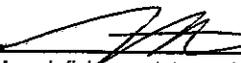


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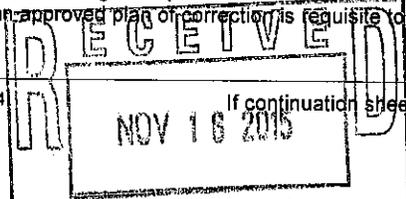
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| NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073 |
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| F 000 | INITIAL COMMENTS Surveyor: 33265 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 10/20/15 through 10/21/15. Wakonda Heritage Manor was found not in compliance with the following requirements: F244, F252, F281, F441, and F514. | F 000 | *Addendums noted with an asterisk per 11/25/15 per telephone with facility administrator, NR/SSDDO/H/EL | |
| F 244 SS=D | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on observation, resident group interview, staff interview, record review, and policy review, the provider failed to ensure resident's concerns about the meals served were listened to and acted upon. Findings include: 1. Interview on 10/20/15 at 11:00 a.m. with a confidential group of residents revealed: *They had a number of concerns regarding meals including: -They had hamburger a lot in one form or another such as hamburger, cheeseburgers, and meat balls. -The hamburger was dry and tough to chew. -They had green beans and corn a lot. | F 244 | *F 244 NR/SSDDO/H/EL Correct to the individual: System change will correct the cited deficiency *the social director (SSD) will be responsible for collecting, reviewing, scheduling to department heads involved, tracking correct to all others, the results of all grievances. All staff will be educated on the correct grievance procedure including follow up/resolution for 11/16/15 by director of nursing services (DNS) System correction: Grievance forms distributed for staff education, placed at SSD office and in chart room for access for all staff. *The Administrator will sign off on all completed/resolved grievances and concerns raised in resident council. Audits will be completed of any grievances filed and/or concerns brought forth weekly for 4 weeks then monthly for 4 months by the administrator or designee. Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. *The DNS or designee will be director of nursing services. NR/SSDDO/H/EL | *12/10/15 NR/SSDDO/H/EL |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE <i>Administrator</i> | (X6) DATE <i>11/2/15</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 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 244 | <p>Continued From page 1</p> <p>-Food was not always hot. -They did not think there was a lot of variety in their meals. *During each meal they had a main entree and an alternative if you did not like the main entree. -They did not always know what the alternative was. *They had recently changed the menus and since then they had noticed the meals had gotten worse. *They had informed the staff many times about their concerns. -They but did not feel there was any follow-up to their meal concerns.</p> <p>Review of the Resident Council minutes revealed: *11/7/14: Dietary discussion: "Pizza." *12/5/14: Dietary discussion: "Pizza. Bacon." *1/9/15: Dietary discussion: "More variety. Pizza. Not ground up enough sometimes." *3/6/15: Dietary discussion: "More pizza. More variety. More food you can eat. Cherry pie." *4/3/15: Dietary discussion: "More fresh fruit, casseroles/hot dish, pizza. Less noodles - some can't eat wheat. Temp [temperature] of food - hot/cold when supposed to be." *6/5/15: Dietary discussion: "People are being missed at meals when they ask what they want." *7/10/15: Dietary discussion: "[Resident name] still being missed at meal times. Temp could be same more often." *8/6/15: Dietary discussion: "Watch topping orders for salads." *10/8/15: Dietary Discussion: "Brats tasted spoiled. Hot dogs 3 days in a row - too much. Not getting what they ordered." *None of the above minutes had any indication they had followed up from one month to the next on their response to the previous concerns.</p> | F 244 | <p>Be responsible for reporting all audits to the QAPI team for review.</p> <p>Correction Date: 12/1/15</p> | |

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| F 244 | <p>Continued From page 2</p> <p>Interview on 10/21/15 at 10:30 a.m. with the social services coordinator revealed: *She facilitated each monthly Resident Council meeting. *Residents frequently had concerns about the meals they were served. *She agreed they did not always get back to the residents explaining what was being done about their dietary concerns or to assess if the problem had been resolved. -But many of the concerns were repeated month to month. *The certified dietary manager (CDM) had not attended many of the meetings. -When she had attended the residents would not say anything about the food. *Sometimes the residents did not say anything, but then after the meeting someone would come and say something about the food.</p> <p>Review of the Resident Council Department Response forms revealed the dietary manager had responded to the following concerns: *4/10/15: "Will add more fresh fruit as it comes into season. We have added pizza to our menu cycle. Will work on (better) sub [substitute] for those who don't like casseroles, some do like casseroles. Will do meal of the month next month." *6/8/15: "Residents are asked what they want at mealtime. I am seeing increased forgetfulness in some. There are times when I will have to remind them what they ordered and that they did order. I do allow them to pick something different if they choose to change at that time. We do have french fries on the menu, will maybe add more often. Will work on adding cabbage, BLTs, and enchiladas (not casseroles).</p> | F 244 | | | |

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| F 244 | <p>Continued From page 3</p> <p>*A Department response form was sent following the 10/8/15 Resident Council meeting, but there had not been a response yet from the CDM.</p> <p>Observation of the noon meal and supper meal on 10/20/15, and the noon meal on 10/21/15, revealed:</p> <p>*Some of the above residents ate very little of their meals.</p> <p>*They expressed dissatisfaction with what they had been served.</p> <p>*They had canned fruit at their meals.</p> <p>Surveyor: 32331</p> <p>2. Interview on 10/20/15 at 5:45 p.m. with the certified dietary manager (CDM) regarding the resident menu revealed:</p> <p>*There had been significant changes to the menu after the consultant registered dietitian's review of the menu on 7/22/15.</p> <p>*Those changes to the menu had included:</p> <ul style="list-style-type: none"> -A discontinuance of the regularly scheduled soup and sandwich for the alternate meals at noon and supper meals on Mondays, Wednesdays, and Fridays. -A discontinuance of the regularly scheduled chef salad for the alternate meals at noon and supper meals on Tuesdays and Thursdays. -An addition of a substitute entree item and vegetable for the alternate meals at each noon and supper meal. <p>*Residents would have been able to continue to have requested soup, sandwich, and/or chef salads at those meals.</p> <p>Interview on 10/21/15 at 2:45 p.m. with the CDM regarding the monthly resident council meetings revealed:</p> <p>*She had attended the meetings in the past when</p> | F 244 | | | |

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| F 244 | <p>Continued From page 4 she had been invited. *She usually received the minutes from each monthly meeting. *She received a Resident Council Department Response form from the social services designee regarding any dietary concerns from the meetings. *On the above 4/3/15 form residents wanted: -More fresh fruit. -Less noodles. -More casseroles/hot dishes. -Pizza. -Hot food served hot. -Meal of the month. -The CDM to attend the next resident council. -The CDM had responded to those requests on that same form on 4/10/15. *On the above 6/5/15 form residents wanted: -To be asked what they would have liked to eat as some were being missed. -Meal of the month ideas that had included cabbage with butter, enchiladas (a corn tortilla rolled around a meat/cheese filling and covered with a sauce), French fries, and a bacon, lettuce, and tomato sandwich. *The CDM had responded to those requests on that same form on 6/8/15. *On the above 8/6/15 form residents wanted: -Salad orders done correctly. -Cucumber salad. -More corn on the cob. *The CDM had not responded to those requests on that same form.</p> <p>Surveyor: 26180 Review of the provider's 6/15/14 Resident Council policy revealed: *"It is the policy of [facility name] to hold one organized group meeting per month for residents</p> | F 244 | | |
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| F 244 | Continued From page 5 to have an opportunity to help plan the activities for the Monthly calendar and participate in their plan of care at the facility. *It is the right of each Resident to bring ideas and concerns to the meeting at any time." *It had not addressed how they followed-up on concerns that were identified by residents in the group meetings. | F 244 | | |
| F 252 SS=D | 483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on incident review, observation, and interview, revealed the provider failed to ensure wheelchairs were kept free of vinyl tears and were clean for two of five sampled residents (1 and 4) who were in wheelchairs. Findings include: 1. Review of a 9/23/15 incident report revealed resident 1 bumped her left arm on her wheelchair during a transfer and received a skin tear. The follow-up investigation stated "Resident is 100 + years old and has frail skin. Will find something to cover her wheelchair arms to try to prevent this happening again." Observation of resident 1 on 10/21/15 revealed: *She was a frail looking woman with fragile skin. *Her wheelchair left arm had a small tear in the | F 252 | <p>*A system change will correct the cited de ficiency. NA/SDDO/HTEL</p> <p>Correct to the individual: *Kandi The wheelchairs of residents 1 and 4 have been repaired. NA/SDDO/HTEL</p> <p>Correct to all others: *All staff educated regarding reporting problems to maintenance. *for 11/10/15 by the DNS with wheelchairs NA/SDDO/HTEL</p> <p>System correction: Safety Survey checklist updated to include wheelchair maintenance. Wheelchair cleaning schedule and inspection checklist updated, to be completed nightly by staff. Audits will be 2 times per week for 4 weeks, weekly times 4 weeks then monthly for 4 months by DNS or designee. *has been NA/SDDO/HTEL</p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to the QAPI team for review. *12/01/15 NA/SDDO/HTEL</p> <p>Correction Date: 12/1/15</p> | |

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| F 252 | <p>Continued From page 6</p> <p>vinyl with edges of the tear that raised up off the arm of the chair.</p> <p>-The wheelchair arms were covered with loose fitting wraps of sheepskin that slid easily up and down the arms exposing the vinyl tear.</p> <p>2. Observation of resident 4 revealed her wheelchair had a softsided arm cushion that was quite soiled and appeared frayed.</p> <p>3. Observation and interview on 10/21/15 at 3:15 p.m. with the administrator regarding the above two wheelchairs revealed the staff reported to the maintenance supervisor (MS) about wheelchair parts that needed repair or replacing. Those wheelchair arms should have been replaced or maintained. He confirmed the sheepskin on resident 1's wheelchair arms should not have been the long term solution.</p> <p>Interview on 10/21/15 at 5:00 p.m. with the MS revealed: *He was responsible for maintaining the wheelchairs and getting arms replaced if necessary. *Nursing washed the wheelchairs at night, and reported to him if there was a problem with the condition of a wheelchair, so he could get it taken care of. -He was unaware resident 1 and 4's wheelchairs were in need of repair. *He had a Safety Survey checklist he routinely reviewed, but wheelchairs were not on that checklist.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility</p> | F 252 | <p>*The survey teams observations regarding medication administration to resident 8, 9, and 10 were utilized in the education process.</p> <p>NR/SSD/HH/EL</p> <p>Correct to the individual: *A System change will correct the cited deficiency. Individual education provided to medication aide B and LPN A by DNS: medications and on administering treatments according to policy was NR/SSD/HH/EL</p> <p>*07/10/21/15 NR/SSD/HH/EL</p> | |
| F 281 SS=D | | F 281 | | |

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| F 281 | <p>Continued From page 7 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33265 Based on observation, interview, and procedure review, the provider failed to monitor residents taking their medications for three of eight randomly observed residents (8, 9, and 11) who received medications. Findings include:</p> <p>1. Observation and interview on 10/20/15 at 5:15 p.m. with medication aide B regarding resident 9 revealed she: *Prepared the medications for the resident. *Brought the medications in a medication cup to the table where the resident was seated. *Informed the resident his medications were in the medication cup. *Set the cup in front of him and walked away. *Stated the resident would take his medications. *Had not returned to see if the resident had taken the medications or not.</p> <p>2. Observation and interview on 10/20/15 at 5:35 p.m. with medication aide B regarding resident 11 revealed she: *Prepared the medications for the resident. *Brought the medications in a medication cup to the table where the resident was seated. *Informed the resident her medications were in the medication cup. *Set the cup in front of the resident and walked away. *Stated the resident would take her medications. *Had not returned to see if the resident had taken the medications or not.</p> | F 281 | <p>Correct to all others <i>NR/SDDO/H/EL</i> All nursing staff <i>NR/SDDO/H/EL</i> educated regarding administering medications and treatments according to policy.</p> <p><i>*On 11/10/15 by DNS NR/SDDO/H/EL</i></p> <p>System correction: Audits will be 2 times per week for 4 weeks, weekly times 4 weeks, then monthly times 4 months by DNS or designee.</p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to the QAPI team for review.</p> <p>Correction Date: 12/1/15 <i>*Audits of 4 randomly selected residents, covering both shifts, will be completed. Residents 8, 9, and 10 to be included at least 4 times throughout the audit process. NR/SDDO/H/EL</i></p> <p><i>*12/01/15 NR/SDDO/H/EL</i></p> | |
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| F 281 | <p>Continued From page 8</p> <p>3. Observation and interview on 10/20/15 at 5:58 p.m. with licensed practical nurse (LPN) A regarding resident 8 revealed:</p> <ul style="list-style-type: none"> *She brought the medication to be used in the resident's nebulizer (machine that aerosolizes liquid so it can be inhaled into respiratory system) to the resident's room. *She located the nebulizer fluid chamber and poured the liquid medication into the chamber. *She informed the resident his nebulizer treatment was ready. *He turned the nebulizer machine on and put the face mask over his nose and mouth. *LPN A told the resident she would be back and left the room. *She stated she would check on him later. <p>4. Interview on 10/21/15 at 4:00 p.m. with the present directors of nursing regarding the above observations revealed they agreed the medication aide and LPN should have stayed and observed the residents to ensure the medication was taken.</p> <p>Review of Patricia A Potter et al, Fundamentals of Nursing, 8th Ed., Elsevier Mosby, St. Louis, Missouri, 2013, p. 615, revealed:</p> <ul style="list-style-type: none"> *The person administering the medication was to stay with the patient until the patient [resident] completely swallowed the each medication. *The person administering the medication was responsible for ensuring the patient received the ordered dosage. **If left unattended, some patients do not take dose or save medications, causing risk to health." <p>Review of provider's December 2009 Medication Administration procedure revealed the person administering the medication was to stay and</p> | F 281 | | | |

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| F 281 | Continued From page 9 observe the resident swallowing the medication. | F 281 | | |
| F 441 SS=E | <p>Review of the provider's undated Nebulizer Treatment procedure revealed the nurse should have monitored the resident's pulse until the medication was used up.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> | F 441 | <p>*The survey team's observations of catheter care for resident 5 and the finger stick blood sugar (FSBS) testing procedure for residents 11 and 12 were utilized in the educational process. NK/SDDO/H/EL</p> <p>Correct to the individual: *A System change will correct the cited deficiency. Individual education provided to CNA C and LPN A by DNS. on 10/21/15 NK/SDDO/H/EL</p> <p>Correct to all others: NK/SDDO/H/EL All nursing staff educated regarding infection control policy & procedure primarily related to FSBS procedure and catheter care. NK/SDDO/H/EL</p> <p>System correction: Audits will be 2 times per week for 4 weeks, weekly times 4 weeks then monthly times 4 months by DNS or designee. *12/01/15 NK/SDDO/H/EL</p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to the QAPI team for review.</p> <p>Correction Date: 12/1/15 *Of Foley catheter care will be completed on 12/1/15. Randomly selected resident, as resident availability allows during both shifts. Resident 5 to be included at least 4 times throughout the audit process. Audits on finger stick blood sugar testing 2 randomly selected residents, during both shifts. Resident 11 and 12 to be included at least 4 times throughout the audit process. Both of these audits</p> | <p>on the infection control policy and procedure was NK/SDDO/H/EL</p> <p>on 11/10/15 by DNS NK/SDDO/H/EL</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/21/2015 |
|---|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR | | STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073 | | |
| (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 441 | <p>Continued From page 10</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: 33265 Based on observation, interview, policy review, and manufacturer's instructions review, the provider failed to ensure infection control practices were followed for maintaining aseptic (clean) technique for: *Foley catheter (tube inserted into bladder to drain urine) care for one of one randomly observed resident (5) requiring Foley catheter care. *Supplies used during blood sugar testing for two of two randomly observed residents(11 and 12) requiring blood sugar monitoring. Findings include:</p> <p>1. Observation and interview on 10/21/15 at 10:30 a.m. with certified nursing assistant (CNA) C completing Foley catheter care for resident 5 revealed she: *Washed her hands and put on gloves. *Got two paper towels and the leg bag (bag urine flows into from Foley catheter that is secured on the leg) from the bathroom. The leg bag tubing connector (end of tubing that fits into Foley catheter tubing) had not had a cover over it. *Placed the paper towels on the floor in front of the resident and then placed the leg bag and the connector without a cover on the paper towels. *Rolled up the resident's pant leg to access the</p> | F 441 | | |

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| F 441 | <p>Continued From page 11</p> <p>Foley catheter bag connector and then removed the Foley bag. She held that under her arm while she picked up the leg bag and connector.</p> <p>*Cleaned the connector of the leg bag with an alcohol swab, and then connected it to the Foley catheter tubing.</p> <p>*Secured the leg bag on the leg and rolled down the pant leg.</p> <p>*Went into the bathroom with the Foley catheter bag and the urinal. She had drained the urine from the Foley catheter bag into the urinal. She emptied the urinal contents into the toilet.</p> <p>*Found the container with the vinegar water solution used to clean the Foley catheter bag and tubing was empty.</p> <p>*Placed the Foley catheter bag in the plastic holder attached to the bathroom wall. There was no cover on the connector at the end of the tubing.</p> <p>*She put the urinal on the floor then removed her gloves and washed her hands.</p> <p>*Retrieved a gallon of vinegar and mixed a half water, half vinegar solution in the bottle and returned to the resident's bathroom.</p> <p>*Washed her hands and put on gloves.</p> <p>*Rinsed out the urinal with water and then used the vinegar/water solution to rinse the urinal again.</p> <p>*Left the Foley catheter bag and connector as they were; not rinsed out. The end connector was not covered.</p> <p>*Removed and discarded her gloves.</p> <p>*Washed her hands.</p> <p>*Stated that was the usual way they completed Foley care in the morning for those residents who used a leg bag.</p> <p>Interview on 10/21/15 at 4:00 p.m. with the two directors of nursing (DON) regarding the above</p> | F 441 | | |
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| F 441 | <p>Continued From page 12</p> <p>observations revealed they agreed:</p> <ul style="list-style-type: none"> *Barrier (material between dirty surface and items wanting to be kept clean) other than a paper towel should have been used and the items should not have been placed on the floor. *There should have been caps to cover the connectors after they were cleaned for storage. *The Foley catheter bag should have been rinsed with water and then the vinegar water solution before storage for the day. <p>Review of provider's 1/11/14 Switching of Urinary Leg Bag/Drain Bag policy revealed:</p> <ul style="list-style-type: none"> *The supplies were to be collected and placed on a clean surface before starting. *The connector on the Foley bag should have been cleaned with an alcohol pad before storage. <p>2a. Observation on 10/20/15 at 4:32 p.m. of licensed practical nurse (LPN) A doing a blood sugar test on resident 12 revealed she:</p> <ul style="list-style-type: none"> *Placed cotton balls for cleaning off the finger on the top surface of the treatment cart that had not been cleaned before use. *Cleaned resident's finger with an alcohol swab, and then wiped it dry with a cotton ball. *Obtained blood needed for test from a finger stick, and then wiped the excess blood off with a cotton ball. *Cleaned the glucometer (machine used to read the level of sugar in the blood) with a Super Sani-Cloth wipe for seven seconds and laid the glucometer on top of the treatment cart to air dry. *Stated this was the standard way of doing the blood sugar testing. <p>b. Observation on 10/20/15 at 5:25 p.m. of licensed practical nurse (LPN) A doing a blood sugar test on resident 11 revealed she:</p> | F 441 | | | |

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| F 441 | Continued From page 13 *Placed cotton balls for cleaning off the finger on the top surface of the treatment cart that had not been cleaned before use. *Cleaned resident's finger with an alcohol swab, and then wiped it dry with a cotton ball. *Obtained blood needed for test from a finger stick, and then wiped the excess blood off with a cotton ball. *Cleaned the glucometer with a Super Sani-Cloth wipe for eight seconds and laid the glucometer on top of the treatment cart to air dry. c. Interview on 10/21/15 at 4:00 p.m. with the two DON revealed they agreed: *There should have been a barrier placed on top of the treatment cart where the cotton balls and the glucometer were placed. *The instructions on the Super Sani cloth wipes container stated the surface being cleaned needed to be kept wet with the solution for two minutes. Review of the provider's January 2012 Disinfection of Glucose (sugar) Testing Meters procedure revealed the glucometer should have been placed on a barrier. Review of undated manufacturer's instructions for the Super Sani cloth wipes stated to keep the surface being cleaned wet with the solution for two minutes then allowed to air dry. The DON was asked for the Assure Platinum glucometer instruction manual, but none was received before the end of the survey. | F 441 | | |
| F 514 SS=D | 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE | F 514 | F 514 NR/SDDOTHEL Correct to the individual: *A system change will correct the cited deficiency. *The documentation regarding resident 2 was utilized in the educational process. NR/SDDOTHEL | *12/01/15 NR/SDDOTHEL |

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| F 514 | <p>Continued From page 14</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 26180 Based on record review, interview, and policy review, the provider failed to ensure one of nine sampled residents (2) had accurate documentation of bowel movements and behaviors. Findings include:</p> <p>1a. Review of resident 2's October 2015 bowel record revealed she had not had a bowel movement (BM) from 10/13/15 through 10/20/15.</p> <p>Review of resident 2's October 2015 Medication Administration Record (MAR) revealed she received Bisacodyl 10 milligrams suppository (for constipation) every three days. She had received one on 10/16/15 and 10/20/15.</p> <p>Interview on 10/20/15 at 2:00 p.m. with licensed practical nurse (LPN) A regarding resident 2 revealed: *The certified nursing assistants (CNA) were supposed to let the nurse know when the resident</p> | F 514 | <p>Correct to all others: All nursing staff will be educated regarding documentation on all bowel movements and behaviors, and reporting as necessary to charge nurse on duty.</p> <p>System correction: Audits of resident 2 & 5 other randomly selected documentation will be done weekly times four weeks then monthly times 4 months by DNS or designee.</p> <p>Monitoring of System: The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The DNS or designee will be responsible for reporting all audits to the QAPI team for review.</p> <p>Correction Date: 12/1/15</p> <p>*the bowel movement and behavior documentation on</p> | |
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| NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073 |
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| F 514 | <p>Continued From page 15 had a BM. *Usually the resident had really good results with the suppository. *She could not say if the resident had a BM in the past six days based on the documentation. *The nurses did not usually follow-up on a scheduled medication for constipation. -It was up to the CNAs to let her know. *She agreed it would be concerning if that resident had not had a BM for six days.</p> <p>Further interview on 10/20/15 at 2:30 p.m. with LPN A regarding resident 2 revealed she had completed a bowel check on the resident. There was no reason to believe she had not had a bowel movement. She believed the CNAs had forgot to document on that resident.</p> <p>b. Review of resident 2's 7/30/15 physician's orders revealed she received Risperidone (a medication for the treatment of psychosis) 0.25 milligrams (mg) one tablet two times (BID) daily for agitation/delusional disorder. That order had originated on 11/21/12.</p> <p>Review of resident 2's 6/17/15 pharmacy consultation report revealed: *The pharmacist recommended "[resident name] receives Depakote (treatment of elevated mood state) 250 mg daily for agitation, lorazepam (antianxiety medication) 1 mg TID [three times a day] for anxiety, mirtazapine (antidepressant) 30 mg QHS [at bedtime] for Depression and Risperidone 0.25 mg BID for Delusional disorder. She is due for dose reduction attempts or documentation on these medications." *The physician responded "Pt [patient] continues to have significant episodes of anxiety/agitation despite above therapy. Reduction in medicine</p> | F 514 | | |
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| F 514 | <p>Continued From page 16 likely to worsen condition."</p> <p>Review of resident 2's June 2015 behavior documentation revealed: *They were monitoring her for being physically abusive, resisting care, socially inappropriate yelling and crying and behaviors that lasted more than one hour. -She infrequently exhibited any of those behaviors based on documentation. *They were not monitoring her delusions (unshakeable belief in something that is not true).</p> <p>Interview on 10/20/15 at 4:15 p.m. with the Minimum Data Set (MDS) assessment registered nurse and director of nursing regarding resident 2 revealed: *When the resident was crying out it was thought to be due to her delusions. *They confirmed they did not document delusions. *Many of the resident's behaviors were not documented, because she did them all the time. -The staff no longer saw them as behaviors. -They agreed they should have been documented because their current documentation had not reflected the ongoing need for the antipsychotic.</p> <p>Review of the provider's March 2011 Behavioral assessment and monitoring policy revealed: **Purpose: To recognize and assist in the management of any inappropriate behavior and give a tool to help measure any potential for harm mentally or physically to themselves or other residents. *To document frequency of occurrences and trends to determine if established interventions are effective."</p> | F 514 | | |
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| F 514 | Continued From page 17 Review of the provider's 9/4/10 medical records policies revealed they had not addressed records being accurate and complete. | F 514 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435094 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 10/21/2015 |
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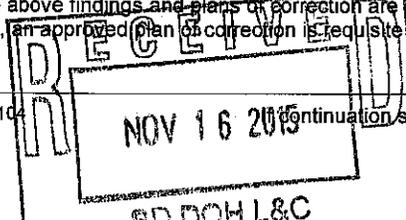
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| K 000 | <p>INITIAL COMMENTS</p> <p>Surveyor: 14180 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 10/21/15. Wakonda Heritage Manor Avera Health was found in compliance 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 | | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE <i>Administrator</i> | (X6) DATE <i>11-12-15</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 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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10701 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/21/2015 |
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NAME OF PROVIDER OR SUPPLIER
WAKONDA HERITAGE MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE
**515 OHIO STREET
WAKONDA, SD 57073**

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| S 000 | Compliance/Noncompliance Statement Surveyor: 33265 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, requirements for nursing facilities, was conducted from 10/20/15 through 10/21/15. Wakonda Heritage Manor was found not in compliance with the following requirement: S294. | S 000 | *Addendums noted with an asterisk per 11/25/15 per telephone with facility administrator. NR/SDDOH/EL | |
| S 294 | 44:73:07:09 Written Menus Any regular and therapeutic menu, including therapeutic diet menu extensions for all diets served in the facility, shall be written, prepared, and served as prescribed by each resident's physician, physician assistant, nurse practitioner, or qualified dietitian. Each planned menu shall be approved, signed, and dated by the dietitian for each facility. Any menu changes from month to month shall be reviewed by the dietitian and each menu shall be reviewed and approved by the dietitian at least annually if applicable. Each menu as served shall meet the nutritional needs of the residents in accordance with the physician's, physician assistant's, or nurse practitioner's orders and the Dietary Guidelines for Americans, 2010. A record of each menu as served shall be filed and retained for 30 days. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 32331 Based on interview, record review, and policy review, the provider failed to ensure the menu changes for all residents on oral diets were reviewed and approved from month-to-month by the consultant registered dietitian (RD). Findings include: | S 294 | Correct to the individual: *A System change will correct the cited deficiency. *The dietary manager (DM) was educated on 11/18/15 by registered dietitian NR/SDDOH/EL Correct to all others: (RD) regarding menu substitution process. NR/SDDOH/EL System correction: *The RD will complete report monthly with the addition of menu substitution sheets. [redacted] will continue to email if a change happens before [redacted] scheduled visit. The RD's audits will be completed on menus weekly for 4 weeks then monthly for 4 months by the Dietary Manger or designee. *These audits will be reviewed by the RD. NR/SDDOH/EL Monitoring of System: monthly. NR/SDDOH/EL The results of the audits will be reviewed at the monthly QAPI meetings with updates made as needed. The [redacted] or designee will be responsible for reporting all audits to the QAPI team for review. *12/10/15 NR/SDDOH/EL Correction Date: 12/1/15 | |

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

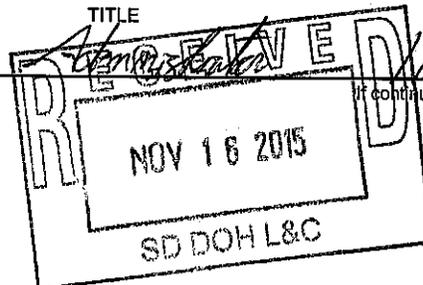
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If continuation sheet 1 of 2

South Dakota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10701 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 10/21/2015 |
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| NAME OF PROVIDER OR SUPPLIER WAKONDA HERITAGE MANOR | STREET ADDRESS, CITY, STATE, ZIP CODE 515 OHIO STREET WAKONDA, SD 57073 |
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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 294 | <p>Continued From page 1</p> <p>1. Interview on 10/21/15 at 2:45 p.m. with the certified dietary manager (CDM) revealed the following statements: *There had been changes on the menu for the residents. *The menu substitution record revealed three changes on the menu documented from 8/4/14 through 10/20/15. -She had no documentation those changes had been reviewed and approved by the RD. *Menu changes were to have been documented, reviewed, and approved by the RD. *The provider was not following their policy for menu substitutions.</p> <p>Review of the provider's 2013 Menu Substitutions policy revealed: *All changes to the menu would have been recorded on the Menu Extension Sheets and the Menu Substitution sheet. *Those changes would have included the date, menu items, substitution, and reason for the substitution recorded on the Menu Substitution Sheet. *Menu changes were to have been evaluated periodically by the RD or designee. *Records of menu substitutions were to have been retained (kept) for twelve months. -Those above records would have been reviewed periodically by the CDM and/or RD or designee to assess for any concerns that might have needed to have been addressed.</p> | S 294 | | |