### Summary of Deficiencies

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Date of Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>E 000</td>
<td>Initial Comments</td>
<td>E 000</td>
<td>Surveyor: 35121 An initial survey for compliance with all applicable Federal, State, and local Emergency Preparedness requirements was conducted on 1/29/18 through 1/31/18. Wheatcrest Hills Healthcare Community was found in compliance with 42 CFR Part 483.73 requirements.</td>
<td>F 000</td>
<td>Initial Comments</td>
<td>F 000</td>
<td>Surveyor: 35121 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities was conducted from 1/29/18 through 1/31/18. Wheatcrest Hills Healthcare Community was found not in compliance with the following requirements: F604, F605, F606, F740, F804, and F812.</td>
<td>Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)</td>
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<tr>
<td>F 604</td>
<td>Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)</td>
<td>F 604</td>
<td>§483.10(e) Respect and Dignity. The resident has the right to be treated with respect and dignity, including:</td>
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<td>2. Residents found to use restrictive devices will be evaluated quarterly by the IDT to ensure the least restrictive device is used, the individual resident care plan addresses the use of the device, the resident's record indicates the date and time of initiation of the device and the reason for use and a physician's order is received for the use of the device. The Administrator, DON, and IDT will review by 2/25/18 the Physical restraint policy. The DON or designee will educate all staff on the policy and what constitutes a restraint or restrictive device by 3/1/18. Staff not in attendance due to illness, vacation, etc., will be educated prior to working their next scheduled shift.</td>
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<td>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</td>
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<td>3. The DON or designee will audit 4 random residents weekly #4, monthly #3 to ensure no restraint is present. Audits will be shared with the DON with the IDT during the monthly QAR meeting for recommendations on the need to continue or discontinue the audit.</td>
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<td>§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to</td>
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**LaVonne Furman**

Administrator

2/22/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be able to correct within 14 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the statement of deficiencies will be placed in the home's file, and a copy will be sent to the state of residence, within 14 days following the date these documents are made available to the facility. If deficiencies are cited, the approved plan of correction is required to continue program participation.
WHEATCREST HILLS HEALTHCARE COMMUNITY

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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 604</td>
<td>Continued From page 1</td>
<td>treat the resident's medical symptoms.</td>
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§483.12(a) The facility must-

§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

This REQUIREMENT is not met as evidenced by:

Surveyor: 35413

Based on observation, interview, record review, and policy review, the provider failed to recognize a recliner with the feet up as a restraint for one of one resident (7).

Findings include:

1. Random observations on 1/29/18 from 2:30 p.m. thru 7:30 p.m. and on 1/30/18 from 8:30 a.m. thru 6:00 p.m. of resident 7 revealed:
   * He was sitting in his recliner with his feet up except for meals.
   * When asked to put his feet down he looked for the remote but could not find it.
   * It was pinned on the back side of his recliner cut off his reach.

Interview on 1/29/18 at 11:00 a.m. with resident 7's wife revealed:
   * Staff would pin the remote to the back of the recliner.
   * That was done so he could not put his feet down and tip himself out of the chair.
F 604 Continued From page 2
Interview with certified nursing assistant (CNA) F on 1/30/18 at 2:33 p.m. revealed:
*It had been on the CNA's care plan to pin the remote to the chair, so he could not reach it.
*He could not find it on the CNA's care plan.
*He usually was in his recliner except for meal times.
*He would play with his remote and his chair would assist him to stand-up.
*He would not consider that a restraint, but he agreed it did restrict his movement.

Interview on 1/30/18 at 2:45 p.m. with the director of nursing regarding the above for resident 7 revealed:
*She said it had been on the CNA's care plan but she did not have enough room for it, so she took it off yesterday.
*She agreed staff were to pin the remote on the back of his recliner.
*He was usually in his recliner from after breakfast to lunch and after lunch to suppertime.
*She agreed the feet up would restrict his movement.

Review of resident 7's 11/8/17 care plan revealed:
"Remote to be pinned to back of recliner out of resident's reach as resident will play with the remote and dump self out of recliner."

Review of the provider's April 2016 Physical Restraint policy revealed:
*Facility would complete an assessment prior to the use of the device and quarterly thereafter.
*Consent to use the restraint must be obtained from the resident or family prior to using the restraint.
-No consent was found in his chart.
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<th>PROVIDER'S PLAN OF CORRECTION (each corrective action should be cross-referenced to the appropriate deficiency)</th>
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| F 604 | Continued From page 3  
*Physical device assessments (restraint assessments) were not provided, by the end of the survey, when requested from the facility.  
-Instead transfer assessments were provided from the facility by the nursing consultant. | | | | 1. Residents 20, 16, and 29 plan of care was updated on 2/1/18 by the MDS Coordinator. | |
| F 657 | Care Plan Timing and Revision  
CFR(s): 483.21(b)(2)(i)(ii)  
§483.21(b) Comprehensive Care Plans  
§483.21(b)(2) A comprehensive care plan must be-  
(i) Developed within 7 days after completion of the comprehensive assessment.  
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--  
(A) The attending physician.  
(B) A registered nurse with responsibility for the resident.  
(C) A nurse aide with responsibility for the resident.  
(D) A member of food and nutrition services staff.  
(E) To the extent practicable, the participation of the resident and the resident's representative(s).  
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.  
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.  
(ii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.  
This REQUIREMENT is not met as evidenced by:  
Surveyor: 26180 | | | 2. All residents are at risk to have missed updates/lack of development on their plan of care. All care plans will be reviewed for accuracy and updated by 3/1/18. The administrator, DON and IDT will review the Care Plan Policy by 2/26/18.  
All staff will be educated by the DON on the care plans and ensuring the care plan is accurate for the care and well-being of the resident by 3/1/18. All staff not in attendance of illness, vacation, etc will be educated prior to working their next scheduled shift.  
3. The DON or designees will audit 4 random care plans each week x 4, monthly x 2 to ensure plans of care are updated as changes occur and are accurate for the care the resident is receiving. Audits will be shared by the DON with the IDT during monthly quality assurance committee meeting for the recommendations on the need to continue or discontinue the audits. | 3/20/18 |
F 657  Continued From page 4
Based on observation, interview, record review, and policy review, the provider failed to ensure 3 of 13 sampled residents (16, 20 and 26) had an individualized care plan with revisions made as changes in care occurred. Findings include:

1. Review of resident 20's 1/1/18 Minimum Data Set revealed:
   * Her diagnosis included: depression, anxiety, traumatic brain injury, seizures, and hypertension.
   * She was alert and oriented but had difficulty with memory.
   * She exhibited the following indicators of depression: decreased concentration and energy.
   * She was on an antidepressant medication.
   * She received no psychological services.

Observation and interview on 1/30/18 at 10:45 a.m. of resident 20 revealed:
* She was alert and oriented to person, place, and time.
* Her recall of recent events was generally good.
* She had just gotten up, had eaten breakfast, and was waiting for the 11:00 a.m. smoke break.
* She ate breakfast in the dayroom adjoining the main dining room by herself.
  - She confirmed she always ate there and preferred that.
* She frequently did not eat what was offered on the menu, but she received what she requested as an alternate.
* She had lost weight and with tears in her eyes stated "If I keep losing weight, eventually I will die. Then I will be out of everyone's hair." She verified that was how she felt.
  - She added that no one in her family came to visit her.
  - She wanted to return to her home area where she would be closer to her family.

F 657
Continued From page 5

-The staff were aware she wanted to return to her hometown.
*She had significant pain in her legs and knee that interfered with her daily activities.
*Her smoking routine was a cigarette every two hours starting at 9:00 a.m.

Review of resident 20's 8/30/17 through 1/30/18 weight record revealed:
*8/31/17 she weighed 218 pounds (lb).
*1/29/18 he weighed 192 lb.
-That was a 26 lb weight loss in six months.

Review of resident 20's social service progress notes revealed:
*5/25/17: "She states she feels down up to 6 days in 2 weeks because she wants to back [as written] in [her hometown] by her family. She has trouble sleeping up to 6 days in the past 2 weeks because of pain in her knees. She is tired all the time. She says if she can't go back to [her hometown] to be my family and her 3 kids she would just as soon die but she wouldn't kill herself."
*11/20/17: "Resident states she has trouble sleeping and is tired daily. She can't concentrate on reading or watching TV right now. She does really concentrate on when it is time to smoke. She says if she can't get back to [home town] she wants to be dead but wouldn't hurt herself."
*1/3/18: "She says she doesn't sleep well due to her knee but it is better and up to 11 days in the past 2 weeks instead of every day. She is tired up to 11 days in the past 2 weeks also. She has trouble concentrating every day she stated.
- She wants to return to her hometown but refuses to quit smoking and I told her this may be a problem to be accepted but she didn't care."
*There was nothing documented regarding a
Continued From page 6
referral to a mental health counselor for the
indicators of depression.
*There was no indication of staff efforts to monitor
her well-being for other indicators of depression
or failure to thrive.

Review of resident 20’s 1/30/18 physician’s
orders revealed there was not an order for any
mental health services.

Interviews on 1/30/18 at 4:45 p.m. and on 1/31/18
at 2:00 p.m. with the social services coordinator
(SSC) regarding resident 20 revealed:
*She had a traumatic brain injury.
*She was obsessed with her smoking schedule
and got agitated at staff over it.
*She wanted to move to Sioux Falls. They had
not yet been successful in finding a facility to take
her because of her smoking.
*She spent her monthly allowance on cigarettes
and pop, and she frequently ran out of money.
*Her brother occasionally visited but not a lot. He
had taken her home for a couple of days but had
brought her back earlier than planned. She was
not sure why.
*She had knee surgery 11/3/17, but she did not
cooperate with the plan for therapy. She needed
to have the other knee done, but the physician
was reluctant to do it because of her lack of
cooperation and follow-through with therapy.
*She was no longer receiving physical therapy
because she had reached a plateau in progress.
*Attempts to contact the family by the SSC had
been unsuccessful.
*They did not return calls.
*To her knowledge they had not visited her when
she had her knee surgery.
*She refused to eat in the main dining room, but
they did not know why.
### Continued From page 7

- That was why she ate alone in the activity room adjoining the dining room.
- Sometimes there was another resident who ate with her.
  * She had not cooperated with the therapy plan after her knee surgery.
  * She was unaware the resident would suggest she purposely was not eating, so she would lose weight and then die.
  - She knew the resident was depressed or was showing symptoms of depression.
  * In the past she had offered the resident to see a counselor, but the resident had refused.
  - She had no documentation of that recommendation.

Interview on 1/31/18 at 11:00 a.m. with the dietary manager regarding resident 20 revealed:
* She was aware she had lost weight.
  * When her consulting dietitian was here they had discussed her weight loss.
  * They basically gave her whatever she wanted to eat, because she had lost weight and was usually refusing the items on the menu.
  * She was unaware the resident had voiced her decrease in food intake was to lose weight, and then if she died would have been out of everyone's hair.
  - They had never discussed the possibility of her decreased food intake being related to depression but agreed that depression could impact her appetite.
  * She used to eat a lot of eggs, but she did not do that anymore; now she liked cottage cheese and chips.

Interview on 1/31/18 at 10:55 a.m. with certified nursing assistant (CNA) A regarding resident 20 revealed:
F 657 Continued From page 8

*She slept a lot and usually slept late in the morning.
*She could have a cigarette every two hours starting at 9:00 a.m. but usually she slept right through that first cigarette.
*They could coax her to get out of bed before the 11:00 a.m. cigarette time but had to do so slowly.
*If she was rushed she might get upset and call them names, or shake her fist at you. Thought she did not hit.
*She was incontinent 95% of the time during the night and was resistant to get up so staff could clean her up.

Review of resident 20's 12/6/17 care plan revealed:
*Focus areas included:
*I have depression and anxiety.
*It acknowledged her brother was responsible for obtaining things such as cigarettes and pop for her, but he did not come to see her.
*She was independent in her toileting but had some incontinence at times, however she was able to change herself.
*She was independent in eating.
*Her desire to move to her hometown.
*Her care plan did not address:
*What made her anxious and what staff did to alleviate that for her.
*There were no interventions other than the medications to address the depression.
*It did not address her speaking of wishing she could die.
*Her weight loss and what staff were doing to ensure no further weight loss.
*What they were doing to assist her in finding someone she could rely on to buy her cigarettes and pop in the absence of her brother.
*How they were helping her accept her long term
F 657

Continued From page 9
placement in the facility if she could not get to her hometown. It did not state if there was an alternate plan regarding that move if it did not happen.
-How they assisted her in budgeting her money so she had enough to get through the month.
-When therapies were discontinued.
-Her frequent incontinence during the night and what was done to reduce the incontinence.

Surveyor: 35121
2. Review of resident 16's medical record revealed he:
*Was admitted on 11/22/17.
*Had diagnoses of: dementia with behavior disturbance, anxiety, adjustment disorder with depression, and Parkinson's.

Observation on 1/31/18 at 10:06 a.m. of resident 16 revealed:
*He was visibly agitated in the hallway in his wheelchair.
-Shook his hands at staff.
-Bit and sucked on his lower lip.
-His lower lip quivered.
-Abruptly looked behind him like someone was walking up behind him, but no one was there.
-Spoke of "all the snakes" and other random things.

Observation on 1/31/18 at 10:06 a.m. of registered nurse (RN) B's interaction with resident 16 revealed:
*She had pushed him in his wheelchair up to the nurse's station.
*She had attempted to redirect and calm him as follows:
-Held his hand.
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| F 657 | Continued From page 10 | - Started conversation about his past car racing.  
- Showed him pictures of his race cars.  
- Encouraged him to sit in his wheelchair after he stood up.  
- Offered to call his wife.  
* Those interventions resulted in him having had short, intermittent periods of lessened shaking and some participation in touch-and-go conversation.  
Observation on 1/31/18 at 11:35 a.m. of resident 16 and RN B revealed:  
"He was at the nurse's station with RN B.  
"He was seated in a wheeled office chair beside her with his wheelchair near by.  
"RN B had continued conversation with him and placed a call to his wife to request she visit him.  
Observation on 1/31/18 at 12:22 p.m. of resident 16 revealed he was in his wheelchair in his room.  
His wife was present and speaking to him. He appeared less agitated.  
Review of resident 19's 12/13/17 care plan revealed:  
* Focus areas:  
"I have dementia with psychosis, depression, anxiety, dementia d/t [due to] Parkinsons. I have behaviors and can be very combative with others. I have inappropriate sexual behaviors."  
* Psycho-Social: I have long and short term memory problems due to dementia and parkinsons."  
* Goals:  
"I would like to be as calm and comfortable as possible on a daily basis to next day."  
"I would like to maintain my cognitive abilities."  
* Interventions:  
"Reassure as needed." | F 657 |
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
<thead>
<tr>
<th>X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
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<tbody>
<tr>
<td>435105</td>
<td>A. BUILDING --------------</td>
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<td>B. WIND ------------------</td>
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<tr>
<th>X3) DATE SURVEY COMPLETED:</th>
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<td>01/31/2018</td>
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NAME OF PROVIDER OR SUPPLIER

WHEATCREST HILLS HEALTHCARE COMMUNITY

STREET ADDRESS, CITY, STATE, ZIP CODE

1311 VANDER HORCK POST OFFICE BOX 939
BRITTON, SD 57430

<table>
<thead>
<tr>
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<td>-&quot;Redirect him when he has inappropriate sexual comments or behaviors.&quot;</td>
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<td>-&quot;Please listen to me if I want to talk to staff about my past.&quot;</td>
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Interview on 1/31/18 at 2:00 p.m. with the director of nursing (DON) regarding resident 18's care plan revealed she agreed it was not updated to reflect his individualized needs.

Surveyor: 36699
3. Review of resident 26's medical records revealed:
   *An admission date of 10/26/16.
   *Diagnoses of polymyalgia rheumatica, chronic atrial fibrillation, long term use of systemic steroids, hypo-osmolality, and hyponatremia.
   *She received high risk medications of Xarelto, lasix, and clonazepam.
   *The 1/22/18 quarterly Minimum Data Set (MDS) assessment indicated she received seven days of an anticoagulant and anti-diuretic.

Review of resident 26's 10/26/17 physician's orders revealed she received "Xarelto tablet 15 mg [Rivaroxaban] Give 15 mg by mouth once a day related to chronic atrial fibrillation."

Review of resident 26's 10/29/17 physician's orders revealed she received "Lasix tablet 40 mg [Furosemide] give 1 tablet by mouth one time a day for edema."

Review of resident 26's 11/2/17 care plan revealed there was no focus, goal, or interventions for:
   *Chronic atrial fibrillation with long-term anticoagulation therapy.
**Wheatcrest Hills Healthcare Community**

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| F 657         | Continued From page 12  
*Potential side effects of bruising and bleeding.  
*Edema with diuretic therapy.  
*Potential side effects of dehydration and electrolyte imbalance.  

Observation and interview on 1/30/18 at 10:07 a.m. with resident 26 revealed:  
*She had a few old bruised sites on her bilateral upper arms.  
*She was picking on an old bruised/scabbed area on left arm.  
*She stated:  
-"I sometimes bump my arms on the dresser, wheelchair, or bed rails."  
-"I have a habit of picking."  

Interview on 1/31/18 at 9:30 a.m. with certified nursing assistant (CNA) C regarding resident 26’s care revealed:  
*She was independent with dressing.  
*Staff would assist her with putting on her bra and ted hose.  
*She would document bruising under the CNA task of skin observation and would report any bruising to the charge nurse.  
*CNA C had documented bruising.  

Interview on 1/31/18 at 9:55 a.m. with MDS coordinator regarding resident 26’s care plan revealed:  
*There was no documentation for:  
-Chronic atrial fibrillation with long-term anticoagulation therapy.  
-Potential side effects of bruising and bleeding.  
-Edema with diuretic therapy.  
-Potential side effects of dehydration and electrolyte imbalance.  
*She stated, "I try to care plan all the active diagnoses. I must of missed them."
Interview on 1/31/18 at 1:50 p.m. with the DON regarding resident 26's care plan revealed her expectations would have been:
*For the care plan to reflect her current health status.
*To have been revised and updated in a timely manner.
*It was the responsibility of all nurses to initiate and review care plans.

Review of the provider's November 2017 Care Planning policy included:
"4. Each resident is an individual. The personal history, habits, likes and dislikes, life patterns and routines, and personality facets must be addressed in addition to medical/diagnosis based care considerations."

"5. Interventions act as the means to meet the individual's needs (not to continue outdated institutional practices). The "recipe" for care requires active problem solving and creative thinking to attain, and clearly delineates who, what, where, when, and how the individual resident goals are being addressed and met."

"11. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur."

§483.21(c)(2) Discharge Summary
When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:
(i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab,
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<td>F 661</td>
<td>Continued From page 14 radiology, and consultation results. (i) A final summary of the resident’s status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident’s representative. (ii) Reconciliation of pre-discharge medications with the resident’s post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident’s consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident’s follow up care and any post-discharge medical and non-medical services. 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 two discharged residents (43) had a discharge summary completed at the time of discharge. Findings include: 1. Review of resident 43’s closed medical record revealed he had been discharged on 11/13/17. There was no discharge summary or recapitulation of the resident’s stay in the record. Interview on 1/31/18 at 2:45 p.m. with the director of nursing revealed the discharge summary would have been completed by the social services coordinator (SSC).</td>
<td>F 661</td>
<td>1. An audit will be conducted by the DON by 3/1/18 to identify other residents that have been discharged to ensure that a discharge summary had been completed. Unable to correct #43 due to resident no longer being in facility. 2. The Administrator, DON and IDT will review the Discharge Policy by 2/26/18. Nurses and the IDT team will be educated on the discharge policy by 3/1/18 by the DON. Staff not in attendance due to illness, vacation, etc will be educated prior to working their next scheduled shift. 3. The DON or designee will audit all discharges since 2/1/18 to ensure the discharge summary was completed. Audits will continue weekly x4, monthly x2. Audits will be shared by the DON with the IDT team during the monthly quality assurance committee meeting for recommendations on the need to continue or discontinue the audits.</td>
<td>3/20/18</td>
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F 661 Continued From page 15

Interview on 1/31/18 at 3:00 p.m. with the SSC regarding resident 43 revealed:
*It would have been their practice to write a discharge summary.
*She was unable to find a discharge summary for that resident.
-It must not have been done.

Review of the provider's March 2013 Discharging the Resident policy revealed "Complete the Discharge Summary/Recapitulation of Stay."

F 740

§483.40 Behavioral Health Services

Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by:

Surveyor: 26180
Based on observation, record review, interview, and policy review, the provider failed to ensure one of three sampled residents (20) with indicators for depression received appropriate care and services. Findings include:

1. Review of resident 20's 1/1/18 Minimum Data Set revealed:
*Her diagnoses included: depression, anxiety,
Continued From page 16

traumatic brain injury, seizures, and hypertension.
*She was alert and oriented but had difficulty with memory.
*She exhibited the following indicators of depression: decreased concentration and energy.
*She was on an antidepressant medication.
*She received no psychological services.

Observation and interview on 1/30/18 at 10:45 a.m. of resident 20 revealed:
*She was alert and oriented to person, place, and time.
*Her recall of recent events was generally good.
*She had just gotten up, had eaten breakfast, and was waiting for the 11:00 a.m. smoke break.
*She ate breakfast in the dayroom adjoining the main dining room by herself.
-She confirmed she always ate there and preferred that.
*She frequently did not eat what she was offered on the menu, but she received what she requested as an alternate.
*She had lost weight and with tears in her eyes stated "If I keep losing weight, eventually I will die. Then I will be out of everyone's hair." She verified that was how she felt.
-She added that no one in her family came to visit her.
--She wanted to return to her home area where she would be closer to her family.

Review of resident 20's 8/30/17 through 1/30/18 weight record revealed:
*8/31/17 she weighed 218 pounds (lb).
*1/29/18 he weighed 192 lb.
-That was a 26 lb weight loss in six months.

Review of resident 20's social service progress notes revealed:
Continued From page 17

*5/25/17: "She states she feels down up to 5 days in 2 weeks because she wants to back [as written] in [her hometown] by her family. She has trouble sleeping up to 6 days in the past 2 weeks because of pain in her knees. She is tired all the time. She says if she can't go back to [hometown] to be my family and her 3 kids she would just as soon die but she wouldn't kill herself."

*11/20/17: "Resident states she has trouble sleeping and is tired daily. She can't concentrate on reading or watching TV right now. She does really concentrate on when it is time to smoke. She says if she can't get back to [hometown] she wants to be dead but wouldn't hurt herself."

*1/3/18: "She says she doesn't sleep well due to her knee but it is better and up to 11 days in the past 2 weeks instead of every day. She is tired up to 11 days in the past 2 weeks also. She has trouble concentrating every day she stated. -She wants to return to [hometown] but refuses to quit smoking and I told her this may be a problem to be accepted but she didn't care."

*There was nothing documented regarding a referral to a mental health counselor for the indicators of depression.

*There was no indication of staff efforts to monitor her well-being for other indicators of depression or failure to thrive.

Review of resident 20's 1/30/18 physician's orders revealed there was not an order for any mental health services.

Interviews on 1/30/18 at 4:45 p.m. and on 1/31/18 at 2:00 p.m. with the social services coordinator (SSC) regarding resident 20 revealed:

*She had a traumatic brain injury.

*She was obsessed with her smoking schedule and got agitated at staff over it.
**WHEATCREST HILLS HEALTHCARE COMMUNITY**

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<th>F 740 Continued From page 18</th>
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<tr>
<td><em>She wanted to move to her hometown. They had not yet been successful in finding a facility to take her because of her smoking.</em></td>
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<td><em>She spent her monthly allowance on cigarettes and pop, and she frequently ran out of money.</em></td>
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<td><em>Her brother occasionally visited but not a lot. He had taken her home for a couple of days but had brought her back earlier than planned. She was not sure why.</em></td>
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<td><em>She had knee surgery 11/3/17, but she did not cooperate with the plan for therapy. She needed to have the other knee done, but the physician was reluctant to do it because of her lack of cooperation and follow-through with therapy.</em></td>
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<td><em>Attempts by the SSC to contact the family had been unsuccessful.</em></td>
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<td>-They did not return calls.</td>
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<td>-To her knowledge they had not visited her when she had her knee surgery.</td>
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<td><em>She refused to eat in the main dining room, but they did not know why.</em></td>
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<td>-That was why she ate alone in the activity room adjoining the dining room.</td>
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<td>-Sometimes there was another resident who ate with her.</td>
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<td><em>She had not cooperated with the therapy plan after her knee surgery.</em></td>
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<td><em>She was unaware the resident would suggest she purposely was not eating, so she would lose weight and then die.</em></td>
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<td><em>She knew the resident was depressed or was showing symptoms of depression.</em></td>
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<td><em>In the past she had offered the resident to see a counselor, but the resident had refused.</em></td>
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<td><em>She had no documentation of that recommendation.</em></td>
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Interview on 1/31/18 at 11:00 a.m. with the dietary manager regarding resident 20 revealed:
**Wheatcrest Hills Healthcare Community**

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**Statement of Deficiencies and Plan of Correction**

**(X1) Provider/Supplier/CIA Identification Number:**

**(X2) Multiple Construction**

A. Building

B. Wing

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**Continued From page 19**

- She was aware she had lost weight.
- When her consulting dietitian was here they had discussed her weight loss.
- They basically gave her whatever she wanted to eat because she had lost weight and was usually refusing the items on the menu.
- She was unaware the resident had voiced her decrease in food intake was to lose weight, and then if she died would have been cut of everyone's hair.
- They had never discussed the possibility of her decreased food intake being related to depression but agreed that depression could impact her appetite.

Interview on 1/31/18 at 10:55 a.m. with certified nursing assistant (CNA) regarding resident 20 revealed:

- She slept a lot and usually slept late in the morning.
- She could have a cigarette every two hours starting at 9:00 a.m. but usually she slept right through that first cigarette.
- They could coax her to get out of bed before the 11:00 a.m. cigarette time but had to do so slowly.
- She was usually incontinent during the night, and was resistant to get up then so staff could clean her up.
- She could get agitated but that is why she would not rush her to get up.

Review of resident 20's 12/6/17 care plan revealed:

- Focus: I have depression and anxiety.
- Interventions: Medications as directed.
- There were no interventions other than the medications to address the depression.
- It did not address her speaking of wishing she could die.
Review of the provider's October 2017 Behavioral Health Management policy revealed "The IT [interdisciplinary team] which includes the Physician will assure the resident receives the necessary behavioral health needs by utilizing internal staff, internal or external groups, counseling either internally or externally and psychologist or psychiatrist visits if indicated."

Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)

§483.60(d) Food and drink
- Each resident receives and the facility provides-
- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;
- §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.

This REQUIREMENT is not met as evidenced by:
- Surveyor: 38413
- Based on observation, interview, and policy review, the provider failed to ensure food was served at acceptable temperatures throughout two of two observed meal services and menu's provided a variety of food choices.

Findings include:
1. Observation on 1/29/18 at 4:45 p.m. revealed:
   - Cook D took the temperature of the fish she had just taken out of the oven.
   - The fish tested at 205 degrees Fahrenheit (F).

   Observation on 1/29/18 at 5:23 p.m. revealed:
   - Cook D went to take the temperature of the fish

   Cook D and E were educated on Food Temp procedure by the Dietary Manager on 1/31/18.

   1. The Administrator, DON and Dietary Manager reviewed the policy on kitchen sanitation, food temperatures and use of thermometers, food storage as well as the cited deficiency on 2/22/18.

   2. A formal in-service will be completed by the Dietary Manager on 2/20/18 with all dietary department staff and/or all staff responsible for preparing and serving of meals to the residents. The in-services will include the importance of preparing and serving meal items at proper temperature to the residents. Staff not in attendance due to illness, vacation, etc. will be educated prior to working next scheduled shift.

   3. The dietary manager or designee will monitor to make sure food temp logs are maintained and food is tempered per policy. Audits will be done by the dietary manager or designee weekly x 4 monthly x2.

   A meeting was held with resident council, Healthcare Services Director, Manager and the Dietary Manager on 2/20/18 to discuss menu options. New menus are being tried, along with the old menus. A new set of menus will be in place by April 1, 2018. This was in agreement with resident council.

   Audits will be discussed by the dietary manager at monthly CAPI meeting for review and recommendations for continuation or discontinuation.
<table>
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<tr>
<th>ID</th>
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<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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<td>804</td>
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<td>Continued From page 21 again when the dietary manager stopped him.</td>
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<td>*He received a briefing from the dietary manager on how to temp foods.</td>
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<td>Observation and interview with Cook D on 1/29/18 from 4:45 p.m. to 6:00 p.m. revealed:</td>
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<td>*When dishing up room trays fish was tempered at 146 degrees F.</td>
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<td>*While serving fish in the tray line it was tempered at 129 degrees F.</td>
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<td>*Cook D could not remember what temperature the fish should be at.</td>
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<td>*Cook D was requested to temp the fish again while serving it and it was 67 degrees F.</td>
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<td>*A resident returned her fish twice and was given a new piece of fish from the steam table.</td>
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<td>-The second time he microwaved her fish, and upon request to temp it, it was 95 degrees F.</td>
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<td>-Cook D stated &quot;The plate is hot, this resident was &quot;picky.&quot;</td>
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<td>-He continued to serve the fish.</td>
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<td>2. Observation and interview of Cook E on 1/30/18 during the supper hour from 4:30 p.m. to 6:00 p.m. revealed:</td>
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<td>*He tempered the turkey patties at 204 degrees F when they came out of the oven.</td>
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<td>*Ham and cheese sandwiches out of the refrigerator were tempered at 55 degrees F.</td>
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<td>-He said he had made them two to three hours ago.</td>
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<td>*When asked what the temperatures would be he stated he did not know, and he would imagine the temps were fine.</td>
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<td>*When asked to temp the turkey burger during serving tray line, it was tempered at 98 degree F.</td>
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<td>*He stated there was not much he could do if the steam table did not keep it hot, and continued to serve from the steam table.</td>
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<td>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSO IDENTIFYING INFORMATION)</td>
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| F 804 | Continued From page 22 | - He denied adding water to the steam table.  
- "It's usually good."  
- All control dials were on high.  
- There was very little steam coming from the steam table.  
  Interview with the dietary manager on 1/30/18 at 10:10 a.m. revealed:  
  * Foods were repeated too many times on the menu.  
  * She got complaints from the residents.  
  * She pointed out there was chicken or turkey served three days in a row.  
  * She then stated turkey or chicken was all the same to the residents.  
  Review of the provider's May 2014 Food Preparation policy revealed the cook ensures that all foods were to have been held at appropriate temperatures, greater that 135 degrees F for hot holding and less than 41 degrees F for cold holding foods.  
  Surveyor: 26180  
  2. Interview on 1/30/18 at 4:00 p.m. with six residents from the resident council revealed:  
  * Food was often times not warm enough  
  * Twice they had fish that was not warm when it was served to them.  
  * They had a lot of repeats on the menu.  
  * They had tater tots a lot, and there were other foods that were served all the time.  
  * They had voiced their concerns about food in the past at their Resident Council meetings.  
  * They did not feel anything had been done about their concerns.  
  F 812 | Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(l)(1)(2) | F 812 |
F 812 Continued From page 23

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Surveyor: 36413
Based on observation and interview the provider failed to ensure food was stored, prepared, and served in a sanitary manner.

1. Observation on 1/29/18 at 2:50 p.m. in the kitchen revealed:
*They had stored flour in a metal tub on wheels.
*The top appeared to have rust on it and it was rough.

Interview on 1/31/18 at 9:00 a.m. with the dietary manager revealed:
*Cleaning of this flour tub was not on the schedule.
*She did not know when it had been cleaned.
*She adds flour to it about every two months.

1. A non-metallic container for the purpose of storing flour will be ordered for use in the kitchen by 2/23/18. Once the container is received the flour will be placed in it for use as needed.

2. The task of cleaning the flour bin will be added to the monthly dietary cleaning schedule. Additional cleaning of the container will occur by the cook on an as needed basis.

3. The dietary manager or designee will monitor to make sure bin is cleaned per schedule and as needed. Audits to include visual inspection of the container and reviewing the cleaning checklist will be performed weekly x4, monthly x2. Audits will be reviewed at the monthly QAPI meeting to recommend for continuation or discontinuation of the audit.
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<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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| F 812 | Continued From page 24 2. Observation and interview of cook E on 1/30/18 during supper hour form 4:30 p.m. thru 6:00 p.m. revealed: *He drank coffee at his food preparation table in the kitchen where he was preparing mashed potatoes.  
*He has his beard covered with a surgical mask and touched it or his face seven times during the observation without washing his hands.  
-He stated he usually did not cover his beard, but thought he should if surveyors were there. | F 812 | Cook E was educated by the Dietary Manager on personal protective equipment on 1/31/18.  
A formal inservice will be completed by the Dietary Manager on Tuesday 2/20/18 with all dietary department staff and/or all staff responsible for preparing and serving meals to the residents. The inservice will include the importance of using proper protective equipment when preparing and serving meal items to the residents. Staff not in attendance due to illness, vacation, etc. will be educated prior to working next scheduled shift.  
The dietary manager or designee will be responsible for ongoing monitoring of the procedure. Monthly audits will be completed by the dietary manager or designee weekly x4, monthly x2 and reported in the GAP meeting for review and recommendation for continuation or discontinuation of audit. |
WHEATCREST HILLS HEALTHCARE COMMUNITY

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<td>E 000</td>
<td>Initial Comments</td>
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<tr>
<td>Surveyor: 14180</td>
<td>A recertification survey for compliance with all applicable Federal, State, and local Emergency Preparedness requirements was conducted on 1/30/18. Wheatcrest Hills Healthcare Community (long-term care facility) was found in compliance with 42 CFR Part 483.73 requirements for emergency preparedness.</td>
<td>K 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
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<tr>
<td>Surveyor: 14180</td>
<td>A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 01/30/18. Wheatcrest Hills Healthcare Community was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</td>
<td>K 000</td>
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<td>The building will meet the requirements of the 2012 LSC for Existing Health Care Occupancies in conjunction with the provider's commitment to continued compliance with the fire safety standards.</td>
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| S 000           | Compliance/Noncompliance Statement
Surveyor: 35121
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/29/18 through 1/31/18. Wheatcrest Hills Healthcare Community was found in compliance. |
| S 000           | Compliance/Noncompliance Statement
Surveyor: 35121
A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 1/29/18 through 1/31/18. Wheatcrest Hills Healthcare Community was found in compliance. |