**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>435105</td>
<td></td>
<td>05/01/2019</td>
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</tbody>
</table>

**NAME OF PROVIDER OR SUPPLIER**

WHEATCREST HILLS HEALTHCARE CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1211 VANDER HOREK ST
BRITTON, SD 57430

**WHEATCREST HILLS HEALTHCARE CENTER**

**SUMMARY STATEMENT OF DEFICIENCIES**

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
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</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
</tr>
<tr>
<td></td>
<td>Surveyor: 16386</td>
</tr>
<tr>
<td></td>
<td>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/29/19 through 5/1/19. Wheatcrest Hills Healthcare Center was found not in compliance with the following requirements: F554, F657, F685, and F880.</td>
</tr>
</tbody>
</table>

**F 554**

Resident Self-Admin Meds-Clinically Approp
SS=E

CFR(s): 483.10(c)(7)

§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by:

Surveyor: 39190

Based on observation, interview, record review, and policy review, the provider failed to:

* Obtain a physician's order for self-administration of medication for two of two sampled residents (17 and 30).
* Complete a medication self-administration assessment for three of three sampled residents (2, 17, and 30).

Findings include:

1. Review of resident 17's 5/1/19 physician's order summary revealed she had orders for the following:
   * Albuterol sulfate nebulization solution 0.083%, one vial inhale orally by nebulizer twice a day.
   * May not self-administer medications; exceptions will be noted.
   - There had been no exceptions noted.

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

Lavonna Gunman

**TITLE**

Executive Director

**DATE**

6/20/2019

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 patient. The findings stated above are all discloseable 90 days following the date of survey whether or not a plan of correction is provided. The findings and plans of correction are discloseable 14 days following the date these documents are made available for the facility. If deficiencies are cited they are required to be corrected and the plan of correction is required to be followed to continued program participation.

FORM CMS-2557(02-66) Previous Versions Obsolete

Event ID: 100757

Family ID: 0109

If continuation sheet Page 1 of 24

SD DOH-OLC
F 554  Continued From page 1

Observation on 5/1/19 at 9:11 a.m. of resident 17's administration of her nebulized medication revealed:

*Licensed practical nurse (LPN) A assembled the nebulizer kit and squirted the vial of medication into the kit.

*She placed the mask on resident 17's face, started the machine, and told her she would be back in ten minutes.

*At 9:33 a.m. we returned to resident 17's room, LPN A shut off the nebulizer machine, and removed the mask from the resident's face.

2. Review of resident 30's 5/1/19 physician's order summary revealed she had an order for the following:

*May not self-administer medications; exceptions will be noted.

-There had been no exceptions noted.

Observation on 5/1/19 at 9:28 a.m. of resident 30's room while watching the administration of her inhaled meter dose medication revealed she had a nebulizer machine in her room.

3. Observation and interview on 5/01/19 at 9:56 a.m. with LPN A regarding self-administration of the nebulizer medication for resident 17 revealed:

*The registered nurse or charge nurse had been responsible for completing the self-administration assessments for residents.

*There had been only one resident in the building that she knew of who could not be left alone during a nebulizer treatment.

-Resident 17 nor resident 30 was that resident.

-She verified in her physician's orders resident 17 did not have an order to self-administer nebulizer medication after set-up.
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<tr>
<td>F 554</td>
<td></td>
<td>Continued From page 2 Requested self-administration assessment's and physician's orders for residents 17 and 30 was made from the director of nursing (DON) on 5/1/19 at 9:45 a.m. Interview on 5/1/19 at 12:03 p.m. with the DON regarding the request for the above information revealed: *Resident 17 had not had an order to self-administer medication, and there had been no assessment completed. *The order and assessment had just been completed for resident 30 on 5/1/19. -No copy had been given to the surveyor. Surveyor: 32332 4. Review of resident 2's electronic and paper medical records revealed a 12/6/18 physician's order for nicotine gum. The resident could keep the gum in her room and self-administer it. Review of resident 2's revised 12/7/18 care plan revealed: *She could self-administer nicotine gum and keep it in her room. *Nursing staff would complete quarterly assessments to determine if she remained capable of self-administering the medication. Review of the assessments section of the medical record revealed: *A Self-Medication Assessment had been completed for the use of nicotine gum. *No medication self-administration assessments were located in the medical record. Interview on 5/1/19 at 1:45 p.m. with the Minimum Data Set (MDS) coordinator regarding resident</td>
<td>F 554</td>
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER: 435105

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
05/01/2019

NAME OF PROVIDER OR SUPPLIER
WHEATCREST HILLS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1311 VANDER HORCK ST
BRITTON, SD 57430

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| F 554             | Continued From page 3 2’s medication self-administration assessment confirmed:  
* It was her responsibility to assess the residents for their ability to self-administer medications.  
* She stated she thought she had completed quarterly assessments for resident 2.  
* She was unable to locate a completed self-administration assessment for her after 5/24/18.  
* She should have been assessed at least quarterly.  
Interview on 5/1/19 at 2:10 p.m. with the DON confirmed resident 2 had not been assessed quarterly for her ability to self-administer the medicated gum.  
5. Review of the provider’s April 2018 Self Administration of Medications policy revealed:  
* If the resident had expressed a desire to self-administer medications the interdisciplinary team would complete and assess the resident's cognitive, physical, and visual ability to carry out that responsibility.  
* The nurse would contact the physician for an order for self-administration of the medication.  
* A reassessment of the resident’s abilities was to have been completed quarterly and annually.  
* If the resident’s mental or physical functioning had changed the resident’s right to self-medicate would have been revoked and re-evaluated by the interdisciplinary team. | F 554 | | |
| F 657 SS=D        | Care Plan Timing and Revision  
CFR(s): 483.21(b)(2)(i)-(iii)  
§483.21(b) Comprehensive Care Plans  
§483.21(b)(2) A comprehensive care plan must be- | F 657 | 1. Resident #20 care plan reviewed and updated. All residents are potentially at risk. All resident care plans will be reviewed for accuracy prior to 5/30/2019.  
See next page-continued. | 5/30/2019 |
Continued From page 4

(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.

(iii) 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: 32355
Based on observation, interview, record review, and policy review, the provider failed to ensure the staff implemented the interventions on the care plan for one of four sampled residents (20) who had limited range of motion (ROM) and physical limitations to her hands. Findings include:

1. Review of resident 20's medical record revealed:
   * An admission date of 7/15/13.
   * Her diagnoses included: alcohol-induced
**F 657**

Continued from page 5

Persisting dementia, seizures, muscle weakness, and contractures.

*She:

- Had cognitive loss and was not interviewable.
- Was dependent upon the staff to anticipate her needs and assist her with all activities of daily living (ADL).
- Had passive ROM exercises done by the restorative aide three to five times a week.

Observation on 4/29/19 at 3:13 p.m. of resident 20 revealed:

*She had appeared:

- Very thin, weak, and frail.
- To not be able to move her arms, legs, and body without staff support.

*She had been:

- Laying in her bed resting.
- Awake and would look at you when spoken to.

*Her:

- Legs, arms, and hands were severely contracted.
- Arms were pulled up to her chest with her hands closed tight into a fist.

There were no devices in her hands to promote stretching and increased ROM for them.

Random observations on 4/30/19 from 7:30 a.m. through 11:10 a.m. and 1:45 p.m. through 3:38 p.m. revealed no change from the observation above.

Review of resident 20's comprehensive care plan revealed:

*There were several different dates for the focus areas, goals, and interventions.

*A focus area: "Hygiene/ADL's/Skin: I need assist with my dressing, grooming, and hygiene. I have body control problems and cognitive loss."
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| **F 657** | Continued From page 6 | *Intervention under that focus area was: "Bilateral hand cones in her hands as much as possible."

Interview on 5/1/19 at 8:06 a.m. with licensed practical nurse (LPN) G regarding resident 20 revealed she:
*Had been in charge of the restorative and exercise programs for the residents.
*Confirmed the resident had been dependent upon the staff to anticipate and meet all of her ADLs.
*Confirmed the care plan and intervention for her hands.
*Was not aware the staff had not been putting the cones in her hands.
*Agreed she had severe contractures to her hands and required the use of those cones to maintain her current level of ROM and skin health.

Interview on 5/1/19 at 10:45 a.m. with the director of nursing regarding resident 20 confirmed the above medical record review and interview with LPN G. The staff should have been placing the cones in her hands as directed by the care plan.

Review of the provider's November 2017 Care Planning policy revealed:
*"Individual, resident-centered care planning be initiated upon admission and maintained by the interdisciplinary team throughout the resident's stay to promote optimal quality of life while in residence."
*"Care plans are accessible to all direct-care staff."
*"It is the responsibility of all direct care members to familiarize themselves with the care plans and review them routinely for changes."

F 657 |
Continued From page 7
Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(i)
§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that:
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.

This REQUIREMENT is not met as evidenced by:
Surveyor: 32355
Based on observation, interview, record review, and policy review, the provider failed to:
*Identify a decline in condition and physical capabilities for one of one sampled resident (32) who had a fall with a major injury.
*Ensure one of one sampled resident (32) who was at risk for pressure injuries had preventative measures and interventions in place to ensure no skin breakdown had occurred.
*Have the physician assess one of one sampled resident (32) with three deep tissue injuries to ensure the appropriate interventions and treatments were in place to promote a healthy and healing process for those wounds.

Findings include:

1. Review of resident 32's medical record revealed:
   *He had been admitted on 10/1/18.

1. Resident #32 has interventions in place to prevent further skin breakdown. All residents are potentially at risk.

2. Executive Director, Director of Nursing, Medical Director and Interdisciplinary team have reviewed the Braden and Skin Integrity policy. All licensed nurses were educated on 5/13/2019 in regards to Skin Integrity policy. Braden Scale assessment, Best practices in pressure ulcer prevention, appropriate dressing and the dressing change competency by the Director of Nursing and the Wound nurse consultant. All staff will be educated on 5/20/2019 by the Director of Nursing in regards to the Skin Integrity Policy and their role in Pressure ulcer prevention. All staff not in attendance will be educated prior to their next working shift.

3. The Director of Nursing or designee will audit 4 residents at risk for skin breakdown to ensure preventative measures are in place to prevent pressure ulcers and timely Braden Scale assessments are completed weekly for those weeks and monthly times four weeks. The results of the audits will be brought to the monthly GAPI committee by the Director of Nursing or designee for further review and recommendation to continue or discontinue the audits.
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<td>F 686</td>
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Continued From page 8

*His diagnoses had included: pneumonia, urinary tract infection (UTI), nondisplaced fracture of right hip, congestive heart failure, osteoarthritis, neuralgia, anemia, chronic obstructive pulmonary disease (COPD), and depression.

*He had:
- Good memory recall and was capable of making his needs known.
- A history of poor decision making abilities to ensure negative outcomes would not have occurred.
*On 12/8/18 he had a fall in his room when attempting to self-transfer from his bed to the wheelchair (w/c).
- That fall had resulted in a right hip fracture and required admittance to the hospital for surgical repair.
*Prior to his fall on 12/8/18 he had:
- Been independent with bed mobility.
- Required staff support to assist him with activities of daily living (ADL) that included transfers, toileting, personal hygiene, and ambulation.
*After his fall on 12/8/18 he had:
- Required the use of a mechanical lift for all transfers.
- Not been able to walk and required the use of a w/c to go from place-to-place in the facility.
- Been dependent upon the staff to assist him with all ADLs.
- That had included bed mobility and repositioning from side-to-side.
*His Braden Scale for Predicting Pressure ulcers score on 1/9/19 was a sixteen indicating he was at risk for skin breakdown.
- There were no further Braden Scale assessments to review after 1/9/19.
*On 1/3/19:
- He had acquired "a deep tissue injury to his left
Continued From page 9

great toe during a transfer with the mechanical lift."
--That injury measured 2.0 centimeter (cm) x (by) 1.0 cm and was purple in color.
-The staff had also identified a deep tissue injury to his right heel.
--That wound measured 1.5 cm x 4.5 cm.
*On 1/11/19 the staff identified a deep tissue injury to his left heel.
-That wound measured 4.0 cm x 2.0 cm
*The staff were to have applied betadine to both of the heel ulcers until resolved.
*The physician and family had been informed of those above wounds.
*There was no documentation to support preventative measures had been put in place in a timely manner to ensure he had not acquired those injuries.

Observation on 4/29/19 at 4:09 p.m. of resident 32's room revealed:
*He was not in his room.
*The bed had an alternating pressure low air loss mattress on it.
*There were several wound care and dressing supplies in a container on the dresser by the bathroom.

Interview on 4/29/19 at 4:13 p.m. with certified nursing assistant (CNA) B regarding resident 32 revealed:
*He:
-Was out of the facility for a medical appointment.
-Had recently been hospitalized for pneumonia and a UTI.
-Was alert, oriented, and capable of making his needs known.
-Had a wound on his left heel.
*She stated:
Continued From page 10

- "I think he got it here."
- "It started out as red, and then we started to elevate his feet when he's in bed."
- "But then it just broke open, and it got worse."
- "He is just so tall, it's hard to position him."
- "She confirmed he had been dependent upon the staff to assist him with all ADLs.

Observation on 4/29/19 at 4:50 p.m. with CNA B with resident 32 revealed:
- "She had prepared to assist the resident to the bathroom.
- "The resident had:
  - Required the use of a mechanical lift to transfer from his w/c to the toilet.
  - Been incontinent of urine.
  - A Rock pressure relieving boot was on his left foot.

Interview on 4/29/19 at 5:00 p.m. with licensed practical nurse (LPN) D regarding resident 32 revealed:
- "He:
  - Was currently out of the facility for a medical appointment.
  - Had recently been hospitalized for pneumonia and a UTI.
  - Had a fall in December and fractured his right hip.
  - His condition had changed for the worse after the fall on 12/8/18.
  - He had:
    - Required more assistance and staff support for all ADLs.
    - Acquired pressure injuries to both of his heels and one of his toes.

Observation on 4/30/19 at 10:00 a.m. of LPN E with resident 32 revealed:
**WHEATCREST HILLS HEALTHCARE CENTER**

<table>
<thead>
<tr>
<th>F 686</th>
<th>Continued From page 11</th>
<th>F 686</th>
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<tbody>
<tr>
<td><em>She had prepared to complete a dressing change to his left great toe.</em></td>
<td><em>The resident had:</em></td>
<td><em>Provider's Plan of Correction</em></td>
</tr>
<tr>
<td><em>The resident had:</em></td>
<td>- Been in his room sitting in a recliner.</td>
<td><em>(Each corrective action should be cross-referenced to the appropriate deficiency)</em></td>
</tr>
<tr>
<td>- Been in his room sitting in a recliner.</td>
<td>- His feet elevated and a Rook boot on the left foot.</td>
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</tr>
<tr>
<td>- His feet elevated and a Rook boot on the left foot.</td>
<td><em>She had removed a gauze dressing from his left great toe to expose an opened stage 3 pressure injury.</em></td>
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</tr>
<tr>
<td><em>She had removed a gauze dressing from his left great toe to expose an opened stage 3 pressure injury.</em></td>
<td>- That wound had been:</td>
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<tr>
<td>- That wound had been:</td>
<td>-- Open and worse in appearance from when initially assessed on 1/3/19.</td>
<td></td>
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<tr>
<td>-- Open and worse in appearance from when initially assessed on 1/3/19.</td>
<td>-- Moist with purulent drainage.</td>
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<tr>
<td>-- Moist with purulent drainage.</td>
<td>-- Approximately 2.0 cm x 1.5 cm in size with 90% granulation and 10% eschar.</td>
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<tr>
<td><em>LPN E:</em></td>
<td><em>Cleaned the wound with the same pair of gloves she had used to remove the old dressing with.</em></td>
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<tr>
<td><em>Cleaned the wound with the same pair of gloves she had used to remove the old dressing with.</em></td>
<td><em>Sanitized her hands, put on clean gloves, and applied the clean dressing per physician's orders.</em></td>
<td></td>
</tr>
<tr>
<td><em>Sanitized her hands, put on clean gloves, and applied the clean dressing per physician's orders.</em></td>
<td><em>Showed the surveyor the wound on the resident's left heel.</em></td>
<td></td>
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<tr>
<td><em>Showed the surveyor the wound on the resident's left heel.</em></td>
<td><em>Had applied betadine to the left heel wound earlier that morning.</em></td>
<td></td>
</tr>
<tr>
<td><em>Had applied betadine to the left heel wound earlier that morning.</em></td>
<td><em>That left heel wound had been:</em></td>
<td></td>
</tr>
<tr>
<td><em>That left heel wound had been:</em></td>
<td>- Black, dry, and approximately 3.0 cm x 1.5 cm in size.</td>
<td></td>
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<tr>
<td>- Black, dry, and approximately 3.0 cm x 1.5 cm in size.</td>
<td>- Left opened to the air.</td>
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Interview on 4/30/19 at 10:30 a.m. with LPN E regarding resident 32 revealed:

*She confirmed the above medical record review and staff interviews.*

*She stated:*  
- "His heels are deep tissue injuries, and so was the big toe."
- "His big toe looks like a stage 3 now."
- "The right heel was almost healed until he went to the hospital, it's worse now."
**WHEATCREST HILLS HEALTHCARE CENTER**

**F 686** Continued From page 12

"She had been a part of assessing and determining those residents who were at high risk for skin breakdown.
"She confirmed he had been at high risk, but prior to his fall he had been able to position himself in the bed.
"She stated:
"We had the pillows in place, but he likes to dig his heels into the bed and scoots down."
"We just now added the Roock boot."
"We put the air mattress on after he got the wounds."
"I'm not sure how he got the sore on his big toe, I think it was from hitting the lift."
"His toes are up and don't hit the footboard when he slides down in the bed."
"When he got back from the hospital after his fall, he would lay in bed as stiff as a board and refused to be moved."
"She confirmed after his fall he had:
- A decline and change in condition for the worse and required more staff support.
- Acquired all three of the wounds while receiving care in the facility.
"The staff were to have repositioned him every two hours, but he had a history of refusing.
"She agreed:
- Her process for completing the dressing change to the left great toe had been unsanitary.
- That process had created the potential for infection and could interfere with the healing process of the wound.

Attempted interview on 4/30/19 at 1:45 p.m. with resident 32 revealed the resident declined stating, "I'm tired, I really have no complaints."

Review of resident 32's 12/19/18 significant change in status Minimum Data Set (MDS)
Continued From page 13

assessment revealed he had:

*A risk for skin breakdown/ulcers.
*No pressure relieving devices for his bed or w/c.
*No repositioning program in place.

Review of resident 32's 3/21/19 quarterly MDS assessment revealed he had:
*A risk for skin breakdown/ulcers.
*Pressure relieving devices for his bed but not the w/c.
*Developed three deep tissue injuries.
*A repositioning program in place.

Review of resident 32's comprehensive care plan revealed:
*Had different initiation and revision dates for all the focus areas developed for him.
*A focus area initiated on 1/3/19: Identified pressure injuries to his left great toe and right heel.
-Intervention for that focus area: Staff were to float his heels when he was in bed.
*A focus area initiated on 1/14/19: Identified a pressure injury to his left heel.
-Interventions for that focus area had been: Staff were to reposition him every two hours.
*Those interventions were not put in place until pressure injuries had been identified or further injury had occurred on 1/3/19 and 1/14/19.

Observation on 5/1/19 at 8:06 a.m. of resident 32 revealed he had:
*Been laying in bed sleeping.
*Been laying on his back with his feet elevated on a foam wedge.
*A rook boot on his left foot.
*Slid down in the bed and his feet were pushing up against the footboard.
F 686  Continued From page 14

Interview on 5/1/19 at 8:15 a.m. with registered nurse (RN) F regarding resident 32 revealed she:

"Confirmed:
- The pressure injuries to his heels and left great toe.
- He had acquired those wounds while receiving care in the facility.
- He had been a significant change for the worse after his fall on 12/8/18.
- The direct care givers used those care plans to guide them with care for all the residents.

"Had:
- Assisted with determining those residents who had been at risk for skin breakdown.
- Assisted the staff with determining pressure relieving measures for those residents.

"Agreed:
- The pressure relieving measures put in place for him had not occurred until after he had acquired those wounds.
- They had been reactive versus proactive when putting those interventions in place.
- They had not been timely when putting those interventions in place for him.

"Had assisted the physician with resident assessments and observations when he was in the facility.

"Confirmed the physician had not assessed those wounds when he had been in the facility and stated:
- "He asked the nurses how the wounds were doing and if we should continue the current treatment."
- "Yes we should have made sure he looked at them."
- "He was independent before his fall with bed mobility but after that he needed help."

Review of resident 32's medical records review
**WHEATCREST HILLS HEALTHCARE CENTER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

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<td>F 686</td>
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<td>Continued From page 15 from 1/1/19 through 4/29/19 and interview at 10:30 a.m. on 5/1/19 with the director of nursing (DON) regarding the resident revealed: The physician had signed orders every two weeks to continue with current treatments for those wounds. The physician had been in the facility and reviewed the resident's status on 1/3/19, 1/10/19, 2/7/19, and 4/4/19. There was no documentation to support the physician had assessed or reviewed the status of those pressure injuries during his visits. There was no documentation to support: -The resident had refused assistance with repositioning and bed mobility. -Interventions were put in place to ensure pressure injuries had not occurred with the change and decline in his health after his fall on 12/8/18. After the medical record had been reviewed with the DON she: -Confirmed the medical record information above. Would not confirm nor comment on whether the staff had been reactive versus proactive when putting interventions in place for him. She stated, &quot;No matter what, the house rule is he was to be repositioned every two hours.&quot; Interview on 5/1/19 at 12:20 p.m. with resident 32's physician revealed and stated: &quot;I believe those are pressure sores and that he has some arterial deficiency, but they were created from pressure.&quot; &quot;They may not heal due to the arterial deficiency.&quot; &quot;By definition pressure wounds are about care and any wound can be prevented.&quot; &quot;There are times they do just happen but not very often.&quot;</td>
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</table>
Continued From page 16

"He had seen the wounds when the resident had been in the hospital recently but not during any nursing home visits.

"That is up to them, and they decide if I should see them or not."

"If they thought I should see him they should have put him on doctor rounds to be assessed."

"He has a history of gout and degenerative arthritis in his toes. Those two things do not work in his favor."

Review of the provider's December 2017 Skin Program policy revealed:

*Policy:
- "To ensure a resident who enters the facility without pressure ulcers/pressure injury does not develop pressure ulcers/pressure injury unless the individual's clinical condition demonstrates that they were unavoidable."
- "To provide care and services to prevent pressure ulcer development, to promote the healing of pressure ulcers/wounds that are present, and prevent development of additional pressure ulcers/wounds."

Review of the provider's February 2014
Prevention of Pressure Ulcers policy revealed:

*Policy: "The purpose of this procedure is to provide information regarding identification of pressure ulcer risk factors and interventions for specific risk factors."

*Procedures:
- "Review the resident's care plan to assess for any special needs of the resident."
- "See policy and procedure for specific task, such as repositioning."

*General guidelines:
- "Pressure ulcers are usually formed when a resident remains in the same position for an
Continued From page 17

extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue."

"The most common site of a pressure ulcer is where the bone is near the surface of the body including the heels and toes."

"Pressure ulcers are often made worse by continual pressure, acute illness and/or decline in the resident's physical and/or mental condition."

"The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, reported to the practitioner, physician, and addressed."

F 880  Infection Prevention & Control

CFR(s): 483.80(a)(1)(2)(4)(e)(f)

§483.80 Infection Control

The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.

1. Unable to correct deficient practice for residents #20 and 32 for observations during survey process. All residents are potentially at risk.

2. The Executive Director, Director of Nursing and interdisciplinary team have reviewed the infection control policy, dressing change policy, hand hygiene policy and pericare policy. All staff will be educated at an all staff meeting on 5/20/2019 on their roles and responsibilities in infection control and prevention. All staff not in attendance will be educated prior to their next working shift.

3. The Director of Nursing or designee will audit hand hygiene, glove use, pericare and dressing changes on a random sample of four residents weekly times four weeks and monthly times two months. RNA B and H and LPN E to be included in these audits. The Director of Nursing or designee will bring the results of the audits to the monthly CAPI meeting for further review and recommendation to continue or discontinue the audits.
STATEMENT OF DEFEICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/ SUPPLIER/CILA IDENTIFICATION NUMBER:
435105

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
05/01/2019

NAME OF PROVIDER OR SUPPLIER
WHEATCREST HILLS HEALTHCARE CENTER
STREET ADDRESS, CITY, STATE, ZIP CODE
1311 VANDER HОРКК ST
BRITTON, SD 57430

(X4) ID PREFIX TAG
F 880
SUMMARY STATEMENT OF DEFEICIENCIES
(Each deficiency must be preceded by full regulartory or LSC identifying information)

ID PREFIX TAG
F 880

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X9) COMPLETION DATE

F 880
Continued From page 18

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv) When and how isolation should be used for a resident, including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which 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; and
(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of
F 880 Continued From page 19

Infection.

§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Surveyor: 32355

Based on observation, interview, and policy review, the provider failed to ensure infection control practices were maintained during:

* Personal care for two of eight sampled residents (20 and 32) by two of three certified nursing assistants (CNA) B and H.
* Dressing change for one of one sampled resident (32) by one of one licensed practical nurse (LPN) E.

Findings include:

1a. Observation on 4/29/19 at 5:38 p.m. with CNA B with resident 32 revealed:

* The resident had:
  - Sitting on the toilet going to the bathroom.
  - Hooked up to a mechanical lift while going to the bathroom.
* She had:
  - Prepared to assist him off the toilet, provide personal care, and transfer him back into the w/c.
  - Washed her hands and put on clean gloves.
* With those clean gloves on she:
  - Got a package of wet wipes from the shelf above the toilet.
  - Took out several of them.
  - Touched the remote on the mechanical lift and raised him up to a standing position.
* With those soiled gloves still on:
  - Took the wet wipes and provided perineal care for him.
  - Got a tube of skin barrier cream off the shelf,
F 880 Continued From page 20
opened it up, and squeezed some on her gloved hand.
- Applied the cream to his bottom and front perineal area.
  *She then:
   - Removed her gloves, pulled up his pants, and finished transferring him into the w/c.
   - Washed her hands and left the room.

Interview on 4/29/19 at 6:00 p.m. with CNA B regarding the above observation revealed:
*That had been her usual process for providing personal care to the residents.
*She had not realized her process for providing personal and perineal care was not performed in a sanitary manner.
*She agreed the process had been unsanitary and had created the potential of cross-contamination of bacteria to the resident.

b. Observation on 4/30/19 at 7:40 a.m. of CNA H with resident 20 revealed:
*The resident had been laying in her bed resting.
*She had:
  - Prepared to provide personal care and assist her with getting out of bed.
  - Washed her hands and put on clean gloves.
  *With those clean gloves on she:
   - Had touched the handles on the water faucet and turned it on.
   - Got a clean washcloth and moistened it under the running water.
   - Touched the handles on the water faucet and turned it off.
   - Washed the resident's face and chest with the washcloth.
   - Put the resident's socks, pants, and shoes on.
   - Got a package of wet wipes and tube of skin barrier cream.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA
IDENTIFICATION NUMBER:

A BUILDING __________________________
B WING __________________________

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

05/01/2019

NAME OF PROVIDER OR SUPPLIER

WHEATCREST HILLS HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1311 VANDER HOREK ST

BRITTON, SD 57430

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

F 880 Continued From page 21

-Removed her soiled incontinent brief.
  *With those soiled still on she:
  -Performed perineal care for her.
  -Put a clean incontinent brief on her.
  -Finished dressing her.
  *She:
  -Had used the same pair of gloves during the entire above process.
  -Removed her gloves after the above tasks had been completed and washed her hands.

Interview on 4/30/19 at 7:55 a.m. with CNA H revealed:
  *That had been her usual process for providing personal care to the residents.
  *She had not realized her process for providing personal and perineal care was not performed in a sanitary manner.
  *She agreed the process had been unsanitary and had created the potential of cross-contamination of bacteria to the resident.

2. Observation on 4/30/19 at 10:00 a.m. with LPN E during a dressing change for resident 32 revealed:
  *She had gathered several supplies to provide wound care for the resident that consisted of:
    -Several opened 4 x (by) 4 gauze dressings.
    -An unopened 4 x 4 package of hydrogel gauze.
    -An unopened 4 x 4 package containing bordered gauze.
    -A pair of scissors.
    -Several small tubes of normal saline.
  *The resident had:
    -Been sitting in a recliner with his feet elevated.
    -A soiled gauze dressing covered his left great toe. That dressing was yellow colored from the drainage of his wound.
  *She:

ID PREFIX TAG

F 880

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 1G5V11 Facility ID: 0109 If continuation sheet Page 22 of 24
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| 680 | - Had placed all of the above supplies on a clean disposable chux for a barrier.  
- Washed her hands and turned the water faucet off without using a barrier.  
- Put on a pair of clean gloves.  
* With those clean gloves on she removed the soiled dressing from the his left great toe.  
* The wound had the appearance of a stage 3 pressure injury and was moist with purulent drainage.  
* With those same soiled gloves on she:  
- Took several of the clean 4 x 4 gauze dressings and moistened them with normal saline.  
- Cleaned the opened wound on his left great toe.  
- Repeated the cleaning process of the wound as above a second time.  
* She then:  
- Removed her gloves and washed her hands.  
- She turned the water faucet off after washing her hands but without using a barrier.  
- Put on clean gloves.  
* With those clean gloves on she had:  
- Opened the package of hydrogel and cut a piece of it to fit the wound bed.  
- Placed the hydrogel on the wound.  
- Opened the package of bordered gauze and cut the edges to fit his toe.  
- Placed the bordered gauze over the hydrogel and secured it in place.  
* She then removed her gloves and washed her hands.  

Interview at the time of the above observation on 4/30/19 with LPN E revealed she:

* Confirmed that had been her usual process for completing that dressing change.  
* Had not recognized the following surfaces as soiled until reviewed with the surveyor:  
- Faucet handles.
**WHEATCREST HILLS HEALTHCARE CENTER**

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<td>F 880</td>
<td>Continued From page 23 -Outside surfaces of the packages containing the wound supplies. *Agreed she should have washed her hands after removing the soiled dressing from his wound and prior to cleaning it. *Agreed the above process had not been completed in a sanitary manner, and there had been the potential for cross-contamination of bacteria to the resident's wound.</td>
<td>F 880</td>
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Interview on 5/1/19 at 10:45 a.m. with the director of nursing and infection control nurse confirmed:
*The processes observed for all the above residents had not been completed in a sanitary manner.
*Those processes had created the potential of cross-contamination of bacteria could be transmitted to the residents.

Review of the provider's July 2017
Handwashing/Hygiene policy revealed:
*"This facility considers hand hygiene the primary means to prevent the spread of infections."
*"All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other residents."
*Hand hygiene needs to be completed:
  -Before and after contact with the resident.
  -After contact with body fluids, visibly contaminated surfaces or contact with objects in the resident's room."

Review of the provider's April 2014 Dressings Clean/Aseptic policy revealed the staff should have removed their gloves and washed their hands after the removal of a soiled dressing and prior to cleaning the wound.
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<th>Initial Comments</th>
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Surveyor: 16385  
A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 4/29/19 through 5/1/19. Wheatcrest Hills Healthcare Center was found in compliance.
### Initial Comments

Surveyor: 40506
A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/30/2019. Wheatcrest Hills Healthcare Center 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 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K211, K223, and K271 in conjunction with the provider's commitment to continued compliance with the fire safety standards.

### Means of Egress - General

CFR(s): NFPA 101

Means of Egress - General
Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.

This REQUIREMENT is not met as evidenced by:

- Surveyor: 40506
- Based on observation and interview, the provider failed to maintain egress paths free of hazards for two of six exits (kitchen and physical therapy areas). Findings include:

1. Observation at 11:40 a.m. on 4/30/19 revealed the path of egress for the physical therapy room to the north exit passed through a vestibule area before reaching the exit discharge location. The area is cluttered with excess materials for cleaning the therapy area. This makes it difficult for patients to exit the area quickly and safely during an emergency.

---

### Corrective Action

1. Area #1 has been cleared of excess clutter and combustible materials to allow for a proper means of egress for exit. Area #2 the tray cart has been removed from the egress corridor allowing for a proper exit width. All residents have the potential to be affected.

2. The Executive Director, Director of Dietary, Rehab Director and Director of Environmental Services reviewed the life safety code in regards to Means of Egress by 5/30/19.

3. The Rehab Director or Designee will monitor the path of egress for no clutter or combustible material for area #1 weekly times four weeks and monthly times two months. The results of these audits will be brought by the Rehab Director or designee to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.

The Director of Dietary or designee will monitor the path of egress in area #2 for proper exit width weekly times four and monthly times two. The results of these audits will be brought to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audits.

---

**Lavonne Furman**

Executive Director

5/21/2019

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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 withdrawal of findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction has been developed or signed. Be aware findings and plans of correction are disclosable 14 days following the date these documents are made available to the public. A plan of correction is required to continued program participation.
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<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>K 211</td>
<td>Continued From page 1 vestibule area had combustible items (including a wooden stair and wooden dresser). Paths of egress must not be used for combustible storage. An exit enclosure shall not be used for any purpose that had the potential to interfere with its use as an exit. LSC 7.1.3.2.3 2. Observation at 1:10 p.m. on 4/30/19 revealed the egress corridor for the kitchen was used for tray cart storage. The corridor width remaining was less than 24 inches and did not allow for exiting. Interview with the maintenance supervisor at the time of the observations confirmed the conditions. He stated that the items were not always located in those spaces. The deficiency had the potential to affect physical therapy occupants in the case of observation one, and kitchen occupants in the case of observation two.</td>
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<td>K 223</td>
<td>Doors with Self-Closing Devices CFR(s): NFPA 101 Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power.</td>
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1. The metal door to the laundry room has been adjusted and now closes and latches appropriately. All residents have the potential to be affected. 2. The Executive Director and Maintenance Director have reviewed the regulation regarding doors with self closing devices. 3. The Maintenance Director or designee will monitor the proper closure of four random doors to include the laundry room door weekly times four weeks and monthly times two months. The Maintenance Director or designee will bring the results of these audits to the monthly QAPI meeting for further review and recommendation to continue or discontinue the audit. Addendum: This will be added to the preventative maintenance plan and documented when completed and if repair was completed. LF 5/21/2019
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<td>K 223</td>
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<td>Continued From page 2  18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8  This REQUIREMENT is not met as evidenced by:  Surveyor: 40506  Based on observation and interview, the provider failed to maintain one of two hazardous areas (laundry room) as required. Findings include:  1. Observation at 11:40 a.m. on 4/30/19 revealed the laundry room in the basement was greater than 100 square feet and contained combustible items. The corridor door was equipped with a closer, but the metal door would not close.  Interview with the maintenance director at the time of the observation confirmed that finding.  The deficiency had the potential to affect 100% of the occupants of that smoke compartment.</td>
<td>K 223</td>
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<td>5/30/2019</td>
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<td>K 271</td>
<td>S</td>
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<td>Discharge from Exits  CFR(s): NFPA 101  Discharge from Exits  Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7  This REQUIREMENT is not met as evidenced by:  Surveyor: 40506  Based on observation and interview, the provider failed to arrange exit discharge as required. On 4/30/19, exit discharge did not meet change in elevation requirements at the south exit from the east wing. TH exit discharged to a concrete pad</td>
<td>K 271</td>
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| K.271 | Continued From page 3  
that was badly broken. Abrupt changes in elevation of walking surfaces shall not exceed 1/4 in. (6.3 mm). Changes in elevation exceeding 1/4 in. (6.3 mm), but not exceeding 1/2 in. (13 mm), shall be beveled with a slope of 1 in 2. Changes in elevation exceeding 1/2 in. (13 mm) shall be considered a change in level and shall be subject to the requirements of ramps.  
Ref. 2012 NFPA 101 Section 19.2.7, 7.7.4, 7.1.6.2  
The maintenance supervisor was present when the deficiency was identified.  
Failure to arrange exit discharge as required increases the risk of death or injury due to fire.  
The deficiency affected an estimated one of three patient wings in the residence and one of six exit doors. | K.271 |
### Compliance/Noncompliance Statement

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/29/19 through 5/1/19. Wheatcrest Hills Healthcare Center was found not in compliance with the following requirement: S 157.

S 000 Compliance/Noncompliance Statement

Surveyor: 40508

A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/29/19 through 5/1/19. Wheatcrest Hills Healthcare Center was found not in compliance with the following requirement: S 157.

S 157 44:73:02:13 Ventilation

Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building’s air-handling system.

This Administrative Rule of South Dakota is not met as evidenced by:

Surveyor: 40508

Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two of two utility rooms. Findings include:

1. Observation at 10:45 a.m. on 4/30/19 revealed the exhaust ventilation for the room used for soiled utility was not functioning. Testing of the grille with a paper towel at the time of the observation confirmed that finding.

2. Observation at 11:15 a.m. on 4/30/19 revealed the exhaust ventilation for a second room used for soiled utility was not functioning. Testing of the grille with a plastic glove at the time of the observation confirmed that finding.

3. The maintenance supervisor was present during the tour on 4/30/19 and confirmed those finding. He revealed he was unaware as to why the exhaust ventilation was not working at those

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<td>S 000</td>
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<td>1. Area #1 the belt was replaced and fan now in working order. Area #2 a new ventilation exhaust fan has been ordered from CDJ electric and will be replaced when it arrives. All residents have the potential to be affected.</td>
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<tr>
<td>S 157</td>
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<td>2. The Executive Director and Maintenance will review the Administrative rule in regards to ventilation.</td>
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<td>3. The Maintenance Director or designee will audit the functionality of ventilation fans weekly time four weeks and monthly times two months. The results of these audits will be brought to the monthly QAPI meeting for review and recommendation to continue or discontinue the audits.</td>
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<tr>
<td>S 157</td>
<td>Continued From page 1 locations. Those soiled rooms were required to have exhaust ventilation directed to the exterior of the building.</td>
<td>S 157</td>
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<tr>
<td>S 000</td>
<td>Compliance/Noncompliance Statement Surveyor: 18385 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 4/29/19 through 5/1/19. Wheatcrest Hills Healthcare Center was found in compliance.</td>
<td>S 000</td>
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