

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

ORIGINAL

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH ST WILMOT, SD 57279	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/15/14 through 7/16/14. Wilmot Care Center Inc was found not in compliance with the following requirements: F241, F280, F309, F332, F371, and F441.	F 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
F 241 SS=D	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. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, interview, and resident rights review, the provider failed to ensure the dignity of residents was maintained by: *Two randomly observed certified nursing assistants (CNA) (F and unidentified) were not speaking to the residents at one of three observed meal services. *One randomly observed nursing assistant (NA) D moving two randomly observed residents (2 and 9) without telling them what they were doing before they had done it at one of three meal services. Findings include: 1. Observation on 7/15/14 during the noon meal service revealed CNAs F and one unidentified CNA sitting at a table with five residents who required some degree of assistance with eating.	F 241	All resident interactions with staff were audited including residents 2 and 9 to ensure staff were communicating with residents when providing cares. The Director of Nursing and Dietary Manager reviewed the Resident's "Bill of Rights" and Dignity Policy with staff including Nurse Aide D and C.N.A. F at an in-service on 8/11/2014. Director of Nursing will audit staff interaction with Residents once a week times four weeks and once a month times two months. The Dietary Manager will audit staff during dining assisting Residents once weekly times four weeks and monthly times two months. Results of audits will be reported by the Director of Nursing and Dietary Manager at the monthly QAPI meetings.	9-1-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

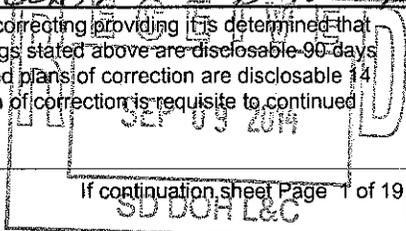
(X6) DATE

Cathy P. [Signature]

Administrator

8-12-14

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 241	Continued From page 1 Neither of those CNAs engaged in any attempt to converse with the residents throughout the meal service. 2. Observation on 7/15/14 at the evening meal revealed NA D: *Adjusted resident 2's legs by uncrossing them without telling him what she was going to do. -She then pulled up on his arms which were tightly crossed in front of his chest. She pushed his wheelchair forward forcing his arms to rest on the table. She had not told him ahead of time what she was going to do. *Then went to resident 9 and removed her oxygen tubing from her nose and pushed the resident in her wheelchair away from the table. She had not told the resident what she was going to do before she had done it. 3. Interview on 7/16/14 at 11:00 a.m. with the director of nurses revealed: *Staff should have talked to the residents at mealtime. *NA D had been newly hired and had not completed her testing yet to become certified. -She should have explained to the residents what she was going to do before she had done it. Review of the provider's 1995 Resident's Bill of Rights revealed: **"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." **"The resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident."	F 241		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	<p>Continued From page 2</p> <p>PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p> <p>Surveyor: 34030 Preceptor: 30170 Based on observation, interview, record review, and policy and procedure review, the provider failed to ensure three of nine sampled residents (2, 5, and 6) care plans were updated for the following: *A physician's ordered fluid restriction for resident 5. *The need for assistance at meals for resident 5. *Behavior management for residents 2 and 6.</p>	F 280	<p>Residents 2, 5 and 6 care plans were reviewed and revised to ensure that the care plans are current with each residents needs.</p> <p>All other residents care plans were reviewed and revised to ensure that the care plans are current with each residents needs.</p> <p>Care plan policy will be reviewed with staff at in-service on 8/11/2014 and 8/12/2014 and education provided to all staff responsible for updating care plans to reflect residents current care needs. Director of Nursing or designee will audit 3-4 care plans once a week times four weeks and monthly times two months. Direct of Nursing or Designee will report results to monthly QAPI meetings.</p> <p style="text-align: right;">9-1-14</p>

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F 280	<p>Continued From page 3</p> <p>*The care plan had been followed for repositioning every two hours for resident 5. Findings include:</p> <p>1. Review of resident 5's April 2014 care plan revealed: *There had been no documentation of his fluid restriction or his need for meal assistance. *He was to have been repositioned every two hours due to his inability to reposition himself.</p> <p>Review of resident 5's quarterly 5/7/14 Minimum Data Set (MDS) revealed he: *Needed extensive assistance of two staff for transfers. *Was at risk for developing pressure ulcers. *Was non-ambulatory. *Needed supervision and assistance for eating. *Was alert but confused.</p> <p>Review of resident 5's 6/6/14 signed physician's orders revealed he was on a 1500 milliliter (ml) daily fluid restriction.</p> <p>Review of resident 5's undated diet card also revealed he was on a 1500 ml daily fluid restriction.</p> <p>Review of resident 5's July 2014 food intake record showed fluids had been recorded at meal times and were between 940 ml and 1,350 ml. There was no further documentation of his fluid intake.</p> <p>Random observations on 7/15/14 from 9:00 a.m. through 6:10 p.m. of resident 5 revealed: *During the following times he had been sitting in his wheelchair and not repositioned by staff. -At 9:00 a.m. he was in his room. He had a mug</p>	F 280			

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F 280	<p>Continued From page 4 of water on his bedside table. -At 10:00 a.m. he was in the dining room listening to music. -At 11:10 a.m. he was in his room facing the window. -At 12:00 noon he was at the dining room table. -At 2:00 p.m. he was in his room visiting with company. -At 3:50 p.m. he continued to sit in his wheelchair in his room. *During the noon and evening meals the following occurred: -At 12:00 noon he had been falling asleep at the dining room table with his food in front of him. He had not eaten nor had he been assisted by staff to eat. -At 5:30 p.m. he had been sitting at the dining room table in his wheelchair taking sips of fluids but had not been eating. The food sat in front of him for forty minutes and at 6:10 p.m. a staff member came to assist him.</p> <p>Interview on 7/15/14 at 4:45 p.m. with certified nursing assistant I regarding resident 5 revealed: *He was transferred using a mechanical lift. *He would ask to use the bathroom. *He was not toileted regularly, but staff would check his briefs at intervals to see if he was incontinent. *He would eat poorly at meals and was not assisted by staff. *He would feed himself. *She was unaware he had been on a fluid restriction.</p> <p>Interview on 7/15/14 at 6:00 p.m. with the director of nursing (DON) regarding resident 5's meal assistance revealed: **He's like a kid, sometimes he eats and</p>	F 280			

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F 280	<p>Continued From page 5 sometimes not." **"He won't let you assist him at times."</p> <p>Interview on 7/16/14 at 1:55 p.m. with the DON revealed she agreed: *There had been no communication between dietary and nursing staff regarding his fluid restriction. *There was no specific instructions for dietary or nursing as to who would provide what amount of fluids. *His care plan had not been updated to reflect his current care needs.</p> <p>Review of the provider's procedure on encouraging and restriction of fluids dated October 2010 revealed: **"Remove the resident's water pitcher from his room. *Take in fluids for resident and record amounts consumed."</p> <p>Surveyor: 26180 2. Observation and interview on 7/15/14 at 3:30 p.m. with CNA F regarding resident 2 revealed: *The resident had a tendency to put his hands in his pants. *She told him to keep his hands at his side. *She needed to anticipate his needs, because he could not carry on a conversation.. *When he put his hands in his pants he should have been checked to make sure he did not have a red scrotum and was itching himself in that area, or if he had a bowel movement. *She stated could not imagine he could participate in a counseling session due to his declined cognitive impairment.</p> <p>Review of resident 2's 5/21/14 social services</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>assessment revealed "He seldom makes eye contact, seldom speaks. He can often be seen attempting to reach into his slacks with his hand, or scratching at his skin. When he reaches into his slacks he will get his hand as far as the band and then usually stops."</p> <p>Review of resident 2's 3/27/14 psychological progress notes completed by the psychologist revealed the resident had been alert but confused, and was unable to express himself.</p> <p>Review of resident 2's 4/25/13 care plan revealed: *The last review had been in May 2014. *He had a problem related to receiving a medication to manage a behavior he exhibited in public. *The goal was to reduce the behavior to less than weekly. *The staff interventions included: -Observe closely with diabetes. -Monitor for depression. -Remove to room if behavior is inappropriate. -Psychology visits. *There were not any interventions to: -Divert the resident and prevent the behavior other than the medications. -Manage his skin care needs if his scrotum was red and itchy. -Monitor for a bowel movement. *There had not been any updates regarding the appropriateness of the psychological visits.</p> <p>Interview on 7/15/14 at 4:00 p.m. with the director of nursing regarding resident 2 revealed they were monitoring his diabetes and depression symptoms, because the medications he was on may have caused his blood sugars to be less</p>	F 280			

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F 280	<p>Continued From page 7 controlled, and depression.</p> <p>3. Review of resident 6's nurses notes revealed on 2/25/14 "Resident refusing to have vitals taken. Hitting and slapping at this nurses hands and arms. Tried to give her 4:00 p.m. medicines with which she promptly spit out and again tried to hit nurse."</p> <p>Review of resident 6's 4/14/14 physician's orders revealed an order to increase the medication Risperdal (an antipsychotic) to 0.25 milligrams daily.</p> <p>Review of resident 6's 5/21/14 MDS revealed she: *Exhibited physical behaviors one to three days in the last seven days. *Exhibited verbal behaviors one to three days in the last seven days. *Had a diagnosis of non-Alzheimer's dementia. *She exhibited no psychosis (mental disorder).</p> <p>Interview on 7/15/14 at 3:00 p.m. with CNA A revealed resident 6's behavior was sometimes brought on by how she was approached. You had to be gentle and not abrupt with her. When she got overly tired she was more apt to become agitated. She liked to go to bed right after supper.</p> <p>Interview on 7/15/14 at 4:00 p.m. with registered nurse C regarding resident 6 revealed: *She thought her behavior varied with the way she had been approached. *You could not approach her abruptly.</p> <p>Review of resident 6's May 2014 care plan revealed: *A problem that read "psychotic" (mental</p>	F 280		

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F 280	Continued From page 8 disorder). -The approaches included administer medications as ordered, and assist to bed when resident requests. *It had not addressed: -What behaviors she exhibited. -How staff attempted to manage the behaviors without the use of medications. -What happened before the behaviors occurred. -What was meant by psychotic for this resident. 4. Review of the provider's May 2014 Use of Nursing Care Plan policy revealed: *"It is the policy of name of facility to provide an individualized nursing care plan and to promote continuity of patient care. *The care plan will include the care plan document, the Medication Administration Record, the Treatment Administration Record, the Diagnoses record and the Restorative Nursing Plan." *Identify objectives and incorporate them into the nursing care plan. *Interdisciplinary problems, goals, and approaches would be recorded. *When a goal was inappropriate or had been met, it will be crossed out with yellow marker."	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Hospice care plan reviewed and Resident #9's Medical record reviewed to ensure that the resident's care plan and the Hospice care plan are integrated for Resident on Hospice. All other Hospice care plans were reviewed as well as the medical record to ensure all other residents receiving Hospice services care plans and Hospice care plans are integrated. Staff inservice on 8/11/2014 reviewed the Hospice plan policy.	9-1-14	

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F 309	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30170</p> <p>Surveyor: 34030 Based on record review, interview, and policy review, the provider failed to combine the hospice plan of care with the provider's plan of care for one of one sampled resident (9) who had been receiving hospice service. Findings include:</p> <p>1. Review of resident 9's 7/10/14 comprehensive care plan revealed: *"Consult for hospice care" and "Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met." *No further reference regarding the resident's care to specify responsibility between hospice and the provider had been found.</p> <p>Interview on 7/16/14 at 11:15 a.m. with the Minimum Data Set coordinator revealed that she had been unaware of the need to combine the hospice care plan with the provider's care plan for a hospice resident.</p> <p>Interview on 7/16/14 at 1:55 p.m. with the director of nursing regarding the above resident's care plan revealed she agreed the care plan should have included the provider's and the hospice service responsibilities.</p> <p>Review of the provider's undated hospice policy revealed: *"When a resident participates in the hospice program, a coordinated plan of care between the facility, hospice agency, and resident/family will</p>	F 309	<p>Director of Nursing or designee will audit care plan for those residents receiving hospice for integration of both facility and Hospice care plans to reflect resident's current plan of care status. This will be audited once a month times three months and reported by the Director of Nursing at the monthly QAPI meetings.</p>	

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F 309	Continued From page 10 be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. *All hospice services are provided under contractual arrangement. Complete details outlining the responsibilities of the facility and the hospice agency are contained in this agreement. A copy of this agreement is on file in the business office and hospice agency."	F 309			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, manufacturer's guidelines, and policy review, the provider failed to administer Novolog (rapid acting insulin) according to the manufacturer's guidelines for two of two sampled residents (5 and 11) observed insulin administrations resulting in the potential for an adverse (unwanted) reaction from the medication. Findings include: 1. Observation on 7/15/14 at 11:22 a.m. of registered nurse (RN) C administering Novolog to resident 11 revealed: *Novolog was administered at the above time. *The resident was not fed until later at 11:45 a.m. Observation on 7/15/14 at 11:28 a.m. of RN C	F 332	Policy for rapid acting insulin reviewed with staff at in-service on 8/11/2014. Residents 5 and 11 will be offered a small snack or glass of juice with injection of rapid acting insulin to help prevent adverse reactions if residents are not going directly into the meal. All other residents' medication administration record will be reviewed and any other resident receiving rapid acting insulin will be offered a small snack or glass of juice with injection of insulin to help prevent adverse reactions if residents are not going directly into the meal. Director of Nursing or Designee will audit Insulin Administration once weekly times four weeks and monthly times two months, and report results to QAPI monthly meetings.	9-1-14	

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F 332	Continued From page 11 administering Novolog to resident 5 revealed: *Novolog was administered at the above time. *The resident was not fed until later at 11:50 a.m. Interview on 7/15/14 at 11:55 a.m. with RN C regarding the above insulin administrations revealed she had: *Known Novolog was a rapid acting insulin. *Stated she should have administered them according to the manufacturer's recommendations. Review of the manufacture's guidelines < http://www.novologpro.com/safety/hypoglycemia.aspx > accessed on 7/17/14, revealed, "Novolog should generally be given immediately (within 5-10 minutes) prior to the start of a meal. Hypoglycemia (low blood sugar) is the most common adverse effect of insulin therapy."	F 332			
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The Air King fan mounted on the wall above the dirty dishes was cleaned. All other fans utilized in the kitchen were audited for cleanliness and cleaned if necessary. The production table located below four sets of wooden cupboards was replaced with a stainless steel table. All other production tables in the kitchen were audited to ensure a sanitary situation with cleanable surfaces and a plan will be put in place to correct if any were found to have uncleanable surfaces.	9-1-14	

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

PRINTED: 09/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH ST WILMOT, SD 57279		
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F 371	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, and policy review, the provider failed to ensure sanitary conditions were maintained that might have resulted in a potential for cross-contamination (bacteria from one area to another area) with the following areas in the kitchen: *One of one fan in the dish machine area. *One of three food production tables. *Eight of eight handles on four sets of cupboards. Findings include:</p> <p>1. Observation on 7/15/14 from 8:52 a.m. through 9:10 a.m. in the kitchen revealed: *In the dish machine area there was an Air King fan mounted on the wall above the dirty dishes on the dirty end of the dish machine. *The fan had multiple built-up brown, black, and tan spots on the spokes and on the blades. *A production table located below four sets of wooden cupboards next to the chest freezer contained bread items, plastic baggies, toast, and bread crumbs in a gallon plastic container.</p> <p>Observation and interview on 7/15/14 at 12:12 p.m. with dietary aid E in the kitchen's dish room revealed: *The Air King fan contained multiple brown, black, and tan spots on the spokes and the blades attached to the wall in the dish room and was oscillating (to swing back and forth). *The fan was turned on the high setting, and it blew from the dirty end of the dish machine area to the clean end. *She stated the fan had been used by the</p>	F 371	<p>The Dietary Manager or Designee will audit the fans and production tables once per week for 4 weeks and once per month for 2 more months to ensure sanitary conditions. The dietary manager or designee will report the results of those audits at the monthly QAPI meetings for review.</p>	9-1-14

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F 371	<p>Continued From page 13</p> <p>employees when washing the dishes. *She stated it was usually on the high to medium setting when it was running.</p> <p>Observation on 7/16/14 at 8:55 a.m. in the dish machine area revealed multiple dirty dishes on the dirty end of the dish room counter below the fan. The fan was on the high setting, and it was oscillating the air from the dirty dishes to the clean dishes.</p> <p>Interview on 7/16/14 at 9:30 a.m. with the dietary manager and registered dietitian (RD) J revealed they: *Agreed the fan should not have been blowing from dirty to clean in the dish room. *Agreed that was a potential for cross-contamination. *Stated there should have been a separation of the dirty from the clean which included air movement from the oscillating fan.</p> <p>Interview on 7/16/14 at 3:00 p.m. with the administrator and the dietary manager revealed: *All the provider's fans were cleaned every two months or as needed. *Both agreed the dish machine area fan needed to have been cleaned more often. *Both agreed the fan should not have been blowing from dirty to clean, and that was a potential for cross-contamination. *Both agreed there was not a specific policy for cleaning the fans in the dish room area.</p> <p>2. Observation on 7/15/14 from 8:52 a.m. through 9:10 a.m. in the kitchen revealed: *A production table located below four sets of wooden cupboards next to the chest freezer contained bread items, plastic baggies, toast, and</p>	F 371		

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F 371	<p>Continued From page 14</p> <p>bread crumbs in a gallon plastic container.</p> <p>*That production table:</p> <ul style="list-style-type: none"> -Had a formica top with four ends that were no longer sealed to the wood. -Had four ends that were separated from the table's formica top. -Had portions of the front of the table with the formica chipped away. -Was no longer a cleanable surface. -Had four legs of the table that were rusty. -Had an open shelf on the bottom that contained loaves of bread, buns, and cutting boards laying on top of a plastic tablecloth that contained an uncleanable felt lining. -Was no longer a cleanable surface. <p>Interview on 7/16/14 at 9:30 a.m. with the dietary manager and RD J regarding the food production table revealed they:</p> <ul style="list-style-type: none"> *Agreed areas of the table were no longer a cleanable surface. *Stated the table was being used for storage of food items and cutting boards that touched food. *Agreed that was a potential for cross-contamination. <p>Review of the provider's 2005 Cleaning Instructions Cleaning Floors, Tables, Chairs policy reviewed the kitchen tables should have been kept clean and sanitary.</p> <p>3. Observation on 7/15/14 from 8:52 a.m. through 9:10 a.m. in the kitchen revealed:</p> <ul style="list-style-type: none"> *Above a production table there were four sets of wooden cupboards that contained eight silver-colored handles that were: <ul style="list-style-type: none"> -Sticky with visible food residue. -Contained a black and brown build-up on back of each of the handles. 	F 371		

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F 371	Continued From page 15 -Worn on the front with parts of the finish no longer present. Interview on 7/16/14 at 9:30 a.m. with the dietary manager and RD J revealed regarding the silver-colored handles on the four sets of cupboards (a total of eight handles) revealed they agreed the handles: *Had lost their finish and contained a build-up of black and brown particles on the back of the handles. *Were no longer a cleanable surface. *Were items that were touched frequently by staff. *Had not been on a cleaning schedule. *Were a potential for cross-contamination.	F 371		
F 441 SS=D	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	F 441	Policy for bathing Resident with Foley Catheter revised. The Director of Nursing will present the updated policy to the staff responsible for these tasks at the in-service on Infection Control on 8/12/2014. Resident 4 bathing process was adjusted according to the newly revised bathing policy. Director of Nursing or Designee will audit bathing of residents with indwelling catheters once per week for 4 weeks and once a month for 2 more months to ensure appropriate bathing guidelines are being used.	9-1-14

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F 441	Continued From page 16 (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: 30170 Surveyor: 34030 Preceptor: 30170 Based on observation, interview, and policy review, the provider failed to: *Ensure one of one sampled resident (4) with a Foley catheter (a tube inserted into the bladder to drain urine) was appropriately bathed in the whirlpool bath. *Provide proper hand hygiene while assisting residents for one of three observed meals with one randomly observed certified nursing assistant	F 441	The Director of Nursing or designee will report the results of these audits at the monthly QAPI meetings for review. Policy for hand washing/ hand hygiene and frequency will be reviewed with staff at in-service for infection control on 8/12/2014. Director of Nursing will provide guidelines to staff for proper and appropriate hand washing/hand hygiene techniques that will aid in lessening transmission of infections while being a dining assistant. Dietary Manager or Designee will audit hand hygiene in dining room once weekly times four weeks and monthly times two months and report results to QAPI monthly meetings.	9-1-14

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F 441	<p>Continued From page 17 (CNA) (F) and two of two randomly observed residents (2 and unidentified). Findings include:</p> <p>1. Observation on 7/15/14 at 10:15 a.m. of resident 4 and interview with certified nursing assistant (CNA) A revealed: *Resident 4 had been placed into the whirlpool tub with his Foley catheter and his leg bag that contained urine. *The CNA stated she would have done nothing else with his leg bag while bathing and proceeded to fill the tub to bathe the above resident. *That was the process she had used for bathing all residents with Foley catheters.</p> <p>Interview on 7/16/14 at 1:55 p.m. with the director of nursing revealed she had believed bathing a resident with a Foley catheter and bag submerged in a whirlpool tub was appropriate.</p> <p>Review of the facility's undated Catheter Tub Bathing Policy revealed: "It is the policy of ____ (facility) to prevent or minimize any chance of infection with an indwelling catheter. The resident can bathe with an indwelling catheter intact."</p> <p>According to the National Institutes of Health accessed on 7/21/14, http://www.cc.nih.gov/cc/patient_education/pepubs/bladder/foley5_17.pdf, regarding bathing of a person with an indwelling catheter (Foley) revealed "sitting in the tub, however, is not recommended."</p> <p>Surveyor: 26180.</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>2. Observation at the supper meal on 7/15/14 revealed:</p> <p>*CNA F was seated at a dining room table between resident 2 and an unidentified resident.</p> <p>*Both residents were being fed their meal by the CNA.</p> <p>*CNA F:</p> <ul style="list-style-type: none"> -Repeatedly went from one resident to the other offering them bites of food using the same hand. -Took paper napkins and wiped the mouths of each of the residents, laying the soiled napkins back on the table in front of the residents. -Stood up and walked to a different unidentified resident and assisted that resident with her meal tray and put a clothing protector on her then returned to the other residents. -Got up from the table and went to the cupboard and got some clean paper napkins and returned to the table. She had not cleaned or sanitized her hands. -Picked up the two soiled napkins from those residents and laid them in the middle of the table. -Had not performed hand hygiene during any portion of that meal service. <p>Review of the provider's April 2012 handwashing policy revealed:</p> <p>*"It is policy of name of facility to provide guidelines to employees for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections."</p> <p>*"Employees will wash hands before starting work, after visiting restrooms, after touching hair or face, after blowing nose or sneezing, after handling garbage or poisonous compounds, and at other times when hands have been soiled."</p>	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435119	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2014
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NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH ST WILMOT, SD 57279
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K 000	<p><i>Admissions noted with an asterisk per Blamly telephone to facility administrator. JB/SDDH/mf</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/15/14. Wilmot Care Center Inc was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiency identified at K046 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:</p>	
K 046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to provide a properly installed, maintained, and tested emergency generator system with approved functioning components. The generator was not provided with a remote manual stop or remote common audible alarm outside of the generator room (see attached copy of National Fire Protection Association [NFPA] 110 1999 edition). Findings include:</p> <p>1. Observation at 11:00 a.m. on 7/15/14 revealed the new 25 kilowatt generator was not provided with a remote manual stop button located outside of the room housing the generator. Interview with</p>	K 046	<p>The facility is in the process of installing a remote manual stop for the generator. The facility is also in the process of installing a remote common audible alarm system at the nurse's station to monitor the status of the new generator.</p> <p><i>* Administrator will be responsible to ensure the work has been completed by the contractor correctly and report to the QA committee following completion. JB/SDDH/mf</i></p>	9-1-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cathy A. Pond</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8-12-14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DISCLOSED

AUG 13 2014

If continuation sheet Page 1 of 2

SD DOH L&C

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K 046	<p>Continued From page 1</p> <p>the administrator and director of environmental services at the time of the observation indicated the generator had been installed within the last nine months. They were unaware on that requirement. Refer to NFPA 110, Section 3-5.5.6.</p> <p>2. Observation at 11:30 a.m. on 7/15/14 revealed the new 25 kilowatt generator was not provided with a remote, common audible alarm located outside of the generator room at a work site readily observable by personnel. Interview with the administrator and director of environmental services at the time of the observation indicated the generator had been installed with the last nine months. They were unaware of that requirement. Refer to NFPA 110, Section 305.6.1 and Table 3-5.5.2 (d).</p>	K 046		

ORIGINAL

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
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NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH STREET WILMOT, SD 57279
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S 000	Initial Comments Surveyor: 26180 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/15/14 through 7/16/14. Wilmot Care Center Inc was found not in compliance with the following requirements: S222 and S225.	S 000	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state law. Without waiving the foregoing statement, the facility states that with respect to:	
S 222	44:04:04:07.03 PREVENTION AND CONTROL OF INFLUENZA Nursing facilities shall arrange for influenza vaccination to be completed annually for all residents. Residents admitted after completion of the vaccination program and before April 1 must be offered influenza vaccine when they are admitted. Influenza vaccination may be waived for residents because of religious beliefs, medical contraindication, or refusal by the resident. Documentation of vaccination or its waiver must be recorded in the resident's medical or care record. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure documentation for the influenza (flu) vaccine was completed in a timely manner for one of nine sampled residents (8). Findings include: 1. Review of resident 8's medical record revealed she: *Had an admission date of 10/4/13. *Had a physician's order on 10/4/13 that she	S 222	Policy on Influenza vaccination reviewed with staff at in-service with consent form presented for influenza vaccine with instructions on proper documentation. Resident 8's physician order for annual flu vaccine was reviewed and noted to ensure and was documented as such. All other resident physician orders were reviewed for flu vaccine orders and noted to ensure the residents receive the flu vaccine and documented as such. Director of Nursing or designee will audit all existing residents and new admits monthly during flu season and report results to QAPI monthly meetings.	9-1-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Cathy A. Powell

Administrative

(X6) DATE

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If continuation sheet 1 of 4

South Dakota Department of Health

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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 222	<p>Continued From page 1</p> <p>could receive the annual flu vaccine if not contraindicated. *Had an immunization record with no information regarding a flu vaccine having been given.</p> <p>Interview on 7/16/14 at 10:45 a.m. with registered nurse C regarding resident 8's flu vaccine record confirmed it was not in her medical record.</p> <p>Interview on 7/16/14 at 12:07 p.m. with the director of nursing (DON) regarding resident 8's flu vaccine record revealed: *She had come from another facility, and she had not had a flu vaccine. *She had refused a flu vaccine upon admission. *She had not been instructed on the benefits of receiving the seasonal flu vaccine. *There was no documentation regarding the reason she had refused the flu vaccine. *The DON agreed the resident's reason for the flu vaccine refusal was not documented.</p> <p>Review of the undated TB [Tuberculosis], Pneumovax, and Flu Vaccination policy revealed: *All residents were to have been offered a seasonal flu vaccination within the flu season unless contradicted. *Documentation was required that provided resident teaching for the seasonal flu vaccination and resident refusal.</p>	S 222		
S 225	<p>44:04:04:07.04 PREVENTION AND CONTROL OF PNEUMONIA</p> <p>Each nursing facility shall arrange for immunization for pneumococcal disease. If immunization is lacking and the resident's physician recommends it, the nursing facility shall</p>	S 225	<p>Policy on Pneumonia Vaccination reviewed with staff at in-service. Consent for pneumonia vaccine presented with instructions on proper documentation. The staff will visit with resident 8 and the physician to determine the need for</p>	9-1-14

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/16/2014
NAME OF PROVIDER OR SUPPLIER WILMOT CARE CENTER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 501 4TH STREET WILMOT, SD 57279		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 225	<p>Continued From page 2</p> <p>arrange for...residents to obtain an immunization for pneumococcal pneumonia within 14 days of admission. Pneumococcal vaccination may be waived for the residents because of religious beliefs, medical contraindication, or refusal by the resident. Documentation of the vaccination or its waiver must be recorded in the resident's medical or care record.</p> <p>Surveyor: 32331</p> <p>Based on record review, interview, and policy review, the provider failed to ensure documentation for the pneumococcal vaccine was completed in a timely manner for one of nine sampled residents (8). Findings include:</p> <p>1. Review of resident 8's medical record revealed she:</p> <ul style="list-style-type: none"> *Had an admission date of 10/4/13. *Had a diagnosis that included COPD (chronic obstruction pulmonary disease) a progressive disease that makes it hard to breathe. *Had an immunization record with no information regarding a pneumococcal vaccine having been given. <p>Interview on 7/16/14 at 10:45 a.m. with registered nurse C regarding resident 8's pneumococcal vaccine record confirmed it was not in the resident's medical record.</p> <p>Interview on 7/16/14 at 12:07 p.m. with the director of nursing (DON) regarding resident 8's pneumococcal vaccine record revealed:</p> <ul style="list-style-type: none"> *She had come from another facility, and she had not had a pneumococcal vaccine. *She had refused a pneumococcal vaccine upon admission. *She had not been instructed on the benefits of receiving the pneumococcal vaccine. *There was no documentation regarding the 	S 225	<p>pneumovax vaccination and proceed according to the resident wishes. All other resident's records were reviewed to ensure pneumovax vaccinations were completed on each resident or noted that they were offered as desired as well as teaching and physician notification. Director of nursing or designee will audit all new admissions monthly for three months to ensure pneumovax vaccinations are being addressed according to facility policy and report results to QAPI monthly meetings. in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p>	9-1-14

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/16/2014
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S 225	<p>Continued From page 3</p> <p>reason she had refused the pneumococcal vaccine. *The DON agreed the reason for the pneumococcal vaccine refusal was not documented.</p> <p>Review of the undated TB [Tuberculosis], Pneumovax, and Flu Vaccination policy revealed: *All residents were to have been offered a Pneumovax (pneumococcal vaccine) if they had not had one. *Documentation was needed as to when and where they had received the vaccine. *If there were no findings of a Pneumovax being provided the provider was to have obtained a physician's order, permission from the resident, or the resident's power of attorney. *Documentation was required that resident teaching had been provided for the Pneumovax vaccination and resident refusal.</p>	S 225		