STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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F 000	INITIAL COMMENTS Surveyor: 40788 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 5/18/21 through 5/20/21. Winner Regional Healthcare Center was found not in compliance with the following requirements: F604, F695, F700, F755, F880, and F909.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §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). §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 treat the resident's medical symptoms. §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	F 604	F604 A nursing meeting was held on May 25, 2021 for all nursing staff. During the meeting (and periodically since), the staff were notified that when the surveyors were observing resident 5 she was restrained several times. Notified them that when she is in the recliner with her legs up and had the tray table in front of her and the fall mats beside her chair and in front of the tray table, it prevented her from being able to rise should she desire to. Discussed that restricting anyone this way is a restraint. Periodic checks have not found resident 5 restained in this way since this meeting. All staff will be required to attend the mandatory in-service meeting on June 15th provided by the DON LSW and Therapy covering restraint use, abuse, and neglect. An audit has been developed and initiated June 8, 2021 to check the room of resident 5 to ensure the tray table is not	06.14.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 06/22/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 604	Continued From page 1 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: 40788 Based on observation, interview, care plan review, and policy review, the provider failed to identify one of one resident (5) seated in a recliner with the leg rest elevated, tray table positioned near her chest, and floor mats against the wheels of that tray table a potential restraint. Findings include: 1. Observation and interview on 5/18/21 at 1:00 p.m. with certified nurse assistant (CNA) M in resident 5's room revealed: *Resident 5 sat in a recliner with the leg rest elevated. *Beneath her was a chair alarm that sounded if she tried to get out of the chair on her own. *She was awake and repeatedly asked about a "little girl" she was worried about. *A tray table was positioned over the armrests of the recliner and in front of her chest. *There was a four inch thick blue mat on the floor against the wheels of the tray table. -Agreed that prevented the resident's ability to get out of the chair on her own. *CNA M had thought the tray table was placed there because the resident had not eaten lunch, but then stated she had. Observation on 5/18/21 at 1:33 p.m. of resident 5 revealed she attempted to push the tray table away from her body, but the floor mat prevented the tray table from moving.	F 604	F604 continued in front of her blocked by a fall mat, so that no restraints are being used. This will be completed by the DON or her designee daily for 2 weeks, then weekly at different times of day for 30 days, and then bimonthly for 3 months. Audits will be reported to QAPI monthly for 4 months. This may be extended at the recommendation of QAPI committee.	

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F 604	Continued From page 2 Interview on 5/19/21 at 2:32 p.m. with director of nursing (DON) B regarding the above observation of resident 5 revealed: *The placement of the mat against the tray table had restricted the resident's freedom of movement and was a restraint. *Confirmed there had been no restraint assessment completed or documented in the resident's medical record. Observation on 5/20/21 at 10:55 a.m. of resident 5 in her room revealed: *She was asleep in the recliner with the leg rest elevated. *A tray table was positioned over the armrests of the recliner and in front of her chest. *A four-inch thick blue mat had been folded in half on the floor in front of and against the wheels of the tray table. *A chair alarm was underneath her. Interview outside of resident 5's room on 5/20/21 at 11:00 a.m. with unlicensed assistive personnel (UAP) H and CNA I regarding resident 5 revealed: *UAP H stated the tray table was placed over the armrests of the recliner and in front of the resident to allow her access to Chapstick and water. *CNA I stated she had "never" positioned the tray table in front of the resident while she was in the recliner and "that's a restraint." *She said CNA M had just positioned the resident in the recliner. Interview in the restorative therapy room on 5/20/21 at 11:10 a.m. with CNA M regarding resident 5 revealed: *He confirmed he had positioned resident 5 in her	F 604		

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F 604	Continued From page 3 recliner in the manner described above. -That was how he usually positioned her in that recliner. *He had not considered that positioning her in the recliner in that manner a restraint. Observation and interview on 5/20/21 at 11:15 a.m. with DON B and CNA L of resident 5 in her recliner in the manner described above revealed: *DON B confirmed how resident 5 was positioned had been a restraint. *CNA L stated "We were always told to do that" referring to how resident 5 was positioned. -She was unable to identify who had given her those instructions. Review of resident 5's 3/23/21 care plan revealed: *She was at risk for falls. -Had recently fallen on 4/9/21. *A fall related intervention stated: "Do not leave res [resident] in her w/c [wheelchair] in her room as she attempts to self transfer. Transfer res into her recliner or into bed when you take her to her room." -It had not identified elevating the leg rest of the recliner, positioning a tray table in front of her, and placing mats in front of the tray table. Review of the revised July 2016 Restraint/Restrictive Device Protocol policy revealed: *Definitions: -"1. Physical restraints include, but are not limited to: side rails, leg restraints, wrist restraints, vest restraints, waist restraints, pelvic restraints, hand mitts, lap cushions, lap belts, lap trays the resident cannot remove."	F 604		

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F 695 F 695 SS=D	Continued From page 4 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, record review, and policy review, the provider failed to: *Follow the physician's order for oxygen titration for one of one sampled resident (10). *Follow the physician's order for continuous oxygen for one of one sampled resident (17). *Ensure oxygen tubing was managed in a way that minimized the risk of contamination for one of one resident (17). Findings include: 1. Observation and interview on 5/18/21 at 5:00 p.m. with registered nurse (RN) E in resident 10's room revealed: *Resident 10 was lying in bed with an oxygen cannula inside his nostrils. -RN E stated he received continuous oxygen. *She had thought the sound of the air conditioner unit in the window was the oxygen concentrator and had not noticed the oxygen concentrator was off. -Oxygen delivery was restarted at 2 liters after the surveyor advised RN E the resident was receiving no oxygen. *Resident 10 was unresponsive throughout the	F 695 F 695	F695 A nursing meeting was held on May 25th for all nursing staff. During the meeting it was discussed that Oxygen orders have to be clearly written and have to be followed as written: #10 had a "Titrate oxygen" order without any clarification. #17 had continuous oxygen ordered and never had oxygen on while the surveyors were here. In addition, her tubing was found on the floor. All staff will be required to attend the mandatory inservice meeting on June 15th provided by the DON and RT to provide oxygen education with current staff and will orient all new employees to correct oxygen usage and supplies. This will cover the appropriate use of oxygen, changing tubing if it has been on the floor, having orders if using humidified oxygen and keeping the bottles full and checking the oxygen to ensure it is working prior to connecting to the resident. Resident #10 has had his oxygen order reviewed. He is usually bedfast and wears oxygen whenever he is in bed. His oxygen order has been changed so it is no longer titrated, and is checked prior to leaving his room for anything.	06.14.2021

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F 695	Continued From page 5 observation and demonstrated no adverse response to the lack of oxygen delivery. Interview on 5/20/21 at 9:20 a.m. with RN E regarding resident 10's 3/17/20 oxygen order revealed: *It had read: "O2 [oxygen] per nasal cannula. Titrate to keep SpO2 > [oxygen saturation level greater than] 90%." *She confirmed the physician's order had not specified an exact amount of oxygen to administer to the resident. -She administered 2 liters of oxygen because that was the amount he had received since she started work in March 2021. *She indicated there was no known plan or process to follow for oxygen titratation. *She had not communicated with the director of nursing (DON) or physician about specific instruction on how to follow through with that physician's order but should have. *His oxygen saturation levels were checked at least twice daily and were above 90%. Observation on 5/19/21 at 9:00 a.m. of resident 10 revealed he attended catholic mass in the facility chapel and had not worn oxygen. Continued observation and interview at 10:10 a.m. with activity assistant N regarding resident 10 revealed she: *Returned him to his room after mass and reapplied his nasal cannula for oxygen delivery. *Stated he had not worn oxygen during church service because she had thought he received oxygen on an as needed basis (PRN). Interview on 5/20/21 at 11:30 a.m. with DON B regarding the physician's order above revealed:	F 695	F695 continued Resident # 17 has had the oxygen order reviewed, the order was changed so the oxygen is used only when her saturations are less than 90%. Her oxygen saturations are completed and recorded every 8 hours and prn by the nurse or medication aid. All oxygen orders have been reviewed and received order changes so there are no more oxygen orders to tritrate oxygen. An audit will be completed to ensure the tubing has been changed and for location of the tubing when not in use, to ensure the oxygen is turned on and being used per physician order. A checklist was made for each resident's room that is on oxygen in regards to oxygen concentrators. This checklist includes the Resident's name, the oxygen order for the resident and the medical professional assisting the resident will check yes/no and initial for the following questions: Is the oxygen cannula clean?, Is water in the humidifier?, Is the oxygenconcentrator on and running at the required oxygen	

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F 695	Continued From page 6 *She confirmed resident 10's oxygen order was incomplete. -The physician should have been contacted for an order that included a specific amount of oxygen expected to be delivered to the resident and an order that specifically identified how to titrate the resident's oxygen. An Oxygen Titration policy was requested of DON B on 5/19/21 at 5:30 p.m. On 5/20/21 at 8:30 a.m. she stated there was no policy. Surveyor: 42558 2. Observation and record review on 5/18/21 at 1:00 p.m. of resident 17 revealed: *She had been admitted to the facility on 6/14/16. *She received comfort care following hospitalization during the autumn of 2017. -Comfort care meaning the family had elected to keep her comfortable with only comfort medications to be provided. -This had included a 1/22/20 physician's order for continuous oxygen at two liters (2L) per nasal cannula (n/c); maintain oxygen (O2) sats(saturations) > (greater than) 90% in the morning and in the evening. *Her diagnoses included: -Pleural effusion, -Other symptoms and signs involving the circulatory and respiratory systems, -Dependence on supplemental oxygen, -Acute on chronic systolic (congestive) heart failure, *Her 4/2/21 minimum data set (MDS) section O was marked 'Yes' for oxygen. *She was in her room laying in a reclining geriatric chair (Broda chair) with her eyes closed and oxygen running at 2L per n/c.	F 695	level for the resident?. Is the tubing changed within the lsat 7 days? Is the tubing stored in the appropriate This checklist will be monitored by the Respiratory Therapist and will be reported to the DON of LTC weekly and reported to QA monthly. The checklist will be monitored daily for one month, then weekly for one month, and then as requested per the QAPI team.	

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F 695	Continued From page 7	F 695		

-The oxygen tubing had been attached to an empty humidification bottle that was attached to the oxygen concentrator.
-The humidification bottle and oxygen tubing had a last changed sticker date of 5/1/21.

Observation on 5/19/21 at 8:05 a.m., 11:51 a.m., and at 2:15 p.m. of resident 17 revealed:
*At 8:05 a.m.:
-Resident had been laying in a reclined position in the Broda chair.
-Her eyes were open with a fixed gaze out the window.
-She did not make eye contact.
*The nasal cannula was laying on the floor with the oxygen concentrator running at 2L.
-The humidifier bottle had remained empty.
*At 11:51 a.m.:
-Resident was in the main dining room awaiting her meal without oxygen.
-Her oxygen concentrator had continued to run in her room with the nasal cannula laying on the floor.
*At 2:15 p.m.:
-Resident had been in her room, reclined in her Broda chair, without the oxygen applied to her nares.
-The tubing continued to be draped over the oxygen machine with the nasal cannula laying on the floor.
-The humidifier bottle remained empty.

Interview and record review on 5/19/21 at 2:19 p.m. with RN E regarding resident 17's oxygen revealed she:
*Had been the charge nurse for the hallway resident 17 was residing on.
*Stated resident 17's oxygen was PRN to keep her oxygen saturation level above 90% and

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F 695	Continued From page 8 needed it most often at night. *Verified resident 17's oxygen saturation was checked two times a day. -Her last reading was 94% that morning at 6:30 a.m. *Stated the humidifiers to the oxygen concentrators were changed when they are empty or along with the tubing every week on night shift. *Verified resident 17's physician order was for continuous oxygen to be worn at all times. *Stated, "That is not how she gets it." 3. Observation and interview on 5/19/21 at 2:30 p.m. of resident 17 in her room with RN E revealed she: *Agreed the humidifier was empty, the nasal cannula was laying on the floor, and the label on the oxygen tubing indicated the date the tubing was to be changed was 5/1/21. -She picked up the nasal cannula off the floor and wrapped it around the oxygen concentrator. *Stated the oxygen order was "...probably entered incorrectly. There was confusion between intermittent and continuous oxygen when oxygen orders are entered [into the computer]." *Monitored resident 17's oxygen saturation at that time. -It had read 96% without supplemental oxygen. *Stated her next step would be to speak with DON B about the oxygen order. Interview on 5/19/21 at 2:48 p.m. with DON B about resident 17 revealed she: *Agreed the oxygen order should have been continuous. -Meaning to be supplying the resident with oxygen at all times. *Stated, "She [resident 17] hasn't worn	F 695		

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F 695	Continued From page 9 continuous oxygen in a long time. I don't know why there is an empty humidifier container hooked to the [oxygen] machine. She does not have an order for humidified oxygen. I'll get that order changed." *Expected the nasal cannula to be replaced if found laying on the floor. *Stated oxygen orders should have been reviewed with each MDS assessment. -She had been the MDS nurse during resident 17's last assessment on 4/2/21. -Stated, "I missed it." Review of resident 17's medication administration record (MAR) for May 2021 under the order stating,"Change O2 tubing Q [every] Friday night at bedtime every Fri [Friday]" had been signed off as completed on 5/7/21 and 5/14/21. Review of resident 17's April and May 2021 'Weights and Vitals Summary' revealed there were 27 out of 30 days where resident 17 had an O2 sat performed on room air (without supplemental oxygen). *On 5/10/21 at 11:22 p.m. resident had an O2 saturation at 75% on room air. -This had been the only saturation below 90%. -Oxygen was applied and a repeat O2 saturation at 1:52 p.m. showed saturation at 97%. Review of the facility's last revised 3/18/21 Oxygen Therapy List revealed: *"Change Tubing & Masks/Nasal Cannulas Q [every] Friday" *Resident 17 had been listed to receive a seven foot nasal cannula, a H2O [humidifier/water container], a connector, and a note stating "continuous/Sat>90%."	F 695		

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F 695	Continued From page 10 Review of the facility's August 2020 Facility Oxygen Therapy Policy revealed: *"Long Term Care:" -"Oxygen administered via nasal cannula or catheter, mask[,] face tent, or other accepted method will be administered upon the order of the attending physician." -"Oxygen-administration equipment will be changed every seven days or sooner if needed."	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Surveyor: 40788 Based on observation, interview, care plan	F 700	F700 Resident #3 has her own bed and effectively uses the side rail for repositioning and tranfers. A side rail assessment was completed on June 9, 2021 to evaluate the effectiveness of the railing. The resident is adamant about having side rails and is adamant about keeping her own bed. Family was contacted and consent received to change the bed to a facility owned bed. This was done on June 11, 2021. Resident #31 was evaluated for appropriaate use of the side rail on May 20, 2021 and does not qualify for use of side rail. The side rail was removed from her bed completely on May 24, 2021. All rooms were inspected for side rail use and the rails remaining have all been assessed and ordered as appropriate to improve resident mobility. There were no side rails on any bed that are being used for the purpose of restraining a resident or restricting their mobility. The use of side rails will be included in the mandatory nursing meeting on	06.11.2021

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F 700	Continued From page 11 review, and policy review, the provider failed to ensure safety assessments had been routinely completed and documented for two of two (3 and 31) sampled residents who had a side rail on their beds. Findings include: 1. Observation on 5/18/21 at 2:00 p.m. of resident 3's bed revealed quarter side rails on her bed. Review of resident 3's care record revealed no ongoing side rail safety assessments for the positioning device used on her bed. Review of resident 3's activities of daily living care plan goal revised on 6/2/20 revealed: "Resident 3 uses quarter rails on her bed for positioning. PT/OT [physical therapy/occupational therapy] will re-evaluate as needed." Interview on 5/19/21 at 2:15 p.m. with director of nursing B regarding side rail safety assessments revealed: *A side rail checklist was completed at the time of admission for all residents. -That checklist included a safety screen and identified the rationale for side rail use taking into consideration that resident's: physical capabilities, cognitive status, safety awareness deficits, fall history, medications, alternate safety interventions used and the intended purpose of the side rail. *She confirmed there was no process for regularly assessing the continued safety and rationale for side rail use after the initial checklist was completed, but there should have been. *There was no PT/OT evaluation documentation form for an assessment. Surveyor: 43844	F 700	F700 continued June 15, 2021 covering restraint use, abuse and neglect and use of side rails with process for initiating side rails. A side rail assessment will be completed by therapy and/or nursing and orders obtained prior to initiation of any side rails, the care plans will be updated by the MDS Coordinator on initiation of the side rails and all care plans on all residents' charts will be reviewed and revised as needed quarterly and prn with the MDS schedule by the MDS Coordinator. An assessment was developed in Point Click Care for quarterly side rail evaluation and was initiated on June 9, 2021 and will be completed as a part of each resident's quarterly MDS assessment process by teh MDS Coordinator. The beds used for new residents will be checked by DON or designee prior to admission to ensure no side rails are on the bed. A report of any new side rails and any injuries sustained due to use of side rails will be presented to the QAPI Committee each month by the MDS Coordinator.	

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F 700	Continued From page 12 2. Observation on 5/18/21 at 1:09 p.m. of resident 31's bed revealed one-quarter side rails on each side of her bed. Review of resident 31's care record revealed no side rail safety assessments. Review of resident 31's activities of daily living care plan did not reflect the use of a side rail. Interview on 5/19/21 at 2:44 p.m. with certified nursing assistant I regarding side rail for resident 31 revealed: *Stated she sees the side rail as a "barrier as we can't get her clear over". *"I don't think she really needs it." *Has never seen her hold it but has seen her lean on it. Interview on 5/19/21 at 3:00 p.m. with registered nurse E regarding side rail for resident 31 revealed: *She was not sure why there was a bedrail. *Stated, "it is not for independence, not for safety, probably just for comfort." Surveyor 40788 Review of the revised July 2016 Restraint/Restrictive Device Protocol policy revealed: *Procedure: -"1. A systematic approach of assessment and evaluation is completed for identified residents at risk for restraint/restrictive device use." -"7. Reassessment/progress evaluation is to be completed quarterly."	F 700		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)	F 755	F755 DON and consultant pharmacist created facility policy Controlled	06.11.2021

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F 755	Continued From page 13 §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Surveyor: 41895 Based on observation, interview, and policy review, the provider failed to: *Ensure narcotics were counted at shift change. *Ensure the narcotics in the emergency kit were	F 755	F755 continued Substance Accounting and Reconciliation to ensure controlled substances are counted at shift change. All pertinent staff including those identified in citation will be educated, receive a copy of the policy, and provide acknowledgement signature they have read, understand, and agree to requirements of policy. New staff will receive education with hire. Consultant pharmacist will conduct audits weekly, this will become facility standard. Audit results will be reported to DON weekly and monthly audit summary will be shared with Quality Assurance Performance Improvement (QAPI) committee. DON and consultant pharmacist reviewed and updated facility policy Emergency Pharmacy Service and Emergency Kits to ensure the integrity of the e-kit inventory and security if refrigerated Lorazepam. All pertinent staff including those identified in citation will be educated, receive a copy of the policy, and provide acknowledgement signature they have read, understand, and agree to requirements of policy. New staff will receive education with hire. Consultant pharmacist will conduct weekly audit, this will become facility standard.	

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F 755	Continued From page 14 accounted for at change of shift. *Account for the disposition of a medication for one of one sampled resident (19) by one of one registered nurse (RN) E. Findings include: 1. a. Observation and interview on 5/20/21 at 10:10 a.m. with RN E during the review of the medication cart revealed: *Two nurses were to count all controlled medications together at each shift change. *They were signed on the shift-to-shift medication count forms and the residents' narcotic count sheets. *The narcotic count sheets were at times confusing and not all nurses signed them. b. Interview on 5/20/21 at 11:00 a.m. with director of nursing (DON) B regarding narcotic counts at shift change revealed she: *Expected the nurses to sign both the shift-to-shift medication count form and the individual narcotic count sheets. *Indicated the individual narcotic count sheets were not a requirement but she expected the nurses to sign off on them at shift change. *The individual narcotic count sheets had been started due to an issue with the accountability of narcotics. *There was not a process in place to audit the accountability of narcotics. c. Record review on 5/20/21 at 12:30 p.m. of the 300 wing narcotic count book revealed: *The shift-to-shift medication count form for April 2021 and May 2021: -The oncoming nurse for the mornings had missed 2 out of 99 opportunities to document. -The off-going nurse for the evening had missed	F 755	F755 Continued Audit results will be reported to DON weekly and monthly audit summary will be shared with QAPI committee. DON and consultant pharmacist reviewed facility policy *Drug Disposition/Destruction* to ensure disposition of all medications is accurately documented. All pertinent staff including those identified in citation will be educated, receive a copy of the policy, and provide acknowledgement signature they have read, understand, and agree to requirements of policy. New staff will receive education with hire. Consultant pharmacist will conduct audits weekly X 2 months, biweekly X 2 months, then monthly until QAPI committee deems. Audit results with be shared with DON as indicated and monthly audit summary will be shared with QAPI committee.	

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F 755	Continued From page 15 2 out of 98 opportunities to document. -The off-going nurse for the morning had missed 2 out of 99 opportunities to document. *The individual narcotic count sheets revealed: -The oncoming staff had missed 21 out of 38 opportunities to document. -The off-going staff had missed 2 out of 38 opportunities to document. d. Record review on 5/20/21 at 12:30 p.m. of the 200 wing narcotic count book revealed: *The shift-to-shift medication count form for April 2021 and May 2021: -The oncoming nurse for the morning had missed one opportunity to document. -The off-going nurse for the evening had missed three opportunities to document. -The off-going nurse for the morning had missed two opportunities to document. *The individual narcotic count sheets revealed: -The oncoming staff had missed 116 out of 292 opportunities to document. -Two residents' forms had not had documentation since 4/2/21. -One resident's form had not had documentation since 4/30/21. e. The provider had been asked for a policy regarding the accountability of narcotics on 5/20/21. *DON B provided a policy to the survey team on 5/20/21 at 2:00 p.m. -She had indicated she had just written the policy. f. Review of the provider's undated Controlled Substance Count policy revealed: *"The individual resident controlled substances sheet will be counted and verified for accuracy at the change of each shift by two nurses and	F 755		

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F 755	Continued From page 16 documented on the Shift to Shift count sheet." 2. a. Observation and interview on 5/20/21 at 11:18 a.m. during review of the medication storage room with RN E revealed: *There was a bottle of lorazepam 2 milligrams (mg) per 1 milliliter (ml) in the fridge in a secured lockbox. -She stated: --It was part of the emergency kit. --The nurses would look at it during shift change but they did not document that it had been counted. --Agreed there was no accountability of the medication. b. Interview on 5/20/21 at 12:12 p.m. with DON B regarding the above observation revealed she did not know how they had been accounting for the Lorazepam. Interview on 5/20/21 at 12:52 p.m. with DON B revealed there was no documentation or accountability for the lorazepam in the refrigerator. c. Review of the provider's reviewed September 2018 Emergency Pharmacy Service and Emergency Kits policy revealed: **"13. Accountability for controlled substances stored in the emergency kit is maintained as follows:" *"c. The incoming and outgoing nurses verify the inventory of controlled substances at each change of shift or exchange of keys." 3. a. Observation on 5/18/21 at 3:40 p.m. of a stand lift in the 300 hallway across from resident 19's room revealed a small white pill on the foot	F 755		

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F 755	Continued From page 17 rest. b. Observation and interview on 5/18/21 at 3:42 p.m. with unlicensed assistive personnel (UAP) K regarding the above observation revealed: *Resident 19 was the only resident on the 300 wing who used the stand lift. *She had watched resident 19 take her pills that morning so thought the pill must have been from another day. *Resident 19 needed to be supervised when taking her medications because she often dropped her pills. *She had given RN E the pill that had been found on the stand lift. c. Review on 5/18/21 at 3:45 p.m. of resident 19's medication administration record and medication supply revealed the medication was furosemide 20 mg. d. Observation and interview on 5/18/20 at 3:50 p.m. RN E revealed: *She took the pill, walked into the medication storage room, and put it into a bottle labeled Drug Buster. *She did not document the destruction of the medication unless it was a controlled drug. e. Interview on 5/18/21 at 4:24 p.m. with DON B revealed all medications were to be documented in risk management [a document integrated into the provider's electronic health record] when destroyed. f. Review of the 5/18/21 risk management report revealed the furosemide tablet had been destroyed. *The documentation had not included the dosage	F 755		

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F 755	Continued From page 18 of the drug, prescription number, or method of destruction. g. Review of the provider's reviewed September 2018 Drug Disposition/Destruction policy and procedure revealed: **"Non-controlled drugs will be destroyed by a licensed nurse and another licensed nurse." **"A documentation note will be written in the resident's medical record (Medication Reconciliation Form) by the person responsible for destroying the medications. The note will be signed by those persons destroying the medications." **"The drug disposition record must contain, as a minimum, the following information: -a. Date destroyed; -b. The name of the drug; -c. Dosage of drug; -d. The prescription number (if any); -e. The quantity destroyed; -f. Method of destruction; -g. Signature of witnesses."	F 755		
F 880 SS=E	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	F 880	F880 People: Why: Lack of Knowledge No role modeling Lack of accountability Environment: Why: Lack of Leadership Lack of bedside surveillance Intensity of resident demands Policies: Why: Lack of adherance to policies No policy for touching inanimate objects No decontamination after	06.14.2021

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F 880	Continued From page 19 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 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.	F 880	F880 continued gloves off Procedures: Why: Adequate staffing levels to enable Process be completed in allotted time Disinfection after each use Weekly deep decontamination of equipment Materials: Why: Not supplied equipment barriers Inconvenient location of sanitizer during carea Sensitivity to hand sanitizer Root Cause Analysis for infection control: Identified issues: There is a general lack of knowledge about infection control practices. There is a lack of role modeling of proper procedure by current staff There is a lack of consistent staff Several of the staff are travelers with varying contract end dates There has been inconsistent auditing for infections control, not actually done when staff is providing the cares in the rooms.	

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F 880	Continued From page 20 §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 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: 40788 Based on observation, interview, record review, and policy review, the provider failed to maintain appropriate infection control practices for: *Proper hand hygiene and glove use by one of one RN (E) between a transition in resident care for one of one sampled resident (10). *Cleaning of reusable medical equipment by one of one unlicensed assistive personnel (UAP) (H) and one of one CNA (I). *Proper hand hygiene for one of one RN (E) and three of three CNAs (I, J, and O) while providing activities of daily living care for 3 of 3 sampled residents (1, 21, and 31). *Placing a barrier between a glucometer and related supplies on an over the bed table by one of one RN (E) for one of one observed resident (14) while performing a blood glucose test. Findings include: 1. Observation and interview on 5/18/21 at 5:00 p.m. with RN E preparing to administer resident 10's medication via a gastric feeding tube revealed she:	F 880	F880 continued Staff have the perception that they are having reaction to the frequently required hand hygiene. Forgetfulness Lack of adherence to policies There is a lack of routine with the change over of staff so not familiar with the actual care needs. Hand hygiene compliance, lack of appropriate cleaning and disinfection of reusable medical equipment and lack of appropriate procedural techniques with use of barriers remains an infection prevention and control priority. Although improvement in infection control compliance is a complex challenge, it is achievable by multidisciplinary intervention. Providing continuous intensified education, training, surveillance with reminding and feedback is essential to maintain a high level of infection control compliance. Altering human behavior, HH role models, and providing suitable work environment, and materials are essential to attaining high levels of compliance in infection control. A high level of effort and awareness is every HCW's responsibility and should always be engaged in the long term care facility.	

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F 880	Continued From page 21 *Performed hand hygiene and put on gloves. *Determined the resident had slid down in his bed and required repositioning before medication administration. -Called for assistance from another staff person. -Moved the bed away from the wall with her gloved hands and placed herself between the wall and the resident's bed. -With the assistance of a second staff person using the repositioning sheet underneath, the resident was placed in an upright position. -Pushed the bed back against the wall. *Without removing her unclean gloves or performing hand hygiene, she opened his feeding tube to administer his medications then closed it following medication administration. *Agreed glove removal and hand hygiene was expected after repositioning him and before administering medication. Surveyor: 41895 2. a. Observation and interview on 5/18/21 at 3:15 p.m. with CNA I after using a stand lift with resident 31 revealed: *She pushed the lift out of the room and left it in the hallway without disinfecting it. *The footrest of the lift had been covered with dirt and dust. *Agreed the lifts should be disinfected after each use with spray or wipes. *She usually would have cleaned it but got busy and forgot. *She did not go back and disinfect it after our interview. b. Interview on 5/18/21 at 4:24 p.m. with DON B revealed she expected the CNAs to: *Disinfect the oximeter and other reusable medical equipment between uses. *Clean the lifts after each use with spray	F 880	F880 Problem- Hand hygiene compliance Implementing-Employee Health/Infection Control will do hand hygiene competency upon hire also a video will be shown on how to do hand hygiene. This will be required for all new hires at Winner Regional, but will not include agency staff. Staffing coordinator for agency staff will complete competency as part of their orientation. Intervention-Staff will be educated on the steps of proper hand hygiene. They will also be educated on when hand hygiene is expected. For example hand hygiene is required before, during, after, and in transition of resident care task. Audits-audits will begin on 6/14/2021, with all new hires by infection control or designee. Also, 5 employees will be chosen at random to be audited by infection control or designee monthly and required to correctly demonstrate proper hand hygiene. If the employee fails to complete all the steps correctly they will be reeducated on how to preform proper hand hygiene. They will then be re-audited in two weeks. Problem-Proper glove use Intervention-Staff will be educated on proper glove use. The education will include removal of gloves after caring for a patient/resident. Not wearing the same gloves for the care of more than one patient/resident. Changing gloves and doing proper hand hygiene when moving	

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F 880	Continued From page 22 disinfectant or wipes. *Deep clean the lifts on the night shift. *There had not been a cleaning schedule for the lifts. c. Observation and interview on 5/19/21 at 9:31 a.m. of UAP H obtaining an oxygen level on resident 31 revealed she: *Had entered the room performed hand hygiene, pulled the oximeter out of her pocket, and put it on resident 31's finger. *Then put the oximeter back into her pocket, exited the room, and performed hand hygiene. *Indicated she had put the oximeter in her pocket so she could do hand hygiene and then would have cleaned it when she returned to the medication cart. *Agreed her pocket would have been dirty and she should have cleaned the oximeter before checking resident's oxygen level. *Agreed the oximeter could have been contaminated and she should not have put it in her pocket. d. Review of the provider's revised May 2019 Infection Control policy revealed: "All reusable supplies/equipment will be cleaned and disinfected when visibly soiled, prior to use on another patient, storage on the unit [,] or transport to Central Sterilizing." 3. a. Observation on 5/18/21 at 4:30 p.m. of CNA J assisting resident 1 with activities of daily living revealed CNA J: *Had been wearing a pair of gloves and repositioning resident 1 to assist with incontinence care. *Removed the contaminated gloves. -Did not perform hand hygiene.	F 880	F880 from contaminated to a clean site during care of a patient/resident. For example: When repositioning a patient in bed, glove change and hand hygiene must be done before administering medication. Audits-Problem and interventions were discussed by DON in nurses meeting on 5/25/2021. Audits will be done by infection control or designee once per week for 8 weeks, and then when expectations are met, monitoring will be reduced to twice monthly for one month, as long as expectations continue to be met monitoring will be reduced to once a month for 4 months, then quarterly or as determined by QAPI team. Problem-Handling food items with bare hands Intervention-Education will be provided to staff that there will be no bare hand contact with food. Use of the following is required when handling food for patients/residents; gloves, tongs/utensils, deli tissue/foil sheets/ napkins, or silverware. Audits- Problem and interventions were discussed by DON in nurses meeting on 5/25/2021. Audits will be done by infection control or designee once per week for 8 weeks, and then when expectations are met, monitoring will be reduced to twice monthly for one month, as long as expectations continue to be met monitoring will be reduced to once a month for 4 months, then quarterly or as determined by QAPI team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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F 880	Continued From page 23 *Opened and closed four dresser drawers, opened and closed the closet door, reached into his pocket, pulled out his walkie-talkie, asked someone to bring him some incontinence wipes, and put the walkie-talkie back in his pocket. *Without performing hand hygiene he put on a new pair of gloves. *CNA I entered the room and handed him a package of incontinence wipes. *Opened the wipes and used them to perform incontinence care for resident 1. *During the incontinence care with the same contaminated gloves he reached into the package of wipes four times to retrieve more wipes. *Removed those contaminated gloves and put on a new pair without performing hand hygiene. *Assisted the resident to roll onto his right side and removed the soiled incontinence brief from under him. *Removed the soiled gloves and without performing hand hygiene he put a clean incontinence brief on the resident. *Washed his hands and put on a new pair of gloves, then he took another wipe, and cleaned some bowel movement off the back of the resident's left upper leg. *Removed his gloves and exited the room without performing hand hygiene. *Returned to the room with the Hoyer lift and performed hand hygiene. Interview on 5/18/21 at 4:50 p.m. with CNA J about the above observation revealed he: *Should have performed hand hygiene each time he removed his gloves. *Agreed he had missed several opportunities to perform hand hygiene. b. Observation on 5/19/21 at 10:39 a.m. of CNA I	F 880	F880 Problem-properly disinfecting reusable medical devices, which are used for multiple patients/residents. Intervention-DON and infection control will implement a policy and procedure to be followed for proper cleaning of reusable medical devices that are shared between patients/residents. Procedure in place at this time is that each item is to be disinfected prior to leaving room and prior to entering another patient/residents room. Education will be provided to staff. Audits- Audits will be done by infection control or designee once per week for 8 weeks, and then when expectations are met, monitoring will be reduced to twice monthly for one month, as long as expectations continue to be met monitoring will be reduced to once a month for 4 months, then quarterly or as determined by QAPI team. Problem-Barrier between blood glucose monitor and other surface Intervention-Individual blood glucose monitors have been purchased so that each resident has their own. Policy will be updated by DON and infection control to reflect individual use of glucose monitors. Cleaning procedure after use will also be reflected as well as placing a proper barrier between machine and related supplies. Education will be provided to staff.	

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F 880	Continued From page 24 providing incontinence care for resident 21 revealed she: *Was wearing a pair of gloves. *Performed peri care, wearing the same gloves started to the bathroom with the washcloth, dropped the washcloth onto the floor, picked it up, went into the bathroom, rinsed that washcloth she had just dropped, and used that washcloth to clean the resident's perineal area. *With the same contaminated gloves on, put on a clean incontinent brief and put a Hoyer sling under him. *Then removed her gloves and performed hand hygiene. 4. a. Observation and interview on 5/20/21 at 8:32 a.m. of RN E performing a blood glucose test for resident 14 revealed: *The glucometer and supplies were in a cloth zippered bag. *She set the glucometer bag on the residents bedside table without a barrier. *Put on a pair of gloves. *Opened the bag up, set the glucometer, and a container of test strips on the bedside table without a barrier. *Cleaned one of his fingers with an alcohol pad, poked it with a lancet, and then set the lancet on the bedside table. *With her contaminated gloves on she had reached into the glucometer bag and retrieved a cotton ball. *Finished performing the blood glucose. *Removed her gloves, collected the supplies, and left the room without performing hand hygiene. *Went back to the medication cart and set the glucometer bag, the glucometer, and the strips on top of the cart with out a barrier. *Cleaned the glucometer with a disinfecting wipe	F 880	F880 Audits- Audits will be done by infection control or designee once per week for 8 weeks, and then when expectations are met, monitoring will be reduced to twice monthly for one month, as long as expectations continue to be met monitoring will be reduced to once a month for 4 months, then quarterly or as determined by QAPI team.	

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F 880	Continued From page 25 wrapped it in the wipe and left it on the medication cart. b. Interview on 5/20/21 at 10:00 a.m. with RN E regarding the above observation revealed: *Each wing had a glucometer that was used for the residents on that wing. *She did not know what a barrier was until the surveyor had educated her. *Stated is was a good idea to use a paper towel as a barrier so the glucometer and supplies did not get contaminated from the unclean surface. *She did not disinfect the test strip container because she was worried about the integrity of the label on the bottle. *Agreed the glucometer and supplies would have been contaminated from the surface and her contaminated gloves. *Agreed she should have washed her hands when exiting the room. *Agreed the bag the glucometer was kept in was not a cleanable surface. c. Review of the provider's reviewed August 2018 Blood Glucose Policy revealed it: *Had not addressed using a barrier when in a resident room to prevent cross contamination. *Instructed to clean the meter with a cotton swab or soft cloth dampened with water. *Did not indicate to disinfected the glucometer between uses. Surveyor: 43844 5. a. Observation on 05/19/21 at 8:58 a.m. of care provided to resident 31: *CNA O: -Picked up a mat from floor. -Obtained new clothes from the closet. -Washed resident 31's arm. -Assisted certified nursing assistant I with	F 880		

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F 880	Continued From page 26	F 880		

perineal care.
--Obtained clean wipe from the container.
-Emptied trash can.
-She used the same contaminated gloves and had missed three opportunities to perform hand hygiene.
*Registered nurse E:
-Applied skin protector wipe to toe with missing toenail, cream to her buttocks, and powder to her groin.
-She used the same contaminated gloves and had missed three opportunities to perform hand hygiene.
*Certified nursing assistant I:
-Disposed of the used incontinent brief in a trash can.
-Removed clean pink housecoat from the closet.
-Assisted CNA I with perineal care.
--Obtained clean perineal wipe from the container.
-Held resident 31's hand.
-She used the same contaminated gloves and had missed four opportunities to perform hand hygiene.

Interview on 5/19/21 at 2:44 p.m. with CNA I:
*Agreed she had held resident 31's hand after doing perineal care without performing hand hygiene.
*Agreed she should have removed gloves and performed hand hygiene before holding resident 31's hand.
*Confirmed she had completed infection control training in February 2021 when she started working at the facility.
*Had been a CNA for over 30 years.

Interview on 5/19/21 at 3:00 p.m. with RN E:
*Agreed she did not perform hand hygiene when

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F 880	Continued From page 27 she provided care to resident 31. *Agreed she should have removed gloves and performed hang hygiene when moving from a dirty area to a clean area of a body when care was provided. b. Interview on 5/19/21 at 4:30 p.m. with DON B revealed she had expected: *All staff to wash hands when entering and exiting a resident's room, when removing gloves, after contact with a resident, and when moving from a dirty task to a clean task. *Additional hand hygiene would be completed depending on circumstances of duties. *If the washcloth was dropped on the floor CNA I should have used a new clean washcloth. 6. Review of the May 2019 revised Hand Hygiene policy revealed: *Procedure: -"4.iv. Change gloves any time you move from a contaminated area to a clean area during the care of a patient..." -"2. Decontaminate hands upon removal of gloves or other personal protective equipment."	F 880		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by:	F 909	F909 On review of resident #3's bed, she has her own bed and her manufactured rail was a full length rail. It was changed to a facility bed on June 11, 2021 so a railing can be compatible with the bed frame. Resident #31 had the side rails removed after evaluation was completed. The MDS Coordinator is doing a side rail evaluation quarterly on all residents with side rails. Once the evaluation is completed, she will notify maintenance	

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F 909	Continued From page 28 Surveyor: 40788 Based on observation, interview, and policy review, the provider failed to assess side rails on two of two sampled residents' beds (3 and 31) initially or routinely as a part of a preventative maintenance program to ensure those side rails were compatible with the bed frame, in good working order, and safe from possible resident entrapment. Findings include: 1. Observation on 5/18/21 at 2:00 p.m. of resident 3's bed revealed: *A side rail on her bed. -The side rail bar extended across the width of the bed under the mattress to the opposite side of the bed and secured to that frame with black zip ties. Interview on 5/19/21 at 2:10 p.m. with maintenance staff person C regarding side rail maintenance revealed: *He confirmed he was responsible for applying side rails. *There was no equipment safety evaluation or assessment completed at the time side rails were attached to a bed. *There was no preventative maintenance schedule or evaluation of side rails after they were installed. -He relied on staff to let him know if there was an issue with a side rail, for example if it became loose.	F 909	F909 continued to do an equipment safety evaluation. An audit tool was developed for maintenance to document after they have examined the bed and completed the safety and side rail check. A side rail use policy was developed. Audits will be completed by maintenance and MDS coordinator or designee and MDS will bring a report of completed assessments to QAPI monthly. This will be an ongoing process.	

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

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E 000	Initial Comments Surveyor: 40788 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 5/18/21 through 5/20/21. Winner Regional Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 06/23/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435056	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2021

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 5/18/21. Winner Regional 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 the deficiencies identified at K200 and K321 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 200 SS=D	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain egress doors as required at one randomly observed exit door location (helipad exit). Findings include:	K 200	K200 No residents were harmed relating to K200. The findings were that a handmade, laminated sign stating "NOT AN EXIT" had been taped to the door, even though clearly marked with permanent illuminated signage indicating that it is an EXIT. The laminated sign was removed immediately. Another finding was that being an exit, it must be paved to the public way (street) and it is not. Surveyor 18087 felt that because there was another exit already paved to the public way and within the acceptable distance between Exits, we could remove the permanent signage from the Heli-Pad door and the door could be used strictly as intended. A phone conversation the very next day confirmed his initial	06.14.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 06/16/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	435056	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2021

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K 200	Continued From page 1 1. Observation on 5/18/21 at 3:00 p.m. revealed the exterior door to the helipad was marked as an exit. The exit discharge was not paved to the public way (street), it was paved only to the helipad. Also, the door had a laminated sign on it stating "Not an Exit". Interview at the time of the observation with the maintenance supervisor confirmed those conditions. He stated the sign was placed on the door to keep staff from using the door on a regular basis to exit the building. Failure to provide working egress doors as required increases the risk of death or injury due to fire. The deficiency affected 100% of the smoke compartment occupants.	K 200	K200 continued thoughts and the permanent EXIT sign has been removed. The handmade, laminated "NOT AN EXIT" sign has been adhered on the door. These corrections were implemented by the maintenance department with final inspection by the Maintenance Supervisor.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321	K321 No residents were harmed relating to K321. The findings were pipe penetrations through a 1-hour firewall. The large pipes were insulated and fit the opening of the sheet rock perfectly but were not fire caulked to seal the final fit. This needed fire caulking has been done. The smaller pipes were insulated as well but the hole in the sheetrock was extremely oversized. A larger piece of sheetrock with the correct sized hole cut in it was placedover the existing sheetrock and tight against the pipe. This final fit was then sealed with fire caulk around the pipe as well as around	06.14.2021

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	435056	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2021

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K 321	Continued From page 2 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain one randomly observed hazardous area (boiler room) separated from the egress corridor as required. Findings include: 1. Observation on 5/18/21 at 3:25 p.m. revealed the boiler room piping extending through the one-hour fire-rated corridor wall above the lay-in ceiling was not sealed on the corridor side. The open piping penetrations must be sealed with an approved fire-stop material such as intumescing fire caulk. Interview with the maintenance supervisor at the time of the observation confirmed those findings. The deficiency affected 100% of the smoke compartment occupants.	K 321	K321 continued the sheetrock patch. These pipes were then traced to the area where they leave the space above the lay-in ceiling and enter into the attic. These penetrations were not fire caulked appropriately. This has been corrected also. One last thing we did then was to inspect the hall side of the boiler room wall for any other improper penetrations. None were found. The Maintenance Supervisor will re-educate the team as to the importance of proper fire walls and to inspect other fire walls in the future should we have more ceiling tile out. We will also instruct vendors who may make penetrations to seal them appropriately. These corrections were implemented by the maintenance department with final inspection by the Maintenance Supervisor.	

South Dakota Department of Health

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	10713	A. BUILDING: _____ B. WING _____	05/20/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 5/18/21 through 5/20/21. Winner Regional Healthcare Center was found not in compliance with the following requirement: S166.	S 000		
S 166	44:73:02:18(1-2) Occupant Protection The facility shall take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents; (3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used; This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the emergency nurse call devices in three randomly observed locations (men's public toilet room at the main entrance, the two unisex toilet rooms at the nurse station). The emergency staff call system for resident use must be capable of being easily activated by a resident. The system must be utilized and maintained in a manner to ensure it is a	S 166	S166 The faciility shall take at least the following precautions: 1) Develop and implement a written and scheduled preventative maintenance program; 2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by residents. 3) Provide a call system for each resident bed and in all toilet rooms and bathing facilities routinely used by residents. The call system shall be capable of being easily activated by the resident and must register at a staff station serving the unit. A wireless call system may be used. Education will be provided to all housekeeping staff regarding the proper placement of call cords in the bathrooms of residents' rooms and public bathrooms. This education will be completed by June 15. Call cords in all bathrooms will be	06.14.2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 06/16/2021

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10713	A. BUILDING: _____ B. WING _____	05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 166	Continued From page 1 consistent and effective means for a resident to alert staff of the need for assistance. The ends of the emergency nurse call system device cords were twelve inches above the floor or wrapped around the device and did not extend to the floor. Findings include: 1. Observation on 5/18/21 at 1:30 p.m. revealed the men's public toilet room at the main entrance was equipped with a nurse call device with cord. The cord extended only to within twelve inches of the floor. The cords would not be able to be reached from a prone position on a floor location if needed. 2. Observation on 5/18/21 at 2:45 p.m. revealed the two public unisex toilet rooms adjacent to the nurse station were equipped with emergency nurse call devices. One toilet room's nurse call had the cord wrapped around the device and it did not extend to the floor. The second toilet room's nurse call's cord extended only to within twelve inches of the floor. The cords would not be able to be reached from a prone position on a floor location if needed. Interview with the maintenance supervisor at the time of the observations confirmed those findings. He stated the housekeeping staff may have raised the cords when cleaning the rooms. This deficiency has the potential to affect all residents who use those toilet rooms.	S 166	S166 continued checked every day in rooms that are cleaned by housekeeping. The current checklist used by housekeepers will be modified to include a line item for the housekeeper to validate that the call cord in the bathroom is in the appropriate location. Five random checks in the bathroom will be done by the director of operations once a week for 1 month, then transition to five random checks in the bathrooms monthly for three months and then transition to five random checks inthe bathrooms for three months.	
S 000	Compliance/Noncompliance Statement Surveyor: 40788 A licensure survey for compliance with the Administrative Rules of South Dakota, Article	S 000		

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	805 EAST 8TH ST WINNER, SD 57580

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S 000	Continued From page 2 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 5/18/21 through 5/20/21. Winner Regional Healthcare Center was found in compliance.	S 000		