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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435038	A. BUILDING _____ B. WING _____	C 01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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F 000	INITIAL COMMENTS A complaint health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted on 1/10/24. Areas surveyed included neglect, resident rights, and dietary services. Tekakwitha Living Center was found not in compliance with the following requirements: F604 and F803.	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 indicated, the facility must use the least restrictive	F 604	F 604 Administrator, DON and interdisciplinary team reviewed and revised the policies and procedures related to restraints All other residents were assessed for restraints on 1/11/2024. Completed by the DON. DON or designee will audit residents for restraints weekly for four weeks and monthly for two additional months. MDS coordinator will receive further training on restraints. Administrator provided training on 1/24/2024 All staff will be educated on restraints at the all-staff meeting by Administrator and MDS Coordinator on 2/20/2024. If staff can't attend Administrator or DON will do 1 on 1 training with these staff members.	2/24/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Jessica Wood — Administrator - EPH — 2-8-24

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 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: Based on South Dakota Department of Health (SD DOH) Complaint report review, observation, interview, medical record review, and policy review, the provider failed to ensure one of one sampled resident (6) who had been dressed in a Onesie (one-piece close-fitting garment with an opening in the back) restraint to prevent him from removing his clothing had the following: *Approval of the use of a the Onesie restraint from resident 6's guardian. *An assessment to ensure the Onesie restraint was not used for staff convenience. *A physician's order for the use of the restraint. *Used the least restrictive restraint for the least amount of time. *Documented the restraint in the care plan. *A routine re-evaluation to ensure the Onesie was appropriate and necessary. Findings include: 1. Review of the SD DOH complaint reports received anonymously on 12/28/23 and again on 1/8/24 revealed: *The staff made resident 6 wear a Onesie. *Resident 6 did not like wearing it. *He was unable to use the bathroom independently because he could not take the Onesie off by himself. *He had exposed himself one time "But he was blind so he did not know where he was." *Another complaint stated resident 6 had urinary incontinence and urinated on the floor. 2. Observation and interview on 1/10/24 at 3:00	F 604	F 604 Resident 6's care plan as been updated to assist him with toileting more often to prevent incontinence. Completed on 1/11/24 by DON. Staff was informed of care plan change immediately. All residents assessed for restraints by DON or designee will report findings at monthly QAPI meetings continuously until determination.	

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F 604	Continued From page 2 p.m.with resident 6 revealed: *He was wearing a t-shirt and jogging pants. *The clothing was not sewn together. *Resident 6 confirmed: -He sometimes had worn the Onesies but he did not like wearing them. -It was very difficult and he could not use the toilet independently. -He had to rip them off his body and they torn so he could not wear them now. 3. Interview on 1/10/24 at 3:30 p.m. with registered nurse E regarding resident 6 and the use of Onesies revealed: *Resident 6 used to wear the Onesies frequently but resident 6 had ripped off the Onesies. *He did not have the money to purchase more. *He had cognition problems, but could speak and make himself understood. 4. Review of resident 6's medical record revealed: *He had "moderate to severe" cognition. *There was no physician's order for the use of the Onesies. *His care plan had no documentation regarding the use of the Onesie restraint. *There was an incontinence problem that indicated he had bowel incontinence and had bowel movements on the floor, in and out of his room. *He should have worn loose fitting and easy to remove clothing. *Staff were to assist him to the bathroom every two hours. *There were no restraint assessments located in the medical record. *The nursing progress notes had not identified the use of the Onesies restraint.	F 604		

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F 604	Continued From page 3 *The most recent Minimum Data Set assessment on 11/29/23 had not indicated resident 6 used any restraints. 5. Interview on 1/10/24 at 4:00 p.m. with the director of nurses (DON) A regarding resident 6's use of Onesie restraints revealed: *The Onesies were purchased approximately one year ago. *Resident 6 did not like to use them because he could not get out of them without assistance from staff. *The staff were not using them as much as they had, because the resident had torn them apart trying to get them off. *The staff were supposed to assist him to the bathroom every two hours so he would not urinate or have bowel movements on the floor. *He used the Onesie restraint approximately twice a week. 6. Interview with DON A and social services designee B regarding the Onesies revealed: *They were not aware the Onesies were considered restraints. *They both were not aware that a physician's order and an initial assessment were required for the use of the Onesie. *A re-evaluation of the restraint to ensure whether the restraint was beneficial to continue its use. *The restraint had not been added to the resident's care plan. 7. Review of the provider's undated Use of Restraint policy revealed: *Restraints were to have been used only after the alternatives had been tried unsuccessfully. *Restraints were only to have been used to treat the resident's medical symptoms, and never for	F 604		

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F 604	Continued From page 4 discipline or staff convenience. *Physical restraints were defined as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricted freedom of movement or restricts normal access to one's body. *If the resident could not remove the device in the same manner in which the staff had applied it and it restricted his typical ability to change position or place, that device would have been considered a restraint. *Prior to placing a resident in a restraint, a pre-restraining assessment and review to determine the need for restraints. The assessment was to have been used to determine possible underlying causes and to determine if there were less restrictive interventions that may have improved the symptoms. *Restraints were to have been only used upon a written physician's order and after obtaining consent from the resident or representative. The order was to have included the following: -The reason for the restraint. -How the restraint was to have been used. -The type of restraint and the period of time for the use of the restraint. *Guidelines were to have been implemented and documented when the resident was in restraints. *Restrained individuals should have been reviewed regularly (at least quarterly) to determine whether they were candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination. *Care plans for residents using restraints would reflect interventions that address the underlying problems that could have been causing the symptoms. -The care plan should also included the	F 604		

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F 604	Continued From page 5 measures to reduce or eliminate the need for restraint use.	F 604		
F 803 SS=F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on menu review, interview, and policy review, the provider failed to ensure therapeutic diet extensions were developed and approved by one of one registered dietitian (RD) D for the second meal options served to residents on a	F 803	F 803 RD will approve/revise therapeutic diet extensions by 2/24/24 RD will review menus monthly for three months to ensure proper therapeutic diet extensions All dietary staff was educated on therapeutic diets at monthly dietary meeting by dietitian on 2/6/2024. Quiz given after presentation to properly ensure staff understood the therapeutic diets. DM or designee will audit therapeutic diets are being followed weekly for four weeks, and monthly for two additional months. Ordered 2024 Diet and Nutrition Care Manual - Comprehensive Nutrition Care Guide - 2024 Manual. Received on 1/30/2024 Administrator, RD and DM reviewed, revised or created policies and procedures related to therapeutic diets DM or designee will present findings and continue audits at monthly QAPI meetings continuously until determination.	2/24/24

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F 803	Continued From page 6 therapeutic diet. Findings include: Review of the provider's Fall/Winter Menu for Week 1 that was approved by the RD D revealed that: *Wednesday's noon meal was three ounces of chicken in dressing, mashed potatoes and gravy, green beans, and fruit sauce. -The renal extension for that diet approved by RD D was boiled chicken, mashed potatoes, gravy, green beans, and drained fruit sauce. -There was no second meal option listed on the menu. *Wednesday's noon meal written on the menu board for the residents to view was beef stroganoff and peas. -That Wednesday's noon meal was not approved by RD D for Wednesday. -The substitute/alternate meal written on the menu board for residents was chicken enchilada casserole and peas. --There was no documentation to support RD D had approved that substitute/alternate meal. Interview on 1/10/24 at 11:40 a.m. with dietary manager (DM) C regarding the resident's menus and therapeutic diet extensions revealed: *She was the dietary manager and was not certified. *She had worked an average of 170 hours every two weeks, as she had been the only cook. *Two different meal options were served to residents at the noon and supper meals. -There were no therapeutic diet extensions for the second meal option. *She confirmed she was not aware of what the therapeutic diet extensions for any of the second meal options would have been.	F 803		

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F 803	Continued From page 7 Interview via telephone conference on 1/10/24 at 4:16 p.m. with RD D regarding therapeutic diet extensions revealed: *She had developed and approved the menus. -Two different meal options, the main option, and a second meal option option, were served to residents at the noon and supper meals. -She had not developed any therapeutic diet extensions for the second meal option. *Regarding second meal options, she stated, "It is left up to the cooks, they use leftovers or what is already cooked." *Her expectation was for the cooks to go through the 5-week approved menu and find the diet extensions for the second meal option as "it should be somewhere in the menu". *After discussing DM C's interview from 1/10/24 at 4:16 p.m. regarding no diet extensions for the second meal option, she stated, "That is not good, we will definitely figure that out." Interview and policy review on 1/10/24 at 5:14 p.m. with the DM C regarding the provider's 6/30/20 Diet Manual and Therapeutic Diets policy, and the provider's 6/5/20 Menu Standards policy revealed: *The Diet Manual and Therapeutic Diets policy included the following: -"The Nutritional Services Diet Manual shall serve as an effective resource to provide education and direction for appropriate nutritional care to the patients [residents]. The manual will be located in the Dietitian's office and the Dietary Managers's office." --DM C confirmed there was no Nutritional Services Diet Manual available. *The Menus Standards policy included: -"Nutritional needs of patients [residents] will be provided in accordance with the recommended	F 803		

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F 803	Continued From page 8 dietary allowances of the US [United States] Dietary Guidelines of Americans." --DM C confirmed she was not aware of what the US Dietary Guidelines of Americans was.	F 803		