

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>12/17/2015</b>
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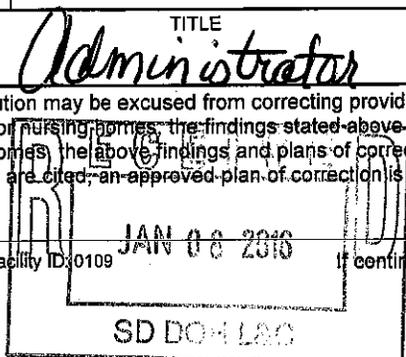
NAME OF PROVIDER OR SUPPLIER  <b>WHEATCREST HILLS HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430</b>
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F 000	<p><i>*Addendums noted with an asterisk per 1/25/16 per telephone with facility DON. DK/SPDOH/EL</i></p> <p>INITIAL COMMENTS</p> <p>Surveyor: 16385</p> <p>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 12/14/15 through 12/17/15. Wheatcrest Hills Healthcare Community was found not in compliance with the following requirements: F221, F280, F281, and F441.</p>	F 000	<p>Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Administrator or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.</p>	
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355</p> <p>Based on observation, interview, record review, and policy review, the provider failed to ensure a device with the potential to be used as a restraint was assessed and had a consent form for one of four sampled residents (3) who slept in a recliner at night. Findings include:</p> <p>1. Random observations from 12/14/15 through 12/17/15 of resident 3 in her room revealed she was sitting in her wheelchair (w/c). She had not been observed resting in her bed or recliner.</p> <p>Review of resident 3's medical record revealed: *An admission date of 5/21/15. *She had been admitted in a weakened condition and required strengthening from physical and occupational therapies.</p>	F 221	<p><b>F221</b></p> <p>1. Resident 3 has had a quarterly device assessment completed.</p> <p>2. All residents are at risk.</p> <p>3. The Administrator, Director of Nursing (DON), and Interdisciplinary Team have reviewed the policy and procedure on device use, including those devices that</p>	

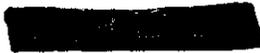
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>J. Donnell Furman</i>	TITLE <i>Administrator</i>	(X6) DATE <i>1-6-16</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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F 221	<p>Continued From page 1</p> <p>*Her current Brief Interview for Mental Examination Status score was thirteen. That score indicated she had good memory recall.</p> <p>*She was alert, oriented, and capable of making her needs known to the staff.</p> <p>*On 10/21/15 at 4:30 a.m. she had fallen out of her recliner without injury.</p> <p>Review of resident 3's 10/21/15 Unusual Occurrence Report revealed:</p> <p>*Comments regarding incident: "Came out of another residents room and heard a bang, her light came on, went to see and saw resident on floor."</p> <p>*Situation surrounding event: "CNA [certified nursing assistant] heard noise coming from resident room, when she got there she found resident sitting on floor with recliner in highest position."</p> <p>*Background data: "Resident alert and oriented, is able to make needs known, hard of hearing."</p> <p>*Assessment: "No injury noted at this time."</p> <p>*Intervention: "Keep recliner remote out of residents reach."</p> <p>Review of resident 3's 10/21/15 Fall Scene Investigation Report revealed:</p> <p>*The resident had raised the recliner into the highest position by using the hand remote.</p> <p>*She had slid out of the recliner with no injury.</p> <p>*The initial intervention had been to keep the recliner remote out of the resident's reach.</p> <p>*Fall team meeting notes:</p> <p>- "Resident forgetful, does not always make safe choices. Rare occurrence."</p> <p>- Conclusion: "To keep recliner remote out of residents reach."</p> <p>Continued review of resident 3's medical record</p>	F 221	<p>have the potential to be restrictive or a restraint. Findings from the cited deficiency were reviewed. Education provided that those residents not using their bed to sleep may have bed removed from room to allow for more space for free activity. Additionally, all staff will be in-serviced by the DON no later than January 13, 2016 on the above. Staff not in attendance due to illness, vacation, etc., will be educated prior to working their next scheduled shift.</p> <p>4. The DON or designee will audit four random residents a week for four weeks to ensure: any restraint device used has had an assessment, MD order, and consent signed for its use and that there are no interventions or devices employed that would restrict residents and could be considered a restraint. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation/discontinuation of audit.</p> <p></p> <p>*DH/SDDOHEL</p>	<p>* 2/1/16 DH/SDDOHEL</p>

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F 221	<p>Continued From page 2</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>*There had been no physician's order allowing the staff to place the recliner remote out of her reach.</li> <li>*No documentation to support resident 3 had been educated on the risks and benefits of not having access to her recliner remote.</li> <li>*There had been no consent form signed by the resident or family giving permission for her to not have access to her recliner remote.</li> </ul> <p>Interview on 12/15/15 at 10:00 a.m. with resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*At night she preferred to sleep in her recliner.</li> <li>*During the day she would have rested in her w/c or recliner.</li> <li>*She recently slid out of her recliner when she had tried to put the footrest down. She stated "I held the remote to long and the chair went up to high."</li> <li>*Periodically her legs would hurt when they were elevated. During those times she would have preferred to put her legs down.</li> <li>*She did not have access to her recliner remote and required the staff to assist her with putting her legs down.</li> <li>*When she was in the recliner the staff would place the remote on the floor out of her reach. She stated "The staff say the nurses tell them I don't need it."</li> <li>*She stated "I would like to have my remote so I can put my legs down when they hurt, that helps them. I don't always like waiting for the staff."</li> </ul> <p>Interview on 12/17/15 at 10:08 a.m. with licensed practical nurse (LPN) C regarding resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*She agreed the resident was alert, oriented, and capable of making her needs known to the staff.</li> </ul>	F 221		

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F 221	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>*She had been aware the staff were placing the recliner remote out of reach from the resident.</li> <li>*She stated "It's for her safety. She raises the recliner up to high and she will slide out."</li> <li>*She had not been aware that was considered a type of restraint.</li> <li>*She had not been aware the staff were telling the resident "The nurses say I don't need it."</li> <li>*She had not been responsible for the restraint assessments or making sure the consent form had been signed.</li> </ul> <p>Interview on 12/17/15 at 10:10 a.m. with the director of nursing regarding resident 3 revealed:</p> <ul style="list-style-type: none"> <li>*She agreed by not allowing the resident access to her recliner remote it had prevented her from getting out of the chair. She had not considered that a type of restraint.</li> <li>*She had considered it a safety measure to ensure the resident did not raise the recliner up to high and slide out.</li> <li>*She had not been aware: <ul style="list-style-type: none"> <li>-The staff were telling the resident she did not need the remote.</li> <li>-The resident's legs would periodically hurt when they were elevated.</li> <li>-During those times of discomfort the resident had preferred to have her legs in the down position.</li> <li>-The resident preferred to have access to her remote.</li> </ul> </li> <li>*She agreed the resident should have been re-evaluated to ensure the appropriateness of that intervention to prevent falls.</li> <li>*She confirmed there had not been: <ul style="list-style-type: none"> <li>-Education provided to the resident or family on the risk or benefits of not having access to her recliner remote.</li> <li>-A consent form signed by the resident or family</li> </ul> </li> </ul>	F 221		

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F 221	Continued From page 4 allowing the staff to keep the recliner remote out of reach from the resident.  Review of the provider's August 2013 Restraints Mechanical policy revealed: *"The needs for a restraint, the type and duration, will be determined by the interdisciplinary team." *"The physician will be contacted with the concerns and requests of the team, if appropriate, and order will be obtained at this time. Order must contain reason for use, when to be used, and diagnosis causing need." *"A consent must be obtained." *"Residents using a mechanical restraint will have a quarterly review to determine the continued necessity of the restraint." *"Any restraint used will be the least restrictive and will increase from that trial use, using the most restrictive only as a last resort."	F 221			
F 280 SS=D	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.  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	F 280			

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F 280	<p>Continued From page 5 and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32355 Based on observation, interview, record review, policy review, and job description review, the provider failed to ensure two of ten sampled residents' (2 and 3) care plans had been reviewed and revised to reflect the resident's individual needs. Findings include:</p> <p>1. Review of resident 2's medical record revealed: *An admission date of 6/22/12. *Diagnoses history of cellulitis (skin infection) of the right arm, depression, high blood pressure, and history of pressure ulcers (injury to skin from continuous pressure and frequently over a bony area) to her bottom. *She had required extensive assistance of one to two staff members for transfers (moving from one surface to another) and bed mobility. *Her wheelchair (w/c) was her primary mode of getting around and she was unable to walk. *She had been at risk for skin breakdown and currently had a stage III (wound from constant pressure) pressure ulcer to her right buttock.</p> <p>Random observations of resident 2 from 12/14/15 through 12/15/15 revealed she had been sitting in her w/c. She had not been observed sitting in her recliner or laying down in her bed.</p> <p>Review of resident 2's 10/23/15 quarterly</p>	F 280	<p><b>F280</b></p> <p>1. Residents 2 and 3 have had their care plans reviewed and updated.</p> <p>2. All residents are at risk.</p> <p>3. The DON will educate all staff no later than January 13, 2016 on care plans and ensuring the care plan is accurate for the care and well-being of the residents. Staff not in attendance due to illness, vacation, etc., will be educated prior to working their next scheduled shift.</p> <p>4. The DON or designee will audit four random residents a week for four weeks to ensure the care plan is accurate and reflects the care needs of the resident. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations for continuation or discontinuation of audit.</p> <p> *DH/SDDOTHEL</p>	<p>*2/1/16 DH/SDDOTHEL</p>	

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F 280	<p>Continued From page 6</p> <p>Minimum Data Set (MDS) assessment revealed: *She had been at risk for pressure ulcers. *She had not required: -A pressure reducing device for her chair or bed. -A turning or repositioning program.</p> <p>Interview on 12/15/15 at 2:15 p.m. with licensed practical nurse (LPN) C regarding resident 2 revealed: *She had confirmed: -The resident required staff assistance with transfers and bed mobility. -The w/c had been the resident's primary mode of getting around. She did not walk. -The resident had a history of pressure ulcers to her bottom. -The resident was at risk for pressure ulcers. *The resident would have refused at times to be moved out of her w/c during the day and preferred to lay on one side when in bed during the night. *The resident had been repositioned upon toileting. *She had not been responsible for the updating of the care plans.</p> <p>Interview on 12/17/15 at 10:45 a.m. with certified nursing assistant (CNA) D regarding resident 2 further confirmed the above interview with LPN C.</p> <p>Review of resident 2's current care plan revealed: *A focus area of "Hygiene/ADL's [activities of daily living]/skin: I have OA [open area], muscle weakness, and body control problems. I have a history of pressure ulcers." *An intervention area that failed to identify: -What her turning and repositioning program consisted of. -Her refusal to be repositioned during the day</p>	F 280		

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F 280	<p>Continued From page 7 while in her w/c. -Her refusal to be repositioned onto a different side while laying in bed.</p> <p>2. Review of resident 3's medical record revealed: *An admission date of 5/21/15. *Diagnosis of congestive heart failure (poor functioning of the heart) with increased swelling in her legs. *A 6/1/15 physician's order for Ace wraps to be applied to her legs during the day and off at bedtime. *She was capable of feeding herself after set-up by the staff.</p> <p>Random observations from 12/14/15 through 12/15/15 of resident 3 revealed during the daytime hours she had been wearing regular socks. No Ace wraps had been observed on her legs.</p> <p>Observation of resident 3 revealed: *On 12/14/15 at 6:00 p.m. she had been sitting in her w/c at the dining room table eating supper. *Attached to the table was plastic tubing that extended down lower than the table top. On the end of the tubing was a red tray. *Her supper meal had been placed on the red tray that extended down below the table top. *On 12/15/15 at 12:00 noon her meal had been served and set-up as above.</p> <p>Interview on 12/15/15 at 12:05 p.m. with resident 3 revealed she had preferred the red tray to be lower than the table top. That had allowed her to have easier access to her meal. When she had extended her arms too far that would hurt her shoulders. That device and set-up had allowed</p>	F 280			

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F 280	<p>Continued From page 8 her to eat her meals with less pain.</p> <p>Interview on 12/17/15 at 9:00 a.m. with LPN C regarding resident 3 revealed: *She had confirmed the physician's orders to wear Ace wraps during the day and off at bedtime. *The CNAs were responsible for putting them on in the morning. *The resident frequently refused to wear them.</p> <p>Review of resident 3's current care plan revealed: *No documentation to support: -She should have worn Ace wraps during the day and off at bedtime. -She had frequently refused to wear those Ace wraps. -She had required her meal to be served and set-up on a tray that extended lower than the table top.</p> <p>3. Interview on 12/17/15 at 1:30 p.m. with the MDS coordinator and director of nursing (DON) revealed: *All the nurses had been responsible for reviewing and revising the care plans. *There had been a schedule implemented for the nurses to follow on which care plans to review and revise. *They would have expected the nursing staff to update the care plans as changes occurred and according to the schedule. *They agreed all of the above areas of concern for residents 2 and 3 should have been found on their care plans. *Their care plans had not reflected the current level of care, refusal of treatments/care, and assistance they had required from the staff.</p>	F 280		

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F 280	Continued From page 9 Review of the provider's August 2014 Care Planning policy revealed: *"Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence." *"Care planning is constantly in process; it begins the moment the resident is admitted to the facility and doesn't end until discharge or death." *"Each staff member working with the individual resident is responsible to read, utilize and offer input to improve the care plan content ongoing."  Review of the provider's June 2006 LPN Team Leader job description revealed: *"Assist in planning, directing and providing resident care." *"Update care plans to reflect current approaches and goals for each resident."  Review of the provider's undated Staff RN job description revealed "Duties: To assure that resident care plans are current and address the individual needs of each resident."	F 280		
F 281 SS=D	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: 32355 Based on observation, record review, interview, policy review, and job description review, the provider failed to ensure:	F 281		

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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 281	<p>Continued From page 10</p> <p>*The physician and family were notified in a timely manner for one of ten sampled residents (2) who had a change in condition.</p> <p>*Physicians' orders were followed for one of ten sampled residents (3) who required the use of oxygen and Ace wraps.</p> <p>Findings include:</p> <p>1. Review of resident 2's medical record revealed:</p> <p>*An admission date of 6/22/12.</p> <p>*Diagnoses of history of cellulitis (skin infection) of the right arm, depression, high blood pressure, and history of pressure ulcers (injury to skin from continuous pressure and frequently over a bony area) to her bottom.</p> <p>*She had required extensive assistance of one to two staff members for transfers (moving from one surface to another) and bed mobility.</p> <p>*Her wheelchair (w/c) was her primary mode of getting around and she was unable to walk.</p> <p>*She had been at risk for skin breakdown and currently had a stage III (wound from constant pressure) pressure ulcer to her right buttock. The pressure ulcer had been identified on 11/25/15.</p> <p>Review of resident 2's 11/25/15 Initial Weekly Wound Documentation form revealed:</p> <p>*The resident had a stage III pressure ulcer to her right buttock.</p> <p>*Treatment: "Cleanse as directed. Apply hydrogel to wound bed. Cover with bordered foam dressing. Will have Dr [doctor] examine as needed. Cushion to w/c. Prefers to not use pressure relieving air mattress."</p> <p>*No documentation to support the physician or family had been notified of the pressure ulcer.</p> <p>Review of resident 2's Weekly Wound</p>	F 281	<p><b>F281</b></p> <p>1. Residents 2's MD and family have been notified of resident's change of condition. Resident 3 is receiving the ordered liters per minute (LPM) of oxygen and her order for ACE wraps to legs has been changed by the physician.</p> <p>2. All residents are at risk.</p> <p>3. The DON will educate nursing staff no later than January 13, 2016 on ensuring the physician and family are notified of resident changes in condition and ensuring physician orders are followed and refusals of such are documented and physician notified of such refusals. Staff not in attendance due to illness, vacation, etc., will be educated prior to working their next scheduled shift.</p> <p>4. The DON or designee will audit four random residents a week for four weeks to ensure the following: any changes of condition have documented physician and family notification; and physician orders are followed. Any refusals by the resident are documented and the physician is notified of such. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations for continuation or discontinuation of audit.</p> <p><i>*2/1/16</i> <i>DK/SDDO/H/EL</i></p> <p><i>*DK/SDDO/H/EL</i></p>	

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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>
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F 281	<p>Continued From page 11</p> <p>Documentation form of her stage III pressure ulcer revealed:</p> <p>*On 12/01/15 an analysis and plan: "Resident has history of breakdown to bottom. Will have Dr examine on rounds."</p> <p>*On 12/09/15 an analysis and plan: "Will have Dr examine as needed."</p> <p>*On 12/15/15 an analysis and plan documentation revealed the same as written above.</p> <p>*No documentation to support:</p> <p>-When or if the physician had been notified of the pressure ulcer.</p> <p>-The family had been notified of the pressure ulcer.</p> <p>Review of resident 2's physician's orders revealed the resident's stage III pressure ulcer to her right buttock had been initially assessed nine days later on 12/3/15 by the physician. There had been no documentation to support the physician had not been notified of that pressure ulcer until 12/3/15.</p> <p>Review of resident 2's progress notes from 11/25/15 through 12/16/15 revealed no documentation to support the family had been notified of her change in condition.</p> <p>Interview on 12/15/15 at 2:20 p.m. with licensed practical nurse (LPN) C regarding resident 2 revealed:</p> <p>*She had been the wound nurse and would have checked the resident's pressure ulcer weekly.</p> <p>*She had confirmed the physician had not been notified until nine days later on 12/3/15.</p> <p>*The resident had a history of pressure ulcers and the physician had been okay with the protocols the provider had in place to follow for wound care.</p>	F 281		
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F 281	<p>Continued From page 12</p> <p>*She had confirmed the physician would not have been notified of the pressure ulcer until in the facility to assess the residents.</p> <p>Interview on 12/17/15 at 1:20 p.m. with the director of nursing (DON) revealed she would have expected the staff to have notified the physician and family when a change in condition had been initially identified.</p> <p>Review of the provider's June 2013 Resident, Physician, and Family Notification policy revealed: *Policy: "To assure all necessary parties are notified promptly when a resident has had a change in condition which may necessitate orders from the physician and maintain accuracy with the resident's overall plan of care." *Procedures: "The facility will inform the resident, physician and family or legal representative when there is a change in condition such as but not limited to: -A significant change in the resident's physical condition. -A need to alter treatment significantly, such as discontinuing an existing treatment or commence a new treatment."</p> <p>2. Random observations of resident 3 from 12/14/15 through 12/17/15 revealed: *She had required the use of oxygen continuously. *The oxygen amount to be delivered to the resident had varied from 2.5 liters per minute (lpm) to 3.0 (lpm). *She had worn regular socks. At no time had she been observed wearing Ace wraps to her legs.</p> <p>Review of resident 2's 9/24/15 physician's orders revealed:</p>	F 281		

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F 281	<p>Continued From page 13</p> <p>*On 5/22/15 she had an order for oxygen to be delivered at 2.0 lpm continuously for every shift. *On 6/1/15 she had an order to wear Ace wraps to her lower legs for swelling during the day. They were to have been removed at bedtime.</p> <p>Review of resident 2's December 2015 treatment administration record revealed: *The nursing staff had been documenting she was: -Wearing the Ace wraps during the day. There had been no documentation to support she had refused to wear them. -Using oxygen continuously at 2.0 lpm. There had been no documentation to support the amount of oxygen delivered to the resident could have been increased to 2.5 or 3.0 lpm.</p> <p>Interview on 12/15/15 at 10:30 a.m. with certified nursing assistants (CNA) A and B revealed: *They had confirmed resident 2 had used oxygen. *They had been responsible to ensure she used it continuously. *They did not know how many lpm of oxygen she had required. *The charge nurses were responsible to ensure the resident received the correct lpm.</p> <p>Interview on 12/17/15 at 10:10 a.m. with LPN C regarding resident 2 revealed: *She was aware the resident had an order for Ace wraps to be worn during the daytime and off at night. *The CNAs were to have put them on in the morning and removed them at night. *The charge nurses had been responsible to ensure they were on and removed. *She stated "She refuses to wear them most of the time."</p>	F 281		

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F 281	<p>Continued From page 14</p> <p>*She had no documentation to support the resident had refused to wear the Ace wraps. *She confirmed the charge nurses had been documenting the resident was wearing the Ace wraps. *She stated "She doesn't really need them. I'll get them discontinued today when the doctor is here." *She confirmed the charge nurses were responsible to ensure resident 2 had been receiving the correct lpm of oxygen. *She was not aware the oxygen level being delivered to the resident had not been the correct lpm.</p> <p>3. Interview on 12/17/15 at 2:25 p.m. with the DON revealed the charge nurses were responsible to ensure treatments were accurate, required continued use, and were appropriate for the residents.</p> <p>Review of the provider's June 2006 LPN Team Leader job description revealed: **Assist in planning, directing and providing resident care." **Administer medication and treatments in accordance to facility procedure and accepted nursing standards as per physician orders." **Provide timely and accurate documentation of assessments and interventions in the resident medical record." **Recognize signs and symptoms of change of condition and reports all changes to MD [medical doctor] or PA [physician assistant] in a timely manner." **Responsible for the quality, quantity, accuracy, thoroughness, and reliability of work performed, and for maintaining professional standards required by the job and by regulation in the</p>	F 281			

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F 281	Continued From page 15 long-term care industry.  Review of the provider's undated Staff RN job description revealed: **Duties: -To coordinate timely and accurate nursing assessments, interventions, and evaluations with supporting documentation in the residents record to assure that desired resident outcomes and standards of resident care are provided. -To assure that the attending physician is current on the condition and needs of each resident. -To assure that communication with the resident and/or legal guardian/family member(s) occurs when the current condition and needs of each resident changes."	F 281		
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 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	F 441		

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F 441	<p>Continued From page 16</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, policy review, and manufacturers' instructions, the provider failed to disinfect: *Residents' toilet and sink surfaces per the chemical manufacturers' instructions. *One of one resident whirlpool bathtub by one of one bath aide (E). Findings include:</p> <p>1. Observation on 12/15/15 at 10:00 a.m. of housekeeper F cleaning a resident's room on Paradise hallway revealed she used a cloth soaked in NABC (a chemical used for cleaning).</p> <p>Observation on 12/15/15 at 10:30 a.m. of the environmental supervisor cleaning residents' rooms on the Horizons hallway revealed the same as the above.</p>	F 441	<p><b>F441</b></p> <p>1. Facility sinks and toilets are being disinfected using the manufacturer's recommendation for each product used and the whirlpool tub is being cleaned per the Facility's Cleaning and Disinfection procedure.</p> <p>2. All residents are at risk.</p> <p>3. The Administrator, DON and Infection Control Nurse will review the policy and procedure for appropriate use of cleaning and disinfecting products, as well as, appropriate procedure for cleaning the whirlpool tub. The DON will educate nursing staff and housekeeping supervisor will educate housekeeping staff on the above. Staff not in attendance due to illness, vacation, etc., will be educated prior to working their next scheduled shift.</p> <p>4. The DON or designee will audit four random sink and toilet disinfections a week for four weeks to ensure the cleaning products manufacturer's recommendation for disinfection are followed. Additionally, two whirlpool disinfections will be observed a week to ensure the whirlpool tub cleaning procedure is followed. Audits will be discussed by the DON in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations for continuation or discontinuation of audit.</p>	

\*2/11/16  
DH/SDD/EL

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F 441	Continued From page 17  Review of the above product's manufacturer's instructions on the label revealed to disinfect surfaces the product should have been used full strength, left on for ten minutes, then rinsed with water.  Interview on 12/15/15 at 11:40 a.m. with the environmental supervisor regarding the NABC revealed: *It was diluted with water before use. *That was how they had been using it to clean the residents' rooms. *She thought that process adequately disinfected the room surfaces. *She was unaware of the above manufacturer's instructions to use the product full strength to disinfect surfaces. *Resident's toilet and sink surfaces had not been adequately disinfected.  Review of the provider's undated policy on cleaning residents' rooms revealed there was no mention of the specific disinfectant to be used or if it was to be diluted before use.  2. Observation and interview on 12/15/15 at 10:45 a.m. of bath aide E cleaning the residents' whirlpool bathtub revealed: *She had been a bath aide for years. *That was the only tub used for the residents' baths. *After rinsing the tub with water she proceeded to spray disinfectant on the inside surfaces of the tub continuously for ten minutes. *Without scrubbing she rinsed off the disinfectant with water and was finished with the cleaning. *She stated that was the procedure for cleaning the whirlpool bathtub.	F 441	 *DH/SDDO/H/EL	

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F 441	Continued From page 18  Review of the provider's undated Cleaning/Disinfecting Procedure for Whirlpool Tub instructions posted on the wall of the tub room revealed: **"Close the drain. Turn on the disinfectant wand by turning it counter clockwise." **"Spray all inside surfaces of the tub, all surfaces of the chair as well as those of the pads. You should have about a gallon of water and disinfectant mix in the foot well of the tub." **"Turn off the disinfectant valve by turning clockwise. Scrub all surfaces with the long handled brush and/or a mesh cloth." **"After all surfaces have been thoroughly scrubbed, open the drain. All surfaces must remain wet with solution for 10 minutes between baths and after the last bath of the day or when tub is visibly soiled." **"Thoroughly rinse."  Interview on 12/17/15 at 1:45 p.m. with the infection control nurse regarding the disinfection of the resident rooms and the whirlpool bathtub revealed she agreed adequate disinfection had not occurred.	F 441			

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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>	
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K 000	INITIAL COMMENTS  Surveyor: 25107 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 12/21/15. 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 12/21/15 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 commitment to continued compliance with the fire safety standard.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1  This STANDARD is not met as evidenced by: Surveyor: 25107 Based on observation and document review, the provider failed to maintain a protected path of egress from the basement to the exterior of the	K 033		F

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

TITLE

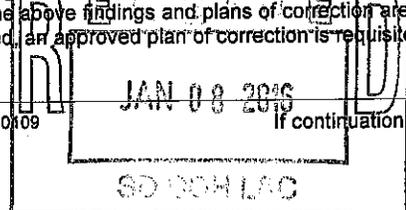
(X6) DATE

*Sharonne Furman*

*Administrator*

*01-06-16*

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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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>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/21/2015</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
K 033	Continued From page 1 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 10:30 a.m. on 12/21/15 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		

ORIGINAL

PRINTED: 12/29/2015  
FORM APPROVED

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>10599</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/21/2015</b>
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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>
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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 000	Compliance/Noncompliance Statement  Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 12/14/15 through 12/17/15 and on 12/21/15. Wheatcrest Hills Healthcare Community was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement  Surveyor: 16385 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 12/14/15 through 12/17/15. Wheatcrest Hills Healthcare Community was found in compliance.	S 000		

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

*Joanne Furman*

TITLE

*Administrator*

(X6) DATE

*01-06-16*

STATE FORM

6899

ZK1811

continuation sheet 1 of 1

