

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

ORIGINAL

PRINTED: 10/21/2015
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 10/07/2015
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	<p><i>*Addendums noted with an asterisk per 11/5/15 per telephone with facility administrator.</i></p> <p>Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/6/15 through 10/7/15. Wilmot Care Center was found not in compliance with the following requirements: F280, F281, F364, F387, F441, and F514.</p>	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 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO 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: 34030 Based on observation, interview, record review,</p>	F 280	<p>Residents 1,2,3,5,6, and 7 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 11/2/2015 and education will be provided to all staff responsible for updating care plans to reflect residents current care needs. Director of Nursing or designee will audit newly updated or completed 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>	11-29-15

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

TITLE

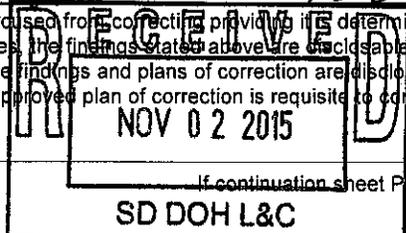
(X6) DATE

Cathy A. Pond

RHA

10-29-15

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided 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 280	<p>Continued From page 1</p> <p>and policy review, the provider failed to ensure care plans had been updated or completed for six of ten sampled residents (1, 2, 3, 5, 6, and 7). Findings include:</p> <p>1. Observation on 10/6/15 at 11:00 a.m. of resident 2's room revealed one side rail up at the head of her bed.</p> <p>Review of resident 2's 8/7/15 Minimum Data Set (MDS) assessment revealed she had side rails.</p> <p>Review of resident 2's medical record revealed current nursing assessments for side rails.</p> <p>Review of resident 2's 10/6/15 care plan revealed no mention of side rails.</p> <p>2. Random observations from 10/6/15 through 10/7/15 revealed resident 5 was either up in her wheelchair or lying in her bed. She did not ambulate.</p> <p>Review of resident 5's 7/22/15 MDS assessment revealed she:</p> <ul style="list-style-type: none"> *Needed extensive assistance of one to two staff members to transfer into bed or to her wheelchair. *Needed total assistance of one to two staff members to toilet and was always incontinent of bladder and bowel. <p>Review of resident 5's medical record revealed:</p> <ul style="list-style-type: none"> *She was severely impaired in her physical and mental abilities. *She needed help from staff with toileting and transferring. *She currently had a blister on her left heel of her foot. 	F 280		

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F 280	<p>Continued From page 2</p> <p>Review of resident 5's 10/6/15 care plan revealed none of the above information on how she was transferred, toileted, or that she had a blister on her heel.</p> <p>Interview on 10/7/15 at 10:00 a.m. with the MDS coordinator revealed she: *Had been in that position for a year. *Also was responsible for the resident care plans. *Was "trying to get caught up" with the care plans. *Agreed some of the residents' care plans were not up to date.</p> <p>Surveyor: 26180 3. Random observations of resident 6 on 10/6/15 from 9:45 a.m. through 5:50 p.m. and 10/7/15 from 7:30 a.m. until 5:00 p.m. revealed she: *Was sleeping in her bed. *Did not get out of bed at any time during the day. *Ate her noon meal and supper meal in her bed with staff feeding her. *Did not respond verbally. *Did not get out of her bed or come out of her room for any activities.</p> <p>Interview on 10/7/15 at 10:45 a.m. with the social services/activity director confirmed resident 6 was basically confined to her bed. She only occasionally got out of bed.</p> <p>Interview on 10/7/15 at 9:15 a.m. with the restorative coordinator regarding resident 6 revealed: *She was basically bed bound. *She was no longer able to tolerate sitting up out of bed.</p>	F 280		

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F 280	<p>Continued From page 3</p> <p>-This had been occurring for about two months now.</p> <p>*Restorative nursing worked with her doing (passive range of motion) PROM exercises.</p> <p>*The only time she was out of bed was when she had a bath.</p> <p>*She required total assistance with all of his ADL's.</p> <p>*The Resident status sheet was what would have been considered the care plan for each resident, and it would have been followed by the nursing assistants.</p> <p>Review of resident 6's 9/8/14 with updates in June 2015 care plan revealed: *Focus: He had an ADL self-care performance deficit related to severe end stage dementia (memory loss). *Interventions included restorative therapy would work with her on transfers with moderate to maximum assistance. *Focus: The resident had a communication problem related to dementia. *The care plan had not addressed she was bed bound.</p> <p>Review of resident 6's undated Resident Status Sheet revealed she was on the walk to dine program. However the above interview with the restorative coordinator had stated she had been bed bound for the past two months.</p> <p>4. Random observations of resident 3 on 10/6/15 from 9:45 a.m. through 5:50 p.m., and on 10/7/15 from 7:30 a.m. until 5:00 p.m. revealed he: *Was sleeping in his bed and remained there all day. *Was fed in his bed by staff during the noon and supper meals.</p>	F 280			

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F 280	<p>Continued From page 4</p> <p>*Did not respond verbally. *Did not get out of his bed or come out his room for any activities. *Wore socks on his hands to prevent him from scratching himself.</p> <p>Interview on 10/7/15 at 9:15 a.m. with the restorative coordinator regarding resident 3 revealed: *He was bed bound. *He was not able to tolerate sitting up out of bed or support himself sitting up. *This had occurred for about 2 months now. *Restorative nursing worked with him PROM exercises. *The only time the resident was out of bed was when he had a bath. *He required total assistance with all of her activities of daily living.</p> <p>Review of resident 3's August 2015 care plan revealed: *Focus: The resident had a behavior problem related to dementia. *It had not addressed: -He was bed bound at the current time. -He wore socks on his hands or why he wore them.</p> <p>Review of resident 3's behavior tracking form from March 2015 through September 2015 revealed he had not exhibited any behaviors such as scratching himself.</p> <p>Surveyor: 33265 5. Review of resident 1's 8/25/15 updated care plan and documentation in medical record regarding falls from 9/1/14 to 10/7/15 revealed:</p>	F 280		

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F 280	<p>Continued From page 5</p> <p>*Focus on the care plan: The resident had an actual fall risk related to dementia and an unsteady gait.</p> <p>*The resident fell six times between 9/26/14 and 11/10/14.</p> <p>-Interventions on the care plan were made on 11/11/14 for the following:</p> <p>-Call lights would be answered in a timely manner to assist the resident.</p> <p>-Personal alarms were removed, because they were an increased irritation to the resident.</p> <p>-Determine and address reasons for falls.</p> <p>-The resident fell six times between 11/11/14 and 2/10/15.</p> <p>-An Intervention on the care plan was added on 2/11/15. The intervention was to have the evening bath aide put the resident to bed after the supper meal.</p> <p>-The resident fell once between 2/11/15 and 4/21/15.</p> <p>-Interventions were made to the care plan on 4/21/15 for the following:</p> <p>-Place pink signs in room to remind resident to use call light.</p> <p>-Put strips on the floor next to the bed to increase traction.</p> <p>-Resident was to go directly to bed after the evening meal to prevent frequent evening falls.</p> <p>*The resident fell ten times between 4/22/15 and 10/7/15.</p> <p>-No interventions had been changed or added during that times frame.</p> <p>6. Review of resident 7's 4/16/15 updated care plan and documentation in the medical record regarding falls from 9/1/14 to 10/7/15 revealed:</p> <p>*The resident had been admitted on 4/3/15.</p> <p>*Focus on the care plan: The resident was at high risk for falls related to the multiple sclerosis.</p>	F 280		
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F 280	<p>Continued From page 6</p> <ul style="list-style-type: none"> -Interventions were added to the care plan on 4/14/15 and were: -Anticipate and meet the needs of the resident. -Follow facility fall protocol. -Pt (physical therapy) to evaluate and treat as ordered. <p>*The resident fell three times between 4/14/15 and 10/7/15.</p> <p>*No interventions had been changed or added since the initial interventions were documented on 4/16/15.</p> <p>7. Interview on 10/7/15 at 11:05 a.m. with the administrator revealed falls were a monthly topic in the quality assurance meetings. Who was falling and the circumstances of the falls were discussed in the meeting. Attempts to get to the reason for the falls were made during the meeting.</p> <p>Interview on 10/7/15 at 4:10 p.m. with the director of nursing revealed she agreed that care plans needed to be updated as resident conditions changed.</p> <p>Surveyor 26180 Review of the provider's May 2014 Use of Nursing Care Plan policy revealed: *"It is the policy of [facility name] to provide an individualized nursing care plan and to promote continuity of patient care. *Initial care conferences and post hospitalization care conferences will be done at the next scheduled care conferences after admission. *It will be reviewed on the quarterly review schedule or with significant change of status."</p>	F 280	<p>*All medication cards, including residents 13 and 14 were reviewed for accuracy and corrections made on 10/28/2015 by the DCN. CS/SDDOH/EL</p>	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281		11-25-15

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F 281	Continued From page 7 The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, record review and guideline review, the provider failed to ensure the instructions provided by the physician for the administration of medications matched what was written on the medication administration record (MAR) and the label on the medication container the medication was dispensed from for 2 of 25 random medication administrations, and 2 of 12 random residents (13 and 14). Findings include: 1. Observation and review of records on 10/6/15 at 12:09 p.m. with licensed practical nurse (LPN) D during medication pass revealed: *According to the MAR resident 13 was to receive 0.125 milligram (mg) of Pramipexole (medication for Parkinson disease) three times a day. *LPN D took the medication punch card from the medication cart drawer and reviewed the label. She found the label stated the amount to be given was 0.25 mg three times a day. *A physician's order had been written to increase the medication dosage on 9/15/15. *The pharmacy had sent the new dosage with the present medication punch card on 9/25/15. Interview on 10/6/15 at 5:00 p.m. with the director of nursing (DON) revealed she had not noticed the change in the dosage at the end of the month review of medication punch cards and physician orders.	F 281	*DON contacted pharmacy for label changes to coincide with Doctors orders. Pharmacy has agreed to make changes to cards. *DON or designee will audit all medication cards from pharmacy for accuracy monthly for three months and will report finding to monthly QAPI meetings. *All nursing staff were inserviced on 11/2/15 on verifying physician orders, prescription labels, and MARs match. All nurses will be responsible for verifying new prescriptions and new orders. CS/SDDOH/EL	11-25-15

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F 281	<p>Continued From page 8</p> <p>2. Observation and review of records on 10/6/15 at 5:35 p.m. with registered nurse (RN) E and the DON during medication pass revealed: *According to the MAR resident 14 was to receive two teaspoons of a fiber powder in one-half a glass of water two times a day. *RN E took the bottle containing the fiber out of the medication cart drawer, reviewed the label, and found the label stated one tablespoon of fiber powder. *The physician's order was reviewed and found to be two teaspoons of fiber powder. *RN E stated she had previously been following the container label. *RN E shared the differing instructions with the DON. *The DON stated she remembered that order change and had sent that order change to pharmacy herself. She had no idea why the two instruction labels were not matching.</p> <p>A request was made for a policy regarding transcriptions of medication orders. The DON stated there was no specific policy regarding the above.</p> <p>Review of the provider's June 2013 Medication Administration General Guidelines revealed: *The right dose should have been checked with each medication administration. *All current medications, dosages, and administration schedules should have been listed on the resident's MAR. *To ensure accuracy in administration of medications the staff administering the medication was responsible for checking to see if the medication and dosage schedule on the resident's administration record matched the label</p>	F 281			

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F 281	Continued From page 9 on the medication package. *The first accuracy check was to have been comparing the directions for use on the label with the MAR. *The second accuracy check was to have been comparing the MAR with the package label. *The third accuracy check was to have been done when returning the medication package to the storage area where the package label and MAR were to be reviewed. *If there had been a change a "Directions Changed Refer to Med Sheet" sticker should have been placed on the medication package. -No sticker with that message was on the above medication package.	F 281		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, and policy review, the provider failed to ensure nutritional value of food was maintained for two of two meal services for three of three sampled residents (3, 4, and 6) who were on pureed (smooth consistency) diets. Findings include: 1. Interview on 10/6/15 at 11:40 a.m. with cook A revealed she: *Had prepared the pureed foods for residents 3,	F 364	All dietary staff were in-serviced on 10/28/2015 on the policies and procedures regarding pureed foods and the use of broth to thin the puree. The Dietary Manager will audit one meal per shift, per week, for four weeks and then one meal per shift, per month thereafter, to ensure the accuracy of the preparation of pureed foods. Procedures will be discussed at the November 2, 2015 in-service. Results of the audits will be reported by the Dietary Manager or Designee to the monthly QAPI meeting for further review. *including meals provided to residents 3, 4, and 6. CS/SDOHH/EL	11-25-15

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F 364	<p>Continued From page 10 4, and 6 for the noon meal. *Would use water or milk to thin pureed foods. *Had pureed all the food for that meal with water.</p> <p>Observation on 10/6/15 of the noon meal revealed resident 4 ate that meal in the dining room. Residents 3 and 6 ate in their room.</p> <p>Interview on 10/6/15 at 12:00 noon with the dietary manager (DM) revealed he would prepare pureed foods with water or broth.</p> <p>Interview on 10/6/15 at 4:45 p.m. with cook B revealed she: *Had prepared the pureed foods for residents 3, 4, and 6 for the evening meal. *Would use broth or a little water to thin pureed foods.</p> <p>Observation on 10/6/15 of the evening meal revealed resident 4 ate that meal in the dining room. Residents 3 and 6 ate in their room.</p> <p>Interview on 10/7/15 at 2:15 p.m. with the DM revealed he was unaware that adding water to pureed foods was not an acceptable practice.</p> <p>Interview on 10/7/15 at 3:30 p.m. with the director of nursing regarding the residents that received pureed foods revealed she: *Would have expected the cooks to have used a liquid with nutritive value such as broth or gravy to get the required consistency. *Agreed the addition of the water added no nutritional value for the food portions served to those residents on a pureed diet.</p> <p>Review of the provider's undated Menu Planning/Guidelines for Pureed Foods</p>	F 364		

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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) COMPLETION DATE
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F 364	Continued From page 11 preparation policy revealed approved pureed recipes for all pureed diets were to have been used.	F 364		
F 387 SS=E	<p>483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on record review, interview, and statement review, the provider failed to ensure the residents' physician was doing a full assessment of the resident's health every sixty days for 3 of 10 sampled residents (1, 4, and 10). Findings include:</p> <p>1. Review of resident 1's complete medical record revealed: *He had been admitted on 10/7/13. *He had diagnoses of Lewy Body dementia (an abnormal deposit of protein in the brain that leads to problems with thinking, movement, behavior, and mood), anxiety, major depressive disorder, atrial fibrillation (heart rhythm disorder), and heart failure (heart not working adequately). *He was seen by physician F on the following dates: -11/5/14.</p>	F 387	<p>The Policy on residents being seen by a physician at least every 30 days for the first 90 days after admission, and at least once every 60 days thereafter and no later than 10 days after the date the visit was required was reviewed with residents' 1,4, and 10 physician. All other residents' records were reviewed to ensure timelessness of physician visits. The Director of Nursing or Designee will audit the residents' records to ensure timely visits by the physician for three months and will report to QAPI monthly meetings for further review.</p> <p><i>* All CS/SDDOH/EL</i></p> <p><i>*who are due for their required physician visits, CS/SDDOH/EL</i></p>	11-25-15

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

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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 10/07/2015
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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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F 387	<p>Continued From page 12</p> <p>-1/14/15 seventy days between visits. -4/20/15 ninety-six days between visits. -6/17/15 fifty-eight days between visits. -8/28/15 seventy-two days between visits.</p> <p>2. Review of resident 4's complete medical record revealed: *He had been admitted on 10/12/00. *He had diagnoses of dementia (brain disease that causes decrease in the ability to think and remember eventually affects a person's daily function), schizophrenia (a mental disorder often characterized by abnormal social behavior and failure to recognize what is real), paralysis agitans (shaking palsy, another term for Parkinson's disease), macular degeneration (blurred vision and objects may appear distorted, color vision may be altered), and esophageal reflux (a condition where the stomach contents back-up into the throat). *He was seen by physician F on: -11/5/14. -1/14/15 seventy days between visits. -4/20/15 ninety-six days between visits. -6/17/15 fifty-eight days between visits. -8/28/15 seventy-two days between visits.</p> <p>3. Review of resident 10's complete medical record revealed: *He had been admitted on 4/8/13. *He had diagnoses of alcohol induced persistent dementia, psychosis (changes in personality), and prostate cancer. *He was admitted to hospice on 12/18/14. *He died on 4/26/15. * He was seen by physician F on: -11/5/14 -1/14/15 seventy days between visits. -4/20/15 ninety-six days between visits.</p>	F 387		
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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		
(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 387	Continued From page 13 Interview on 10/7/15 at 4:10 p.m. with the director of nursing revealed: *She was aware physician F had not met the every sixty days expected visits for the above residents. *She had spoken to physician F concerning the every sixty days expectation, and he was aware of it. *She understood there was a ten day leeway given to the physician's visit timeframe. She was not aware if the ten day leeway was used by the physician the clock on the sixty days did not reset. The next visit would then be expected in fifty days instead of sixty days.	F 387			
F 441 SS=F	Review of the provider's Resident Health statement revealed each resident was to be seen by their physician every thirty days for the first ninety days and then every sixty days. 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.	F 441	The Administrator, Director of Environmental Services, DON and the interdisciplinary team have created a policy and procedure for cleaning resident rooms. All policies and procedures will be presented to staff in an in-service to be held on November 2, 2015. The manual for infection prevention and control will be updated and placed in the laundry and housekeeping departments and their whereabouts will be discussed at the in-service also. The Director of Environmental Services or designee	11-25-15	

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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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F 441	Continued From page 14 (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: 34030 Based on observation, interview, manufacturer's information review, and policy review, the provider failed to ensure appropriate infection control measures were in place for: *Disinfection of residents' rooms by one of one housekeeper (A). *Having infection control policies available in the laundry department and laundry staff who were knowledgeable of those policies. Findings include: 1. Observation and interview on 10/7/15 at 9:15 a.m. of housekeeper A cleaning a residents' room in the west hall revealed she:	F 441	will audit staff compliance with infection control policies one time per week for four weeks and then once per month for two more months. The results of the audits will be discussed at the monthly QAPI meetings for further review.	11-25-15	

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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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F 441	<p>Continued From page 15</p> <ul style="list-style-type: none"> *Had worked there for two months on Tuesdays, Wednesdays, and Thursdays. *Had been trained by another housekeeper. *Put gloves on, put toilet bowl cleaner inside the toilet, and scrubbed it. *Sprayed the toilet surfaces with 3M peroxide cleaner and wiped it off with paper towels. -Review of the above product label at that time revealed nothing on the label stated it was a disinfectant. *Sprayed the sink surfaces with 3M neutralizer and wiped it off with paper towels. -Review of that product label stated it was to be used on floors. *Cleaned the rest of the room then removed her gloves and disposed of them. *Did not sanitize her hands before going on to the next resident's room. "I wasn't told to do that." *Was the only housekeeper cleaning residents' rooms that day. <p>Interview and review of the manufacturer's information for the above cleaners on 10/7/15 at 2:30 p.m. with the supervisor of maintenance and housekeeping revealed:</p> <ul style="list-style-type: none"> *The provider had changed cleaning products in July 2015. *Neither of the cleaning products used to clean the above residents' room were disinfectants. *He was unaware of that. *Those cleaners were the only ones present on both housekeeping carts. *He agreed resident rooms had not been adequately disinfected using the above cleaners. <p>Interview on 10/7/15 at 3:30 p.m. with the director of nursing/infection control nurse regarding disinfection of residents' rooms revealed she:</p> <ul style="list-style-type: none"> *Had not been aware the above products were 	F 441		
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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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F 441	<p>Continued From page 16 not disinfectants. *Agreed residents' rooms had not been adequately disinfected using the above cleaners. *Agreed housekeeper A should have sanitized her hands between cleaning residents' rooms.</p> <p>Review of the provider's February 2010 Standard Bathroom Cleaning Procedure policy revealed: **"Spray disinfectant clean[er] over sink area. ("Allow to set for 10 minutes" had been crossed out.) Wipe." **"Spray entire toilet surface inside and out with disinfectant cleaner. Allow to set 10 minutes. Wipe." **"Thorough hand washing is imperative. Washing of hands or use of alcohol based hand sanitizer is required every time gloves are changed, at beginning and end of work shift and breaks. See Standard Hand Washing Policy."</p> <p>Surveyor: 26180 2. Interview on 10/7/15 at 11:10 a.m. and review of the laundry policy and procedure manual with laundry aide A and the laundry supervisor revealed: *Laundry aide A did not work in laundry very often, but she did work on weekends and filled in occasionally. -She had not worked there very long. *The laundry supervisor had been there since April 2015. *They were unaware of the facility procedure for infection control in the laundry. *They did not know who they would ask about infection control. *Initially they were unsure if they had a policy manual that addressed infection control in laundry. -A review of the manual in the laundry room when</p>	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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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F 441	Continued From page 17 they found it, revealed there was not any policies regarding infection control and isolation.	F 441		
F 514 SS=B	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, and interview, the provider failed to ensure two of ten sampled residents (3 and 6) had physicians' progress notes from each required visit. Findings include: 1. Review of resident 3's entire medical record with the director of nurses revealed: *They kept a log of when a resident was seen by their physician. *The resident had been seen on 11/7/14, 2/4/15, 3/9/15, 5/11/15, 7/13/15 and 9/16/15. *There were no physician's progress notes in the record for the 3/9/15, 4/27/15 and 9/16/15 physicians' visits.	F 514	Resident's #3 and 6 records were reviewed and physicians' progress notes were located and added to their charts. The DON or Designee will audit all residents who were seen by their physician each month for three months to ensure progress notes were added to the residents' charts. The DON or Designee will report the results of the Audits to the QAPI meeting for review each month.	11-25-15

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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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F 514	<p>Continued From page 18</p> <p>2. Review of resident 6's entire medical record with the director of nurses revealed: *The resident had been seen by their physician on 10/27/14, 12/8/14, 2/26/15, 4/27/15, 6/15/15 and 8/7/15. *There were no physician's progress notes in the record for the 12/8/14, 4/27/15, and 8/7/15 visits.</p> <p>3. Interview on 10/7/15 at 3:30 p.m. with the director of nurses revealed residents 3 and 6's progress notes should have been part of the resident's medical record.</p> <p>4. Review of the provider's March 2011 Resident health policy revealed: **Each resident will be seen by the Dr [doctor] every 30 days for the first 90 days and then every 60 days." *It had not addressed maintaining copies of the physician's progress notes for the resident's medical record.</p>	F 514			

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

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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 10/06/2015
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	
K 000	<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 10/6/15. Wilmot Care Center Inc was found 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 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000			

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

Colby C. Powell

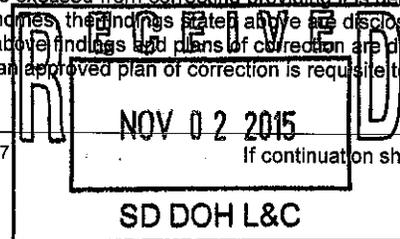
TITLE

NHA

(X6) DATE

10-29-15

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.



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 10/07/2015
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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**

(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	Initial Comments *Addendums noted with an asterisk per 11/5/15 per telephonic with facility admin. Strator: CS/SDDOH/EL 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 10/6/15 through 10/7/15. Wilmot Care Center was found not in compliance with the following requirement: S236.	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 and federal law. Without waiving the foregoing statement, the facility states that with respect to:	
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 33265 Based on interview, record review, and program review, the provider failed to complete a tuberculosis (TB) skin test on admission for one a	S 236	Resident #7 was given the second TB test on October 27, 2015. All staff and residents records were reviewed to verify that all TB tests have been done. The Director of Nursing or the designee will Audit any new employee or resident that has had a TB test to ensure that they are done within a 14 day time frame. Audits will be once per month for three months and the DON, or Designee will report the results at the monthly QAPI meeting for review. *All nursing staff were educated on TB testing requirements on 11/2/15 by the DON with the expectation that all nursing will follow through with the TB policy as necessary. CS/SDDOH/EL	11-25-15 *for all new residents and staff CS/SDDOH/EL

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

TITLE

(X6) DATE

STATE FORM

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MCSK11

NHA 10-29-15

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continuation sheet 1 of 2

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 10/07/2015
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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 236	<p>Continued From page 1</p> <p>one sampled resident (7). Findings include:</p> <p>1. Review of the resident 7's complete medical record revealed: *The resident was admitted on 4/3/15. *The first of two required TB skin tests was given on 4/3/15. *There was no documentation the first TB skin test was read. *There was no documentation of a second TB skin test being given.</p> <p>Interview on 10/7/15 at 3:00 p.m. with the director of nurses (DON) revealed: *She agreed the two-step TB skin test was not completed for resident 7 within fourteen days of admission.</p> <p>Review of provider's March 2011 Resident Health statement revealed the expectation was to have a two-step TB skin test completed within fourteen days of admission to the facility.</p>	S 236		