

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

**ORIGINAL**

PRINTED: 02/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHEATCREST HILLS HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430</b>	
(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: 23059 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 2/3/15 through 2/5/15. Wheatcrest Hills Healthcare Community was found not in compliance with the following requirements: F164, F248, F323, F371, and F441.	F 000		
F 164 SS=C	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment	F 164		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *DeWonne Furman* TITLE: Administrator (X6) DATE: 2-24-15

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused for not correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction 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 164	Continued From page 1 contract; or the resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, interview, policy review, and document review, the provider failed to ensure a space was provided for all residents, families, and resident/family groups to meet privately without staff interruption. Findings include:  1. Interview on 2/3/15 at 3:30 p.m. with eleven residents and three family members during the group interview revealed the majority of residents and family members voiced concern over having no place to meet privately. Both residents and family members stated church services were frequently interrupted by staff, other residents, and visitors, because it was held in the TV room. Observation of that room throughout the survey revealed it had one set of doors leading to the resident room hallways that could be closed. The other entryway opened to the front foyer and was across from the dining room. There was no door on that entryway that could be closed to ensure privacy.  Confidential interviews on 2/3/15 at 4:30 p.m. and at 4:45 p.m. with a resident and family member revealed they had asked the administrator several times for a private place to meet. They stated they were always told no doors could be added to the TV room.  Interview on 2/4/15 at 9:40 a.m. with the director of nursing and the director of clinical services for South Dakota revealed if residents wanted a	F 164	No specific residents were identified in F164. A private area for residents and families will be set up in the area now used for the copier. A chair and telephone will be placed in this area. Church services will be held in the rehab area, which would be unoccupied on Sundays. The charge nurse will make sure everyone is aware that church will be in the rehab area. The administrator or designee will monitor such activity weekly X 2 for 90 days, and also report to the monthly QA meetings X 3 months.  <i>Addendum F164 A private area for residents and families to meet will be set up in room 28, as this area is large enough for larger number of residents and/or families. The administrator or designee will monitor this process weekly X 90 days and</i>	3-20-15	

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F 164	Continued From page 2 private place to meet they could go to the rehab (rehabilitation) room. They confirmed that area would not be available if there were residents or other outside patients receiving rehab services during the day. They also confirmed church services and other meetings could be interrupted at times since there were no doors on one of the entryways to the TV room where those meetings had been held.  Review of the provider's revised August 2013 Privacy policy revealed it did not address the need for a place for residents to meet privately.  Review of the Resident's Rights booklet provided to all residents as a part of their admission packet revealed there should have been private meeting areas for the residents to use.	F 164	<i>(Continued from page 2)</i> <i>also report to the monthly QA x 3 months.</i> <i>Almond RN/DON</i> <i>3-11-15</i>	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES  The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to meet activity needs for one of one resident (11) in isolation. Findings include:  1. Review of resident 11's medical records revealed:	F 248		

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F 248	<p>Continued From page 3</p> <p>*Isolation precautions for clostridium difficile (a contagious infection of the bowels causing diarrhea).</p> <p>-He had been in isolation for several weeks due to that infection.</p> <p>-"He needed to stay in his room to prevent the spread of the infection per the facility's policy", according to his records.</p> <p>*He was able to toilet himself and had been told to wash his hands afterwards.</p> <p>*He had a mild to moderate cognitive deficit (decreased mental ability).</p> <p>Random observations from 2/4/15 to 2/5/15 of resident 11 revealed:</p> <p>*He had been alone in his room in contact isolation.</p> <p>-There was no roommate.</p> <p>*This surveyor saw him ambulate to the bathroom in his room by himself.</p> <p>*Staff entered his room to:</p> <p>-Clean.</p> <p>-Give medications.</p> <p>-Bring meals.</p> <p>*He sat in his recliner and watched TV or napped.</p> <p>*He responded eagerly when he saw someone in the hall and when this surveyor was close to his room doorway.</p> <p>Interviews on 2/4/15 at 5:00 p.m. and on 2/5/15 at 11:00 a.m. with resident 11 revealed:</p> <p>*He was "bored."</p> <p>*He liked to watch TV and had a radio for music, but had nothing else to do in his room.</p> <p>*He was very talkative and social.</p> <p>*Neither the social worker or the activities director had spoken to him about doing activities in his room to keep him busy.</p>	F 248	<p>F 248 Resident 11 was interviewed by the activities director to find out what activities he would like to do in his room while in isolation and the information was documented in the progress notes and the care plan. An in-service for all staff was held on 2/20/15, discussing the need for one to one's with residents in isolation. All residents in isolation will be interviewed by the activities director and the information will be documented in their individualized care plan and progress notes. The Activities Director will monitor the information documented in the care plan and progress notes anytime a resident is considered to be in isolation and continued weekly until the resident is out of isolation. The Activities Director will report the information to the Administrator and/or Director of Nursing anytime a resident is in isolation. The activities director will also report at the monthly QA meetings X 3 months.</p>	3-27-15	

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F 248	<p>Continued From page 4</p> <p>Review of resident 11's 11/26/14 Minimum Data Set assessment revealed it was very important for him to choose activities he liked to do.</p> <p>Review of resident 11's 12/4/15 care plan revealed: *"I like to play cards with my friends" and "I like to be invited to scheduled activities." *Nothing had been found to reflect his change in condition (isolation) or need for different activities due to being in isolation.</p> <p>Interview on 2/5/15 at 11:45 a.m. with the activity director regarding resident 11 revealed: *She had been activity director for two years. *The only activity she provided for resident 11 since he had been in isolation were one-on-one visits. Those visits consisted of her stopping at his doorway to talk to him. *When asked why she had not provided any other activities for resident 11 she replied: -"I didn't think to do it." -"I didn't think I could take anything into an isolation room."</p> <p>Interview on 2/5/15 at 12:20 p.m. with the director of nursing, the director of clinical services for South Dakota, and the activity director regarding resident 11 revealed: *The activity director had appropriate training for her position. *The activity director had been unaware of the purpose of a meaningful one-on-one visit and had not provided that for the resident. *An updated activity assessment for resident 11 had not been done. *They agreed meaningful activities had not been provided for him while he was in isolation.</p>	F 248		
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F 248	Continued From page 5  Review of the provider's January 2014 Quality of Life-Accommodation of Needs policy revealed: "The resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered."  Review of the provider's undated policy on Provision of Meaningful Activities revealed: "It is the policy of [the facility] to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. All residents are entitled to activities, and the facility will use its resources to individualize resident activity programs to make sure each resident is provided with needed assistance."	F 248			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and policy review, the provider failed to ensure resident safety for:	F 323			

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F 323	<p>Continued From page 6</p> <p>*A resident supply room by the nurses station containing a staff coffee pot with hot coffee that was accessible to residents.</p> <p>*Security of chemicals from residents with cognitive impairment (decreased mental ability) in two areas of one of three resident hallways (Horizons and Rustic Lane). Findings include:</p> <p>1. Random observations from 2/3/15 to 2/5/15 of a resident supply room by the nurses station revealed:</p> <p>*A coffee pot with hot coffee and staff coming in and out of the room to get coffee. *The door was not locked. *Residents were observed in the area including residents with cognitive impairment.</p> <p>Observation on 2/4/15 at 6:00 p.m. of the above supply room revealed:</p> <p>*The door was open and the coffee pot was on. *Resident 7 who was cognitively impaired was in her wheelchair by that door. *This surveyor was the only person in the area at the time. *After 10 minutes a staff member came for resident 7 and took her to supper. *Upon checking the supply room door it was found that it would not stay closed as the latch would not work.</p> <p>Interview on 2/5/15 at 11:30 a.m. with the maintenance supervisor and the administrator during the facility walk through revealed:</p> <p>*They were unaware the door was not working. *They agreed having hot coffee in a clean supply room that was accessible to residents with cognitive impairment had not been safe.</p>	F 323	<p><i>(continued from page 9)</i></p> <p>The storage closet on Rustic Lane is locked. An in-service for all staff was held 2/20/15 to inform all staff that the disinfecting wipes are to be out of resident's reach and that the storage closet on Rustic Lane is to be locked at all times. The DON or designee will monitor and complete written audits 2x/week x 90 days to make sure disinfecting wipes are placed out of resident's reach. The DON, Administrator or designee will complete written audits 2x/week x 90 days to ensure the storage closet on Rustic Lane is locked. Results of the audits will be reported by the DON at the monthly QA meetings X 3 months.</p>	3-27-15	

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F 323	<p>Continued From page 7</p> <p>Review of the maintenance supervisor's monthly maintenance schedule showed on 2/2/15 "all the doors in the facility had been checked for proper operation (latching and no gaps between door and frame)."</p> <p>Review of the provider's January 2014 Safety and Supervision of Residents policy revealed: **"Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities."</p> <p>Surveyor: 32331</p> <p>2. Observation on 2/3/15 at 9:55 a.m. in the Horizons area on the west hall in an unlocked cupboard next to the sink in the dining area revealed: *One opened container of Medline Micro-Kill disinfectant (kills germs) wipes. *One opened container of Oxivir Tb disinfectant/deodorant/sanitizer wipes. *Each container's label contained a caution to keep out of reach of children. *There were five residents with cognitive impairment in the dining room. *There was one staff person F in the dining room.</p> <p>Interview on 2/3/15 at 10:00 a.m. with licensed practical nurse C revealed: *The Horizons area had residents that were cognitively-impaired. *She stated that was the reason those residents were there. *Residents needed to have close monitoring and observation in that area for safety reasons.</p> <p>Surveyor: 23059</p>	F 323	<p><del>The storage closet on Rustic Lane is locked. An in-service for all staff was held 2/20/15 to inform all staff that the disinfecting wipes are to be out of resident's reach and that the storage closet on Rustic Lane is to be locked at all times. T DON or designee will monitor and complete written audits 2x/week x 90 days to make sure disinfecting wipes are placed out of resident's reach. The DON/ Administrator or designee will complete written audits 2x/week x 90 days to ensure the storage closet on Rustic Lane is locked. Results of the audits will be reported by the DON at the monthly QA meetings X 3 months.</del></p> <p><i>duplicate answer y</i></p>	

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F 323	Continued From page 8 3. Observation on 2/3/15 at 9:35 a.m. revealed there was an unlocked storage room on Rustic Lane. That storage room contained gallon containers of shampoo, body wash, and disinfectant. The five one-gallon containers of disinfectant all contained a warning to keep out of reach of children. All of those containers were stored on a shelf that was accessible to residents.  Interview on 2/5/15 at 3:30 p.m. with the human resources/scheduling coordinator revealed the above door was always locked. She stated she checked all of the storage doors each day to ensure they were locked. She stated she was surprised that door had been unlocked at the time the surveyors entered the facility.  Review of the provider's December 2013 Storage of Chemicals policy revealed: **"To assure all chemicals and biologicals are stored safely when not under the direct supervision of the appropriate staff." **"All chemicals such as those used for sanitizing or cleaning will be kept locked away from residents when not in current use by the staff at the facility."	F 323	F 323 Adjustments were made to the supply room door so that the door closes properly and a keypad lock has been placed on the door so that it will be locked at all times. Res #7 will not be able to open the keypad, nor will any of the other residents. An in-service for all staff was held on 2/20/15 to inform all staff that the door is to be locked at all times. The administrator or designee will complete written audits 2x/week x 90 days to make sure door is continually locked, and results will be reported at the monthly QA meetings X 3 months. by the DON or designee <i>Annast RVIDON 3-11-15</i> No specific residents were identified in regard to the disinfectant wipes. The Micro-Kill and Oxivir Tb disinfecting wipes have been removed from the cupboard next to the sink in the Horizons area. All disinfecting wipes have been placed out of resident's reach. <i>he continue on pg 7</i>	<i>3-27-15</i>
F 371 SS=E	483.35(i) 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		

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F 371	Continued From page 9  This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained for the following in the kitchen: *The wiping cloths used to wipe down the food counters and equipment had not been placed in a sanitizer. *Two of two window sills had uncleanable surfaces. *One of one Dutch door (a door divided horizontally) had uncleanable surfaces. Findings include:  1. Observation on 2/3/15 in the kitchen from 9:15 a.m. through 9:38 a.m. revealed: *A wet cloth laying on the dirty side of the three-compartment sink. *One cloth soaking in the first sink of the three-compartment sink that contained suds. *Two windows: -One window was located behind the food mixer and the sill had a significant amount of peeling, scarred, and chipped surfaces that were uncleanable. -One window was located behind the three-compartment sink and the sill had a significant amount of peeling, scarred, and chipped surfaces that were uncleanable. *One Dutch door located between the kitchen and the dining room that had a glued piece of partical directly above the door handle. -The finish of that partical board had been worn off to bare wood creating an uncleanable surface.	F 371	F371 No specific residents were identified in F371. Red sanitizer disinfectant buckets for the sanitizing cloths used in the kitchen area have been purchased and a new policy and procedure written on proper sanitizing of the food counters and equipment. An all staff in-service was held on 2/20/15 to inform staff about the proper use of the bucket and the cleaning cloths. All dietary staff was in attendance. The dietary manager or designee will monitor the bucket usage and mixture 2xdaily, 5 days a week for 90 days. The dietary manager will report to monthly QA meetings x 3 months.  The window behind the food mixer and the one behind the three- compartment sink have both had the window sills replaced with a cleanable surface. A solid door has been ordered and the dutch door will be replaced upon receipt of the new one. The windows and door will be monitored 1x/week for 90 days by the administrator or designee, who will then report to monthly QA meetings X 3 months.	3-27-15

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PRINTED: 02/18/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/05/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>WHEATCREST HILLS HEALTHCARE COMMUNITY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	<p>Continued From page 10</p> <p>2. Observation on 2/3/15 at 12:02 p.m. in the kitchen revealed: *One wet cloth laying on the dirty side of the three-compartment sink. *One cloth soaking in the first sink of the three-compartment sink that contained suds.</p> <p>Observation and interview on 2/4/15 at 8:45 a.m. with a.m. cook G revealed: *She had taken a cloth that had been soaking in the first sink of the three-compartment sink that contained suds. *She had used the above cloth to wipe down the food production counters and the equipment. *She then placed the above cloth on the dirty side of the three-compartment sink. *She stated she cleaned the counters using a cloth from the first sink of the three-compartment sink. *She stated the above sink contained dish soap, and it did not contain a sanitizer.</p> <p>3. Interview on 2/3/15 at 4:05 p.m. with the maintenance supervisor and the dietary manager regarding the window sills and the Dutch door in the kitchen revealed they agreed: *The window sills had a significant amount of chipped and peeling paint and needed to have been replaced. *The dietary manager stated the windows "leaked." *The Dutch door had a partial board in the middle of the door that had exposed bare wood, and it was no longer a cleanable surface.</p> <p>Interview on 2/4/15 at 4:10 p.m. with the dietary manager regarding the wet cloths located on the dirty end of the three-compartment sink and soaking in the first compartment of the</p>	F 371			

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F 371	Continued From page 11 three-compartment sink revealed: *All cloths used to wipe down the food production counters and equipment needed to have been taken out of a sanitizer for proper sanitizing. *The dish soap in the first sink of the three-compartment sink was not a sanitizer. *She agreed there needed to be consistent use by all dietary staff with proper sanitizing of the food production counters and the equipment. -She had both a chlorine bleach and a quaternary (quat) sanitizer in the kitchen for sanitizing the counters and the equipment.  Review of the provider's undated Standard Cleaning Weekly, Monthly, and Yearly Schedule in the kitchen revealed: *The kitchen doors were to have been done yearly. *The window sills were to have been done monthly.  Review of the provider's January 2015 Kitchen Cleaning Chart revealed window sills were not listed on the monthly schedule.  Review of the provider's undated policy on sanitizing food surfaces revealed the procedure was the following: **1. Wash with soap and warm, clean water. 2. Rinse with clean water. 3. Sanitize using 1 teaspoon of bleach per 1 gallon of water. 4. Allow to air dry." *The policy had not included any further information regarding how the food surfaces were to have been sanitized using the wiping cloths.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 12  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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.	F 441			

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F 441	<p>Continued From page 13</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, policy review, and manufacturer's instructions, the provider failed to disinfect one of one whirlpool bathtub. Findings include:</p> <p>1. Observation and interview on 2/4/15 at 8:40 a.m. with certified nursing assistant (CNA) D revealed: *Only one whirlpool tub was being used in the facility. *To clean the tub between resident baths she: - Gloved then sprayed the disinfectant on all surfaces. The disinfectant was Classic whirlpool tub cleaner. -Without waiting scrubbed the surfaces of the inside of the tub, then rinsed it with water. -Then repeated the process as above. -Stated she would run the air jets at the end of the day. *The disinfectant had not been left on the surfaces of the tub for any length of time before rinsing it.</p> <p>Review of the manufacturer's instructions for the Classic whirlpool tub cleanser revealed in order to disinfect surfaces the product needed to be left on for ten minutes before rinsing it off.</p> <p>Review of the provider's October 2014 whirlpool tub cleaning policy revealed "...spray all surfaces again and continue to allow contact of the disinfectant for the amount of time per the disinfectant manufacturer's instructions."</p> <p>Interview on 2/4/15 at 4:00 p.m. with the director of nursing and the infection control nurse</p>	F 441	<p>F441 No specific residents were identified in F441. The procedure for Whirlpool Tub Disinfecting were reviewed and revised on 2/18/15. An in-service for all nurses and CNA's was held on 2/20/15. An instruction sheet pertaining to tub disinfecting was placed in the tub room within easy view to assist any staff cleaning the tub to use correct procedure. The DON or designee will monitor and complete written audits 2x/week x 90 days on the Whirlpool Tub Disinfecting. The results of the audits will be reported at the monthly QA meetings x 3 months by the DON.</p>	03-27-15	

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F 441	Continued From page 14 revealed they agreed the whirlpool had not been properly disinfected between resident baths.	F 441			

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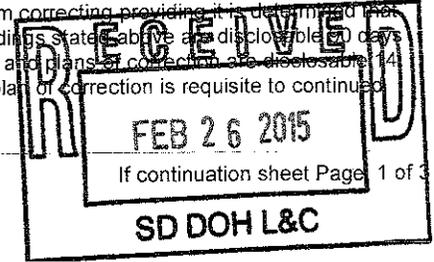
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K 000	INITIAL COMMENTS  Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 2/4/15. Wheatcrest Hills Healthcare Community was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.  The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 2/4/15 upon correction of the deficiency identified below.  Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiency identified at K038 in conjunction with the provider's commitment to continued compliance with the fire safety standard	K 000	Addendums noted with an asterisk per 3/9/15 telephone to facility DON. KESDDOHH/MF	
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and document review, the	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>G. Dianne Furman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>2-20-15</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 60 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 033	Continued From page 1 provider failed to maintain a protected path of egress from the basement to the exterior of the building. Three of three basement stairways discharged onto the main level and were not provided with a one hour fire resistive enclosure to the exterior of the building. Findings include:  1. Observation beginning at 2:30 p.m. on 2/4/15 revealed the west basement stairway discharged onto the main level adjacent to the nurses' station. Observation also revealed the north basement stairway discharged onto the main level in the kitchen pantry area. Further observation revealed the east exit from the basement discharged onto the main level in the physical therapy vestibule. A continuous one hour enclosure was not provided to the exterior of the building in those locations. Review of the previous life safety code survey confirmed those findings.  The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.	K 033		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 14180 Based on observation and interview, the provider failed to construct a paved path of exit discharge to the public way at three of four exits (west wing	K 038		

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K 038	Continued From page 2 exit, southeast exit from the east wing, and the south wing exit). Findings include:  1. Observation beginning at 2:00 p.m. until 2:30 p.m. on 2/4/15 revealed: *The west exit (Rustic Lane) was not paved to the public way. The nearest paved public way was approximately 150 feet from the exit. *The southeast exit (Sunshine Way) was not paved entirely to the public way. The driveway was graveled for approximately 30 feet between the exit and the street. *The south exit (Paradise Lane) was not paved to the public way. The nearest public way was a graveled alley approximately 100 feet from the exit. Interview with the maintenance supervisor at the time of the observations confirmed those conditions.	K 038	K 038 The three exits in question (West, southeast and south) will be connected with a cement walkway leading to a public street. <del>Due to the climate in this area, the cement work will be done after the frost is out of the ground. We anticipate this to be complete by June 30, 2015,</del> and the Administrator will send notice to the Department of Health upon completion. The administrator or designee will monitor after each snowfall and keep walkway clear of snow to the public street until project is complete.  <i>* Administrator or designee will report to the QA committee following completion of the project. K/KDD/HH/MF</i>	3-27-15

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South Dakota Department of Health

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S 000	Initial Comments  Surveyor: 23059 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 2/3/15 through 2/5/15. Wheatcrest Hills Healthcare Community was found not in compliance with the following requirements: S301 and S302.	S 000		
S 301	44:04:07:16 Required dietary in-service training  The dietary manager or the dietitian in ...nursing facilities...shall provide ongoing in-service 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 Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on record review and interview, the provider failed to ensure four of nine required annual in-service training sessions (food safety, food-borne illness, leftover food handling policies, and time and temperature controls for food preparation and service) were offered for all food-handling staff yearly. Findings include:  1. Record review of the required in-service training sessions for 2014 through January 2015 for all food handling staff revealed:	S 301		

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

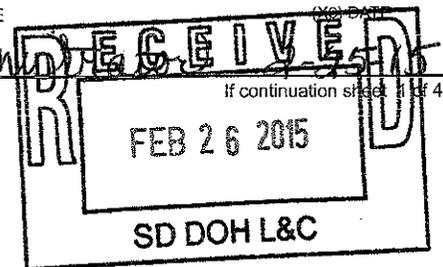
*Dawnne Swoman*

TITLE

*Administrator*

(X6) DATE

If continuation sheet 1 of 4



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S 301	Continued From page 1  *Those staff had not all received annual training on the following: -Food safety. -Food-borne illness. -Leftover food handling policies. -Time and temperature controls for food preparation and service.  Interview on 2/3/15 at 4:30 p.m. with the dietary manager and on 2/5/15 at 9:30 a.m. with the director of nursing and the director of clinical services for South Dakota regarding required annual in-service training sessions for all food handlers revealed: *Food handling staff were identified as dietary, nursing, and activities. *There had not been an in-service on food safety, food-borne illnesses, leftover food handling policies, and time and temperature controls for food preparation and service for all food handling staff. *They had not known all food handling staff were to have received the above annual in-service training.  Interview on 2/5/15 at 9:30 a.m. with the director of clinical services for South Dakota regarding the above required inservices revealed: *The provider did not have a policy. *He would have expected the facility to have followed the state requirement.	S 301	S 301 No specific residents were mentioned in S 301. Wheatcrest Hills' certified dietary manager will hold an in-service for all food handling staff on 3/20/15 to cover all areas mentioned in S 301. Annually, there will also be a training session on Redilearning assigned to each food handling staff. The dietary manager, DON or designee will monitor in services annually and report to QA annually.	3-27-15
S 302	44:04:07:17 Nutrition and hydration assistance program  ...The program must be approved by the department. To be approved by the department, the program must include instruction from a	S 302		

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S 302	<p>Continued From page 2</p> <p>speech therapist and registered dietitian and consist of ten hours of nursing and clinical experience.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview and record review, the provider failed to have a state-approved training program to train two of two nutrition and hydration assistants (A and B). Findings include:</p> <p>1. Interview on 2/3/15 at 4:30 p.m. with the dietary manager and on 2/5/15 at 9:15 a.m. with the director of clinical services for South Dakota revealed: *The provider utilized nutrition and hydration assistants, employees A and B. *The director of clinical nursing services revealed they had no policy on the nursing and hydration assistance program.</p> <p>Interview on 2/5/15 at 9:15 a.m. with employee A regarding the provider's nutrition and hydration assistance program revealed: *She had completed the program on 5/25/06. *She had not completed a certified nursing assistant or a licensed nurse program. *Her training program had not included instruction from a registered dietitian.</p> <p>Interview on 2/5/15 at 10:50 a.m. with employee B regarding the above revealed: *She had completed the program on 8/28/14. *She had completed a certified nursing assistance program on 12/12/14. *She was not a certified nursing assistant when she had completed the program on 8/28/14.</p>	S 302		
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NAME OF PROVIDER OR SUPPLIER  <b>WHEATCREST HILLS HEALTHCARE COMMUN</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430</b>		
(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 302	Continued From page 3  *Her program had not included instruction from a speech therapist and a registered dietitian.  Review of the provider's nursing facility nutrition and hydration assistance program revealed: *No documentation the program had been approved by the South Dakota Department of Health (SD DOH). *Employee A had completed her training on 5/25/06. *Employee B had completed her training on 8/28/14. *The program was to have been approved by the SD DOH and must have included instruction from a speech therapist and a registered dietitian. *The program was to have consisted of ten hours of training and clinical experience.	S 302	S 302 No specific residents were mentioned in S 302. The nutrition and hydration assistant A will not assist with meals until she has additional training covered under a SD DOH approved program. The nutrition and hydration assistant B is now a Certified Nursing Assistant. Wheatcrest Hills will submit a program for approval to the SD DOH, and will use only that program in the training of nutrition and hydration assistant. The correction will be monitored by the DON or designee monthly X 90 days. The DON will be reporting audit results at the monthly QA meetings X 3 months.	3-27-15