

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

ORIGINAL

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS Surveyor: 32332 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/28/15 through 7/29/15. Weskota Manor was found not in compliance with the following requirements: F275, F281, F323, and F514.	F 000	<i>Addendums noted with an asterisk per 9/1/15 telephone to facility administrator. SJB/SACOH/JJ</i>	
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on record review and interview, the provider failed to ensure a Minimum Data Set (MDS) annual comprehensive assessment had been completed within twelve months for two of nine sampled residents (2 and 6). Findings include: 1. Review of resident 6's MDS assessments revealed her last annual assessment had been completed on 6/5/14. She had quarterly MDS assessments completed on the following dates: *9/4/14. *12/4/14. *2/16/15. *5/29/15. No annual assessment for 2015 was found within the resident's medical record.	F 275	F275 The Director of Resident Care and MDS Coordinator reviewed every resident's MDS history using the Interactive Health Network software. A MDS Flow Sheet was developed, listing each resident and when the resident's last Annual MDS Assessment was completed and what assessment is due next. For residents 2 and 6, the Director of Resident Care set up their Annual MDS Assessment ARD date of 8/14/2015 and those assessments will be completed and submitted by 8/27/15 by the MDS Coordinator. On August 17, 2015, the Director of Resident Care and MDS Coordinator reviewed and revised the MDS Completion Policy to include the process to ensure the proper MDS Assessment is completed. The Director of Resident Care educated the Interdisciplinary Team on the MDS Completion Policy on August 20, 2015. The MDS Coordinator will receive MDS education provided through the CMS website as needed. The director of Resident Care will use the MDS Flow Sheet when making the monthly MDS calendar. The MDS Coordinator will verify monthly, each MDS calendar with the Interactive Health Network software checking if a quarterly or annual MDS is due. The Director of Resident Care will review weekly to see that the correct MDS is completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jacob Bee</i>	TITLE <i>Administrator and CEO</i>	(X6) DATE <i>08/11/2015</i>
---	---------------------------------------	--------------------------------

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.

AUG 24 2015
SD DOR LSC

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 275	<p>Continued From page 1</p> <p>Surveyor: 32332 2. Review of resident 2's MDS assessments revealed her last annual assessment had been completed on 3/20/14. A significant change MDS had been completed on 6/12/14. She had quarterly MDS assessments completed on the following dates: *9/11/14. *12/11/14 *3/5/15. *6/4/15. No annual assessment for 2015 was found within the resident's medical record.</p> <p>Surveyor: 23059 3. Interview on 7/28/15 at 5:37 p.m. with the MDS coordinator revealed she relied on the Department of Social Services (DSS) to notify her of when an annual assessment needed to have been completed. Continued interview on 7/29/15 at 2:00 p.m. with her revealed she had been the coordinator since March. She stated the previous coordinator had provided her with very little training before she left her position. She stated she received a monthly report from DSS as to when assessments for residents were to have been completed. She stated she was not aware DSS did not indicate when an annual assessment needed to be completed. She followed the Resident Assessment Instrument manual for direction in completing the MDS.</p> <p>Interview on 7/28/15 at 5:37 p.m. with the MDS coordinator revealed she confirmed the provider did not have a policy regarding timely completion of comprehensive annual MDS assessments for residents.</p>	F 275	<p>F275 (continued) The Director of Resident Care will report the results of those reviews to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.</p> <p>DIRECT IN-SERVICE TRAINING: The Director of Resident Care provided education to the MDS Coordinator by reviewing the F275 Standard regarding the requirement of an annual assessment for residents and provided education regarding the new MDS Completion Policy on August 17, 2015 to assure that annual assessments are completed. The Director of Resident Care educated the Interdisciplinary Team on the revised MDS Completion Policy on August 20, 2015, including completing annual assessments at least every 12 months. In addition, the MDS Coordinator will review MDS education provided through the CMS website as needed. A record of those in attendance is included with this report.</p> <p style="text-align: right;">* [REDACTED] SG/SC/08/11/15</p>	9/17/2015	

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 F 281 SS=D	Continued From page 2 483.20(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: 22452 Based on observation, record review, and interview, the provider failed to administer to one of one sampled resident (7) a medication as ordered by the physician. Findings include: 1. Observation on 7/28/15 at 11:30 a.m. of resident 7's Advair inhaler (medication for asthma) in the medication cart revealed: *There was a documented open date on the inhaler of 7/1/15. *A new inhaler contained sixty inhalation doses of the Advair medication. *There were nineteen doses of medication left in the inhaler. Review of resident 7's July 2015 medication administration record (MAR) revealed the Advair inhaler: *Was ordered twice a day (BID). *Was documented as administered BID at 7:00 a.m. and bedtime. *Was documented as refused on 7/10/15 at 7:00 a.m. *Was not documented as administered on 7/19/15 at 7:00 a.m. and on 7/24/15 at 7:00 a.m. (The spaces where the staff should have initialed the inhaler as administered had been left blank). *Should have had eight doses of medication left in the inhaler instead of nineteen.	F 281 F 281	F281 On August 1, 2015 the Director of Resident Care completed a Medication Error report and routed it to the appropriate people for their review and signing. The Director of Resident Care met individually with all nurses on August 1, 2015 regarding the new process for documenting on inhalation residents MAR, the number of inhalations left. Once the inhaler dose is given, the charge nurse will write on the residents MAR, the number of inhalations left. Each dose will be reconciled as each dose is given. This process was started on August 1, 2015 when resident 7's new inhaler was opened. The Director of Resident Care will complete weekly reviews for one month and monthly thereafter, on all inhalers to ensure doses are being reconciled each time and that it is accurate. The Director of Resident Care will report the results of those reviews to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.	9/17/2015	

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 3</p> <p>Interview on 7/22/15 at 2:00 p.m. with licensed practical nurse A regarding resident 7 revealed: *She was unaware of the discrepancy of the amount of Advair inhaler inhalations that remained compared to the amount documented as administered. *The two doses on 7/19/15 and on 7/24/15 either were refused by the resident or had not been administered. The staff should not have left the spaces on the MAR blank for those dates. *The resident had difficulty with taking the inhaler some of the time. Her difficulty was with taking deep enough breaths when she inhaled or when they had her rinse her mouth with water and spit after she had been administered the inhaler. *She knew they had informed the resident's physician of her difficulty with the Advair inhaler. *The staff actually set-up the inhaler for the resident that included turning the device on the inhaler to load each separate dose. *The conflicting amount in the inhaler and what was documented on the MAR as administered was the staff's responsibility as the resident was unable to self-administer the inhaler without staff assistance.</p> <p>Interview on 7/23/15 at 3:00 p.m. with the director of nursing regarding resident 7 revealed: *She had been unaware of the discrepancy of the amount of Advair inhaler inhalations as to what had been documented as administered on the MAR. *It likely was medication omissions as the staff were responsible for setting up the Advair inhaler for the resident. *They did not have a policy for inhaler administration but followed the professional standards in Fundamentals and Advanced</p>	F 281			

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382	
(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	Continued From page 4 Nursing Skills book. Review of Gaylene Bouska Altman, Fundamental and Advanced Nursing Skills, 3rd Ed., 2010, pages 585 through 589, revealed: **"Determine the resident's ability to use the inhaler. Determine the client's [resident's] ability to hold and manipulate the equipment and the client's ability to coordinate the release of the medication with inhalation." **"Check the MAR against the health care provider's [physician's] orders." **"Document on the MAR the initials of then nurse who administered the medication."	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, testing, and interview, the provider failed to ensure the edges of greater than fifty percent (%) of residents' doors had been maintained in a safe manner. Findings include: 1. Random observations during the survey from 7/28/15 at 8:45 a.m. through 7/29/15 at 2:30 p.m. revealed greater than 50% of the residents' door	F 323 <i>by 9/17/15. All staff sels0004/15</i>	F323 Maintenance staff will wood-fill and sand all doors that have rough areas or gouges so they are smooth and hazard-free. <i>Free</i> was educated at the employee forum on August 12, 2015 for the need to make sure the doors are completely open when taking equipment and wheelchairs through the doors. They were also educated to report any maintenance needs at the time they see a door needing repair or any other repair needed using the Maintenance Requisition form. A memo regarding this will be distributed to all staff in the August 27th payroll. Information from the memo will be included in Line Up, a daily update for staff. The maintenance staff will complete monthly maintenance reviews monitoring that all doors are maintained in a safe manner. The Maintenance Supervisor will report compliance to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.	9/17/2015

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 323	Continued From page 5 edges had rough areas on the bottom one-quarter of the door. Those door edges were on the latching side of the door. They had gouged out pieces of the wood. Testing by running a hand along those rough areas revealed the wood could catch on residents' legs and ankles causing skin tears or lacerations. Several of those doors had actual splinters that could be removed. Interview and walk-through on 7/29/15 at 10:00 a.m. with the maintenance supervisor revealed he confirmed the above findings. He stated they had tried a method of repairing one door, but it had not been successful. He stated they were continuing to explore options as to what could be done to repair those doors. He confirmed the edges posed a safety risk for residents. Interview and walk-through on 7/29/15 at 2:20 p.m. with the administrator revealed she confirmed the above findings. On one door she removed an approximately three inch splinter of loose wood. She confirmed the condition of the doors posed a safety risk for residents.	F 323			
F 514 SS=E	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	F 514			

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 514	<p>Continued From page 6 preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 23059 Based on observation, record review, interview, and policy review, the provider failed to ensure an assessment had been completed on the safe use of wheelchair seat belts for three of three sampled residents (5, 7, and 8) currently using seat belts. Findings include:</p> <p>1. Observation on 7/28/15 at 8:55 a.m. of resident 5 revealed she was sitting in a wheelchair. She had a seat belt secured at her waist.</p> <p>Interview on 7/28/15 at 9:20 a.m. with certified nursing assistant (CNA) B revealed the resident was able to undo the seat belt on her own.</p> <p>Interview on 7/28/15 at 4:30 p.m. with resident 5 confirmed she was able to release the seat belt on her own. She stated sometimes she had difficulty getting it undone, and would need to call for assistance at those times.</p> <p>Review of resident 5's medical record revealed there was no assessment completed to confirm the safety of the use of the seat belt. There was no documentation to confirm the seat belt was not being used as a restraint.</p> <p>2. Observation on 7/29/15 at 11:25 a.m. of resident 7 revealed she was sitting in a wheelchair. She had a seat belt secured around her waist.</p>	F 514	<p>F514 On August 11, 2015 the Director of Resident Care completed pre-restraining assessments on residents 5,7, and 8. The Director of Resident Care informed each resident's doctor and family that the assessment was completed. The resident's care plans were updated. The Director of Resident Care reviewed and revised the Restraint Policy, defining the use of seat belts. On August 19, 2015, all LPN's and RN's were educated by the Director of Resident Care on their responsibility for obtaining the pre-restraining assessment prior to usage of seat belts for any resident and documenting requirements. Education was provided by the Director of Resident Care to the Interdisciplinary Team on August 20, 2015 on the requirement to complete the pre-restraining assessment and the documentation required. The Director of Resident Care will complete monthly reviews at the At-Risk Meetings and with any MDS Assessments. The Director of Resident Care will report the results of those reviews to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.</p> <p>DIRECT IN-SERVICE TRAINING: On August 19, 2015, all LPN's and RN's were educated by the Director of Resident Care on their responsibility for obtaining pre-restraining assessments prior to usage of seat belts and the documentation required. Education was provided by the Director</p>	9/17/2015	

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382
--	--

(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 514	<p>Continued From page 7</p> <p>Interview on 7/29/15 at 11:30 a.m. with an unidentified CNA revealed the resident was unable to undo the seat belt on her own. She stated the seat belt was in place whenever she was up in her wheelchair.</p> <p>Review of resident 7's medical record revealed there was no assessment completed to confirm the safety of the use of the seat belt. There was no documentation to confirm the seat belt was not being used as a restraint.</p> <p>Surveyor: 32332</p> <p>3. Review on 7/29/15 of resident 8's medical record revealed:</p> <p>*She was gone on an outing that day.</p> <p>*A 7/11/15 entry in the interdisciplinary notes from the MDS coordinator indicated:</p> <p>-She used an electric wheelchair with a seat belt.</p> <p>-She was unable to "undo" the seat belt herself but could call staff, and they would "undo" it for her.</p> <p>*Her 6/25/15 care plan revealed:</p> <p>-She had a diagnosis of right-sided paralysis (loss of the physical functioning of the right side of her body).</p> <p>-"w/c [wheelchair] seat belt - unable to release but alert et [and] knows to call staff."</p> <p>*There was no assessment completed to confirm the safety of the use of the seat belt.</p> <p>*There was no documentation to confirm the seat belt was not being used as a restraint.</p> <p>Interview on 7/29/15 at 1:25 p.m. with the MDS coordinator revealed:</p> <p>*Resident 8 was not able to remove the seat belt but could use the call light to get help from the staff.</p> <p>*She did not consider the seat belt a restraint.</p>	F 514	<p>(continued)</p> <p>of Resident Care to the Interdisciplinary Team on August 20, 2015 and the documentation required for pre-restraining assessments. A record of those in attendance is included with this report.</p> <p style="text-align: right;">* [REDACTED] SB/SOOH/JJ</p>	
-------	--	-------	---	--

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 514	<p>Continued From page 8</p> <p>*There was no assessment form used for deciding if the seat belt would be considered a restraint.</p> <p>*She did observe the resident to see if she was able to remove the belt and her ability to use the call light to call for staff assistance.</p> <p>Interview on 7/29/15 at 3:15 p.m. with the director of nursing revealed:</p> <p>*Resident 8:</p> <ul style="list-style-type: none"> -Was able to remove the seat belt, but was not able to apply the seat belt. -Had not used the seat belt when she was sitting in a recliner or when she was engaged in an activity. -There was no documentation in her chart to indicate the seat belt was or was not a restraint. -There was no documentation to indicate the seat belt was removed during the above times. -Seat belts had previously been assessed as restraints, but staff had stopped using the assessment form. <p>Surveyor: 23059</p> <p>4. Interview on 7/29/15 at 9:50 a.m. with the director of nursing revealed an assessment should have been completed on any resident using a seat belt to determine if it was safe to use. She confirmed no assessment had been completed. She also confirmed a seat belt could be considered a restraint if the appropriate assessment had not been completed.</p> <p>Interview on 7/29/15 at 12:45 p.m. with the Minimum Data Set assessment coordinator revealed she used the side rail assessment to document use of a seat belt. She confirmed that side rail assessment had no area to document the safe use of a seat belt for a resident.</p>	F 514			

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/29/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 514	Continued From page 9 Review of the provider's revised July 2014 Restraint Use policy revealed prior to using a restraint there must have been documentation in the medical record of the following: *The symptoms which led to consideration of restraint use with a pre-restraining assessment. *An individualized resident assessment reflecting interdisciplinary involvement and least restrictive restraint chosen. *The use of any restraining device would be reassessed quarterly. That policy did not specify use of seat belts as a potential restraint.	F 514			

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

ORIGINAL

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382	
(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	INITIAL COMMENTS Surveyor: 32334 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/28/15. Weskota Manor 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 7/29/15 upon correction of the deficiency identified below. Please mark an "F" in the completion date column for the deficiency identified as meeting the FSES to indicate the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 038 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to install a paved path of exit discharge to the public way at one exit. The north exit from the basement had a landing that ended greater than 200 feet from the nearest street. Findings include:	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jacob Blue* TITLE *Administrator & CEO* (X6) DATE *08/21/2015*

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.

AUG 24 2015

SD DOH L&C

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

PRINTED: 08/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 43A095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/28/2015
NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST STREET NE WESSINGTON SPRINGS, SD 57382		
(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 038	<p>Continued From page 1</p> <p>1. Observation at 10:00 a.m. on 07/28/15 revealed the north exit from the east basement was not paved to the public way. It had a concrete landing that ended greater than 200 feet from the nearest street. The terrain from the concrete landing to a public way would make the installation of a sidewalk difficult. Interview with the maintenance supervisor at the time of the observation indicated that basement area was used for storage and laundry. Only staff had access to that basement with a purported maximum of two staff members in the basement at a time.</p> <p>The building meets the FSES. Please mark an "F" in the completion date column to indicate correction of the deficiencies identified in K000.</p>	K 038		F

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST ST NE WESSINGTON SPRINGS, SD 57382
--	--

(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 Surveyor: 32334 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/28/15 through 7/29/15. Weskota Manor was found not in compliance with the following requirement: S165	S 000		
S 165	44:04:02:17 OCCUPANT PROTECTION Each licensed health care facility covered by this article must be constructed, arranged, equipped, maintained, and operated to avoid injury or danger to the occupants. The extent and complexity of occupant protection precautions is determined by the services offered and the physical needs of the... residents admitted to the facility. This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 32334 Based on observation and interview, the provider failed to ensure call cords were readily accessible at all times in one randomly observed location (tub room of north wing). Findings include: 1. Observation at 11:45 a.m. on 7/28/15 revealed a tub room in the north wing. Nurse call pull cords were provided near the tub and near the toilet in that room. Further observation revealed the pull cord at the toilet was broken, and the cord did not extend to the floor where it would be readily accessible for residents. The call cord should reach near the floor, so a resident would be able to grab the cord in a situation where they were laying on the floor.	S 165	S165 Maintenance staff fixed the nurse call pull cord in the north tub room on July 28, 2015. A memo regarding the need to submit work orders to maintenance using the Maintenance Requisition form will be distributed to all staff in the August 27th payroll. The maintenance staff will complete monthly maintenance reviews monitoring that all nurse call pull cords are readily accessible. The Maintenance Supervisor will report compliance to the Risk Management/QI Committee quarterly. The review will continue until the Risk Management/QI Committee advises to discontinue.	9/17/2015

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

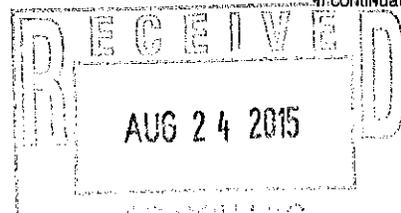
TITLE

(X6) DATE

Steve Blue

Administrator & CEO

08/21/2015



South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10707	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/29/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WESKOTA MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 608 1ST ST NE WESSINGTON SPRINGS, SD 57382
--	--

(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 165	Continued From page 1 Interview with the maintenance supervisor at the time of the above observation confirmed that condition. He indicated he was aware it was not in compliance. He was unsure why it had not been reported or seen in the last preventative maintenance check of that call cord.	S 165		