coming out of all the air jets." **"Try to let the disinfectant set 10 minutes."</p> <p>Review of the manufacturer's guidelines for the whirlpool tub revealed: **"Release the button [disinfectant] after you see solution coming out of the jets and you have 1-1/2 gallons of disinfectant solution in the foot well of the tub."</p> <p>2. Random observation on 6/10/14 of the beauty shop revealed: *Two plastic tubs. One contained perm rods (used to give hair curl in the perming process), and the other tub contained plastic curlers. *Both tubs had large amounts of hair and debris around the curlers and rods and in the bottom of the container.</p> <p>Interview on 6/11/14 at 8:00 a.m. with the licensed beautician E regarding the curlers and perm rods revealed: *She had been "doing hair" for thirty years. *Her practice was to take the curlers and rods home at the end of the week and clean and sanitize them. *She had never heard of disinfecting the above items between use but it "makes sense I guess." *She was unaware of the rules governing her license regarding good infection control practices.</p> <p>Interview on 6/11/14 at 1:50 p.m. with the director of nursing (DON) regarding the cleaning of beauty shop items revealed it had been her expectation multi-use items were cleaned between resident use.</p> <p>Review of the South Dakota Department of Labor</p> | F 441 | <p>2. #</p> <p>The plastic curlers were disposed of and new ones purchased. The Director of Resident Care discussed with beautician E on July 7, 2014 guidelines for cleaning of cosmetology supplies such as perm rods and curlers. The Director of Resident Care developed a Personal Care Room policy. It is posted in the Personal Care Room as well as placed in the General Policy and Procedures Manual. All staff were educated on July 7, 2014. Each beauty operator will be informed that they are responsible for cleaning of their supplies properly. If families are using the personal care room, they are instructed to provide the curlers, etc. for the resident. Families will be informed in the next facility newsletter and upon admission. The Business Office Staff will complete weekly monitor for two weeks and then monthly QI monitors to assure no curlers/perm rods are left in the personal care room. The Director of Finance will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> | 7-31-2014 |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/11/2014 |
| NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR | | | STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382 | |
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| F 441 | <p>Continued From page 20</p> <p>and Regulation, South Dakota Cosmetology Commission, Consumer Information, bullet #2, <http://dlr.sd.gov/bdcomm/cosmet/ccconsumerinfo.aspx#license> stated all multi-use items must be cleaned and sanitized before use.</p> <p>Review of the 2013 South Dakota Cosmetology Commission, Salon Self-inspection Checklist, revealed all hair supplies "should be clean and free from hair and debris."</p> <p>3. Observation on 6/10/14 at 1:50 p.m. of CNA A providing personal care to resident 6 revealed: *The resident had finished using the commode and was lifted up by the stand lift (a mechanical aide to help the resident stand) to clean her private area. *CNA A used personal wipes to cleanse her private area. *Once completed CNA A while holding the soiled wipe proceeded to pull off her soiled gloves leaving the contaminated wipe inside the glove as she pulled it off. *She then tossed the dirty glove onto a blanket in the resident's recliner. *Only after she laid the resident down in bed had she gone back to the chair to get the soiled glove and dispose of it in the waste receptacle.</p> <p>Interview in 6/11/14 with the infection control coordinator regarding hand washing and disposal of contaminated materials revealed: *It was her expectation dirty gloves were to have been put in the waste receptacle immediately after use. *She agreed the above was an infection control hazard.</p> <p>Review of the provider's undated Guidelines for</p> | F 441 | <p>3. 4a. and b. 5. Staff members CNA A, C, D and H were educated individually on July 8, 2014 on the proper hand washing, infection control and glove use practices. The Director of Resident Care reviewed and updated the Hand Hygiene Policy. All staff was educated on July 7, 2014 regarding infection control, hand washing and proper glove use. The Director of Resident Care or designated staff will complete weekly monitoring for two months and monthly monitoring thereafter of 8-10 random observations to ensure proper glove use, hand washing techniques and infection control practices are being done. The Director of Resident Care Services will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue.</p> <p><i>- during cares with all residents including residents 2, 3 and 6. CS/SDOH/MF</i></p> | 7-31-2014 |

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| F 441 | <p>Continued From page 21</p> <p>Preventing the Spread of Multiple Drug Resistant Organisms Gloving policy revealed: **Remove gloves promptly: -After use, -Before touching non-contaminated items, -Before going to another patient, -And perform hand hygiene immediately to avoid transfer of germs."</p> <p>Surveyor: 26180 4a. Observation on 6/10/14 at 11:45 a.m. with CNAs A and C while they were getting resident 3 up from bed for lunch revealed: *They entered the room and put on a pair of gloves. They had not washed their hands upon entering the resident's room. *With gloved hands they removed her soiled incontinence brief, rolled it into a ball, and laid it on the corner of her bed. *With her soiled gloves CNA C went to the resident's closet and removed a clean article of clothing. -She gave that clothing item to CNA A to put on the resident. CNA A still had her soiled gloves on. *CNA A took the Hoyer (a mechanical device to lift the resident) sling and positioned it under the resident. *When the resident had been lifted off the bed CNA A placed her soiled gloved hand in front of the resident's face to prevent the resident from hitting her head on the Hoyer bar. *CNA A folded the resident's blanket and tucked a pillow between the resident's knees. *CNA picked up the soiled items from the bed and put them in a plastic bag. *Neither of the CNAs had washed their hands during the entire process. *CNA C then pushed the resident out of the room and took her to the dining room.</p> | F 441 | | |

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| F 441 | Continued From page 22 Interview on 6/10/14 at 11:58 a.m. of CNA A revealed: *It was not her usual procedure to lay soiled incontinence briefs and other soiled items on a resident's bed. -They should have bagged those items immediately. *She confirmed she should not have held her soiled hand in front of the resident's face. *Her gloves should have been removed and her hands washed prior to that. *She confirmed CNA C had not washed her hands while she was still in the room but had used hand sanitizer out in the hallway. Interview on 6/10/14 at 12:02 p.m. of CNA C revealed she had used the hand sanitizer in the hallway outside of resident 3's room. b. Observation on 6/10/14 at 5:35 p.m. of resident 3 when CNAs D and H were getting her up from bed for the supper meal revealed: *With gloved hands they removed the soiled incontinence pad and laid it in a pile on the bed. *They immediately got her out of the bed using the Hoyer lift. They continued to have the soiled gloves on as they placed her on the commode. *After she was on the commode they bagged the soiled items that had been on her bed. *CNA D removed her soiled gloves and put a new pair on. She had not washed her hands prior to applying new gloves. -She then warmed a washcloth in the bottom of the sink and wiped the resident's eyes. -When she was finished with the wet washcloth she laid it in the resident's rocker recliner. *CNA H had the same gloves on throughout the process removing them before she left the room. | F 441 | | |

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| F 441 | Continued From page 23 5. Interview on 6/11/14 at 2:30 p.m. with the director of nursing revealed the expectation was: *No soiled linens should have been placed on a resident's bed or in a chair. *Gloves should have been changed when they were soiled. *Hands should have been washed when the gloves were removed. *Hands should have been washed when the staff entered the room, and when they left the room. *Hand sanitizer should only have been used after their hands had been washed. Surveyor: 32331 6. Observation on 6/10/14 from 12:12 p.m. through 12:15 p.m. of feeding assistant B revealed she: *Was assisting an unidentified resident eating at an assisted table in the dining room. *Picked up a one-half slice of buttered bread from the resident's plate with her bare hands. *Used the resident's spoon to place ground meat on the bread. *Folded the slice of bread in half with her bare hands and placed it in the resident's hand. *Proceeded to resident 2's table and started cutting up his food with his fork and knife. *Lifted resident 2's right hand and placed his hand on a curved-handled spoon. *Touched her glasses and wiped her hands on her apron. *Obtained a chair, touched her face, and started assisting resident 2 with eating. *Had not washed her hands or used a hand sanitizer during the above listed observations. Review of the provider's 2008 Ready-To-Eat | F 441 | 6. Staff member FA B was counseled and educated to not touch residents food with bare hands and to sanitize/wash hands before touching residents utensils or cups and inbetween feeding residents if she touches anything else. The Food Service Manager reviewed and revised the Ready To Eat Foods Policy. All staff was educated on July 7, 2014 regarding proper food handling techniques and proper hand washing and sanitizing of hands when feeding residents. Deli wraps were placed on the assisted tables at meal times for staff to use when handing food to residents. Hand sanitizer is on the assisted tables during meals for staff to use when assisting residents. The Food Service Manager or designated staff will complete weekly observations for two months and monthly thereafter to ensure proper handling of residents food. The Food Service Manager will report compliance rates to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 | |

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| F 441 | <p>Continued From page 24</p> <p>Foods policy revealed employees were to: *Have used the required utensils when serving ready to eat foods. *Not have had any contact with ready-to-eat foods with their bare hands.</p> <p>Review of the provider's August 2008 General Food Preparation and Handling policy revealed: *Handle utensils, cups, and glasses to avoid touching surfaces that food or drink may have come in contact with. *Use tongs or other serving utensils to serve breads or other items. *Never touch food directly with bare hands.</p> <p>Review of the provider's October 2008 Handwashing policy revealed when to have washed hands: *After touching bare human body parts other than clean hands. *After handling soiled equipment or utensils. *During food preparations, as often as necessary to remove soil and contamination, and to prevent cross contamination when changing tasks. *When working with ready-to-eat food. *After engaging in other activities that contaminate the hands.</p> | F 441 | | |

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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 06/11/14. Weskota Manor 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 (FSSES) dated 06/16/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for the deficiency identified as meeting the FSSES to indicate the provider's intent to correct the deficiencies identified at K062 and K130 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| 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 install a paved path of exit discharge to the public way at one exit. The north exit from the basement had a landing that ended greater than | K 038 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shae Blue* TITLE *Administrator & CEO* (X6) DATE *07/09/2014*

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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| K 038 | Continued From page 1 200 feet from the nearest street. Findings include: 1. Observation at 10:00 a.m. on 06/11/14 revealed the north exit from the east basement was not paved to the public way. It had a concrete landing that ended greater than 200 feet from the nearest street. The terrain from the concrete landing to a public way would make the installation of a sidewalk difficult. Interview with the maintenance supervisor at the time of the observation indicated that basement area was used for storage and laundry. Only staff had access to that basement with a purported maximum of two staff members in the basement at a time. | K 038 | | | |
| K 062 SS=F | The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000. NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to verify the required maintenance of the sprinkler system (backflow preventer and 5 year internal inspection) had been performed. The provider also did not have a copy of the National Fire Protection Association (NFPA) 25 Standard for the Inspection, Testing, and | K 062 | | F | |

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| K 062 | Continued From page 2 Maintenance of Water-Based Fire Protection Systems. Findings include: 1. Review of the provider's sprinkler maintenance records on 6/11/14 revealed no documentation the required annual testing of the backflow preventer had been performed. Interview with the maintenance supervisor at the time of the record review confirmed that finding. 2. Review of the provider's sprinkler maintenance records on 6/11/14 revealed no documentation the required 5 year internal obstruction inspection of the sprinkler system had been performed. Interview with the maintenance supervisor at the time of the record review confirmed that finding. He revealed the provider did not have a copy of the NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. The deficiencies affected multiple components of the building's automatic fire sprinkler system required annual maintenance. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7 | K 062 | The Maintenance Supervisor contacted Building Sprinklers Co. on June 13, 2014 to perform both the 5 year Internal Inspection and the yearly Check Valve Inspection. Building Sprinklers Co. will be on-site on July 14, 2014 to complete these inspections. These inspections have been added to the scheduled inspections by Building Sprinklers Co. The Maintenance Supervisor ordered a copy of the NFPA 25 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems to have on file. The Maintenance Supervisor will report to the Risk Management/QI committee when these inspections are complete. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 | |
| K 130 SS=D | NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to ensure exits were readily accessible at all times for one randomly observed | K 130 | | | |

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| K 130 | Continued From page 3 exit door (southeast corner of the dining room was difficult to open). Findings include: 1. Observation and testing on 6/11/14 at 10:00 a.m. of the exit door at the southeast corner of the dining room revealed the door would not open without using abnormal force. The door was dragging on the sill plate and would not close and latch into the frame unless it was pulled shut. After being pulled shut and latched the door would not easily open. Interview with the maintenance supervisor at 11:00 a.m. on 6/11/14 revealed he was aware the door was not opening and closing properly. He stated the door experienced seasonal periods of tightness due to heaving soil conditions. | K 130 | Maintenance staff will adjust the door in the SE corner of the dining room by July 31, 2014. The maintenance staff will complete monthly maintenance logs monitoring that all exit doors are readily accessible. The Maintenance Supervisor will report compliance to the Risk Management/QI committee quarterly. The review will continue until the Risk Management/QI committee advises to discontinue. | 7-31-2014 | |

SOUTH DAKOTA DEPARTMENT OF HEALTH

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10707 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/11/2014 |
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| S 000 | Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities was conducted from 6/10/14 through 6/11/14. Weskota Manor was found not in compliance with the following requirements: S210, S301, and S376. | S 000 | Addendums noted with an asterisk per 7/17/14 telephone to facility DN. CS/SDDOH/MF *The Director of Nursing will review employees J, K, L, M & N and verify they are free of communicable diseases. CS/SDDOH/MF | |
| S 210 | 44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Rule is not met as evidenced by: Surveyor: 26180 Based on employee file review and interview, the provider failed to ensure five of five sampled new employees (J, K, L, M, and N) were evaluated by a health professional for freedom from communicable diseases. Findings include: | S 210 | The statement "as of the date of this physical, this new hire of Weskota Manor Avera did not have any signs or symptoms of communicable diseases." was added to the Physical Examination form completed and signed by a licensed healthcare professional on all new hires. The licensed healthcare professional will sign off on this statement if such is correct. Once the Physical Examination form is completed on new hires it is reviewed by the Infection Control Practitioner verifying the communicable diseases certification is complete. *The Business Office Manager will review all new employees for appropriate evaluations and report quarterly to the QA committee. CS/SDDOH/MF | 7-31-2014 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shea Blue</i> | TITLE <i>Administrator & CEO</i> | (X6) DATE <i>07/09/2014</i> |
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SOUTH DAKOTA DEPARTMENT OF HEALTH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10707 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/11/2014 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST ST NE WESSINGTON SPRINGS, SD 57382 | | |
| (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 210 | Continued From Page 1 1. Review of employee files J, K, L, M, and N revealed: *They had all been employed in the past year. *They had a health evaluation completed at the time of being hired. *Those health evaluations had not addressed freedom from communicable diseases. Interview on 6/11/14 at 1:30 p.m. with the chief financial officer revealed: *She was responsible for employee files. *Their current health evaluations had not addressed communicable diseases. | S 210 | | |
| S 301 | 44:04:07:16 Required dietary inservice training The dietary manager or the dietitian in ...nursing facilities...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 Rule is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure six of nine required annual inservice training sessions (food safety, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food-handling policies, and time and temperature controls for | S 301 | The Food Service Manager will educate all staff qualified to assist residents with eating and that handle food on July 23, 2014 in the areas of 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 education will be conducted annually for all staff qualified to assist residents with eating and that handle food by the Food Service Manager or Consulting Dietician. The Food Service Manager will report to the Risk Management/QI committee when the education is completed* The review will continue until the Risk Management/QI committee advises to discontinue. <i>*monitor the attendance at the training and at the next quarterly meeting. CS/SDDO/HMF</i> | 7-31-2014 |

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| S 301 | <p>Continued From Page 2</p> <p>food preparation and service) were offered yearly for food-handling staff. Findings include:</p> <p>1. Record review of the required inservice training sessions for 2013 and 2014 for all food handling staff revealed those staff had received no training on food safety, food handling and preparation techniques, food-borne illness, serving and distribution procedures, leftover food-handling policies, and time and temperature controls for food preparation and service.</p> <p>Interview on 6/11/14 at 10:15 a.m. with the director of nursing revealed: *Food handling staff were identified as dietary, nursing, and activities staff. *She confirmed all food handling staff had not received annual inservice training on the above listed areas.</p> <p>Interview on 6/11/14 at 11:12 a.m. with the certified dietary manager revealed: *Food handling staff were identified as the dietary, nursing, and activities staff. *She confirmed all food handling staff had not received annual inservice training on the above listed areas.</p> <p>Review of the provider's May 2014 Inservices policy revealed: *Annually, staff should have received training on the following topics: -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.</p> | S 301 | | | |

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| S 301 | Continued From Page 3 -Sanitation requirements. | S 301 | | |
| S 376 | 44:04:13:16 Fire Extinguisher Equipment Fire extinguisher equipment must be installed and maintained by the following minimum standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3000 square feet (278.7 square meters) of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of the fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet; and (4) Halon chemical extinguishers may be installed and used only in those remote areas that do not present a hazard to staff...or residents. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to mark the locations for two randomly observed fire extinguishers mounted in recessed wall cabinets in two of two resident corridors. Findings include: 1. Random observation at 8:45 a.m. on 6/11/14 revealed the location of two fire extinguishers located in recessed cabinets in the resident room corridor walls were not marked with a sign | S 376 | The Maintenance Supervisor ordered the wall mounted perpendicular signs for the recessed fire extinguisher cabinets. These signs will be installed to the wall surface above the fire extinguisher cabinets by July 31, 2014. The Maintenance Supervisor will report to the Risk Management/QI committee when these signs have been installed. | 7-31-2014 |

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| S 376 | Continued From Page 4 mounted perpendicular to the wall surface above the cabinet. Interview with the maintenance supervisor at the time of the observations confirmed that finding. He stated he was unaware of the requirement. | S 376 | | |