STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING _____ B. WING _____	02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKONDA HERITAGE MANOR	515 OHIO STREET WAKONDA, SD 57073

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 18560 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 2/11/20 through 2/13/20. Wakonda Heritage Manor was found not in compliance with the following requirement: F880.	F 000	Initial Comments: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by state law. For the purpose of any allegation the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
F 880 SS=D	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 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	F 880	F 880 Correct to individual: Individual education provided to RN (staff C) on 2/11/20 and RN (staff D) on 2/13/20 for standard precautions during wound care, including; cleaning surfaces with disinfectant agent before starting dressing changes and use of a barrier, new supplies are required if they fall on the floor or any unclean surfaces, and proper hand hygiene and glove use are required along with education on the need to wipe off supplies with disinfectant before replacing them in treatment cart. Correct to individual: Individual education provided to CNA (staff E) on 2/11/20 for standard precautions during cathetar care. Education included; procedure for emptying urinary catheter bag and wiping toilet handle or other soiled surfaces with disinfectant wipes. Correct to individual: no changes were made with the individual residents' (resident 13, 20, 27) orders for wound care or catheter care. Correct to all others: All residents with any type of wound or skin condition will be assessed weekly for improvement of wound/skin. System correction: All nursing staff will be educated on 03/11/20 at mandatory meeting on Infection Control during wound care and training on clean barriers. All CNA staff will be educated on 3/11/20 on proper catheter care and use of barriers. All education will include return demonstration and compentencies. Infection Control meeting has been scheduled for 3/18/20. Monitoring of system: Audits will be completed 1 time per week x 4 weeks, then 2 times per month x 2 then monthly x 6 months or as determined by QAPI team. Results will be reported by the DON or designee to the monthly QAPI meeting. (Please see addendum on next page RS 03/12/2020)	03/11/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland | TITLE: Administrator | (X6) DATE: 03/02/2020

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 880	Continued From page 1 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 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: 32335	F 880	F880 (Addendum: Correct to individual: Individual education was provided to CNA (staff B) on 02/11/2020 for proper procedure for barrier use in sink when using perineal wipes. RS 3/12/2020) (Addendum: Monitoring of systems: Audits will be completed by the DON or designee for catheter care with proper disinfectant, proper procedure for clean dressing and proper procudere for barrier in sinks when using perineal wipes. All 3 audits will be completed 1 time per week x 4 weeks, then 2 times per month x 2 months, then monthly x 6 months or as determined by the QAPI team. Results will be reported by the DON or designee to the monthly QAPI meeting. RS 3/12/2020)	

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F 880	Continued From page 2 Surveyor: 42478 Based on observation, interview, and policy review, the provider failed to ensure infection control procedures were done appropriately to ensure sanitary conditions were maintained for: *Two of two dressing changes by two of two registered nurses (RN) (C and D) for one of one sampled resident (20). *One of one catheter bag emptying by one of one certified nurse assistant (CNA) (E) for one of one sampled resident (27) with a catheter. *Personal care for one of one sampled resident (13) by one of one CNA (B). Findings include: 1. Observation on 2/11/20 at 4:06 p.m. with RN C during a dressing change for resident 20 revealed: *RN C: -Gathered supplies for a dressing change from the treatment cart which included: --A package with two cotton swabs in it. --Four individual packages of gauze bandage rolls. --A tube of santyl ointment in a plastic bag. --A jar of silvadene cream in a plastic bag. --A package with a large gauze dressing in it, and a roll of tape. -Entered resident 20's room and placed the treatment supplies on the resident's soiled seat of her walker without a clean barrier. -Performed hand hygiene and put on gloves. *Resident had: -A small open area on the top, inner aspect of her right foot and a small open area on the bottom of her right heal that had scant green drainage noted on the removed dressing. *RN C:	F 880		

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F 880	Continued From page 3 -Noticed the package with the large gauze dressing had fallen off the seat and onto the floor, so she picked it up and put it back on the soiled walker seat. *With those same soiled gloves she: -Opened the tube of santyl and squeezed some out onto a cotton swab. -Applied santyl to an open area on the top of her right foot with that cotton swab. -Did the same with another cotton swab and applied it to an open area on her right heal. -Closed the tube and placed it back on the soiled seat. -Picked up the soiled package of the large gauze dressing. -Opened the soiled package and removed the dressing. -Placed, the now soiled dressing, on her right heal over the open sore. -Took the silvadene jar out of it's plastic bag and put the bag back on the soiled seat. -Opened the jar and dipped her glove into the silvadene then placed the jar back onto the soiled seat. -Rubbed the silvadene onto her right foot. -Opened a package of gauze bandage roll and wrapped it around her right foot. -Picked up the tape, that had fallen onto the floor, and taped the roll. -Removed her gloves, did hand hygiene and put on new gloves. -Picked up the silvadene jar and dipped her gloved hand into it and rubbed it onto her left foot. -Placed the jar back onto the resident's soiled walker seat. -Took off her gloves, did hand hygiene and put on clean gloves. -Wrapped her left foot with a gauze bandage roll. -Took off her gloves, did hand hygiene and put on	F 880		

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F 880	Continued From page 4 clean gloves. -Put the tube of santyl back into the soiled plastic bag. -Put the jar of silvadene back into the soiled plastic bag. -Picked up the two soiled unused packages of gauze bandage rolls and the two soiled plastic bags with medication in them and left the room. -Placed these soiled items back into the treatment cart in a common drawer with supplies used for other residents. -Removed her gloves and performed hand hygiene. Interview on 2/11/20 at 4:35 p.m. with RN C regarding the above observation confirmed and agreed she should have: *Used a clean barrier to put her treatment supplies on when doing the dressing change. *Done hand hygiene and changed her gloves after she picked up the items from the floor. *Not placed the soiled large gauze dressing over the open area on the resident's heal. *Not brought soiled treatment supplies from the resident's room and put them back into the cart with other resident care items. 2. Observation on 2/13/20 at 9:44 a.m. with RN D near the end of a dressing change for resident 20 revealed: *She had been: -Sitting on the floor in front of the resident's feet. -Wrapping the resident's left foot with a gauze bandage roll. *There had been -Empty and opened packages on the floor in front of RN D. -Tape and a jar of medicated cream sat on the floor.	F 880		

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F 880	Continued From page 5 -No barrier between the floor and the supplies. *RN D: -Picked up the jar and tape off the floor and put it on the resident's dresser. -Took off her gloves, did hand hygiene, and put a clean glove on her right hand. -Picked up the jar with her right gloved hand and left the room. -Placed the jar on a barrier on the treatment cart. -Removed her glove and did hand hygiene. -Got a disposable germicidal wipe and wiped down the jar. -Placed the jar in the treatment cart and did hand hygiene. Interview immediately after the above observation with RN D confirmed she had put the treatment supplies on the resident's soiled seat of her walker without a barrier. She stated she did not have a clean barrier for her treatment supplies. She agreed she should have placed her treatment supplies on a clean surface to maintain a clean procedure. 3. Observation on 2/11/20 at 11:01 a.m. with CNA E during the emptying of a urinary catheter bag for resident 27 who was on isolation precautions and in a shared room revealed: *CNA E: -Walked with the resident to his room and assisted him to sit down. -Did hand hygiene. -Put on a gown, gloves, and a mask. -Obtained two alcohol pads from a basin in the resident's room. -Had put a paper towel on the floor and placed a non-sterile collecting container on it. -Opened the spigot of the catheter bag and wiped it with an alcohol pad.	F 880		

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F 880	Continued From page 6 -Drained the urine from the bag into the container. -Lifted up his catheter tubing so the urine would drain from the tubing into the bag then into the container. -Had done this for approximate two minutes. -Had allowed the spigot of the catheter bag to touch the inside and top of the non-sterile collecting container and to dip inside the urine on-and-off for the entire two minutes. -Cleaned the spigot with an alcohol pad. -Closed the spigot and replaced it into it's holder. -Picked up the container and threw away the paper towel. -Emptied the urine from the container into a shared toilet. -Turned on a shared sink with the back of her gloved hand and put water into the cylinder to rinse out the urine. -Turned off the water with the back of her gloved hand. -Poured the water into a shared toilet. -Flushed the shared toilet with her soiled gloved hand. -Took off her gown, gloves, and mask and placed them in the isolation garbage. -Performed hand hygiene and left the room. Interview on 2/11/20 at 11:25 a.m. with CNA E regarding the above care revealed she: *Did not realize she should have not let the spigot touch the non-sterile collecting container or let it dip into the urine. *Agreed the toilet handle was contaminated and should have been disinfected. 4. Interview on 2/13/20 at 3:04 p.m. with director of nursing (DON) A regarding the above observations of dressing changes and the	F 880		

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F 880	Continued From page 7 emptying of a catheter confirmed: *There was an infection control breech with the dressing changes. -A barrier should have been used. -No contaminated treatment supplies should be put back into the treatment cart. *The spigot of the catheter bag should not have touched the non-sterile collecting container. *The toilet handle should have been disinfected after it was contaminated with the CNA's soiled glove. Review of the provider's June 2019 Urinary Catheter System Maintenance policy revealed: "Emptying the collecting bag regularly, avoiding splashing and preventing contact of the drainage spigot with the non-sterile collecting container" Review of the provider's non-dated competency of Urinary Emptying Drainage Bag revealed: "Avoid touching the tip of the tubing to the graduate (a non-sterile collecting container)." The DON was unable to provide a policy or competency for a dressing change. They used the Potter and Perry Fundamentals of Nursing as a resource on proper dressing technique and infection control. Surveyor: 42750 Surveyor: 26632 5. Observation on 2/11/20 at 8:35 a.m. revealed CNA B: *Washed her hands in the sink and placed the dry perineal wipes in the sink to wet them. *She then put on gloves and picked up the wipes from the sink and sprayed perineal wash on them. *She used those wipes to perform perineal care	F 880		

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F 880	Continued From page 8 for resident 13. Interview on 2/13/20 at 9:59 a.m. with DON A revealed: *She confirmed CNA B had contaminated the perineal wipes by placing them in the sink after she had just washed her hands. *She confirmed there was no policy concerning use of the perineal wipes. They use the Potter and Perry Fundamentals of Nursing as a resource on infection control. Potter and Perry Fundamentals of Nursing states in Chapter 29, page 445, Box 29-1: Vehicles of contamination include contaminated items and water among others.	F 880		

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E 000	Initial Comments Surveyor: 18560 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 2/11/20 through 2/13/20. Wakonda Heritage Manor was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R Stockland

TITLE: Administrator

(X6) DATE: 02/25/2020

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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	435094	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2020**

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 2/11/20. Wakonda Heritage Manor was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K233 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		0
K 223 SS=D	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. 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: 27198 Based on observation and interview, the provider failed to maintain two randomly observed	K 223	K 223 System correction: Maintenance director adjusted the doors and closures on the soiled laundry holding room door and the furnace room door on 02/25/2020. These doors now close and latch correctly in order to provide fire separation of those rooms from the corridor. System monitoring: Maintenance director or designee will conduct audits of all doors with self-closing devices 1 time per week for 4 weeks, then monthly for 1 year. If any problem is noted, it will be fixed immediately. All results from audits will be reported at the monthly QAPI meeting by maintenance director or designee.	02/25/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland

TITLE: Administrator

(X6) DATE: 03/02/2020

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K 223	Continued From page 1 hazardous areas (soiled holding room and furnace room) as required as part of a preventative maintenance plan. Findings include: 1. Observation on 2/11/20 at 1:05 p.m. revealed the door from the corridor to the soiled holding room was not latching into the door frame with the automatic door closer. That door was required to latch to maintain the fire separation of that room from the corridor. Interview with the maintenance supervisor at that same time confirmed that observation. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of that smoke compartment. 2. Observation on 2/11/20 at 1:44 p.m. revealed the door from the corridor to the furnace room was not latching into the door frame with the automatic door closer. That door was required to latch to maintain the fire separation of that room from the corridor. Interview with the maintenance supervisor at that same time confirmed that observation. The deficiency affected one of numerous requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of that smoke compartment.	K 223		
K 712 SS=D	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712	K 712 (see next page)	

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	435094	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2020**

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WAKONDA HERITAGE MANOR	**515 OHIO STREET** **WAKONDA, SD 57073**

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K 712	Continued From page 2 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on record review and interview, the provider failed to ensure fire drill procedures were conducted quarterly for the required shifts (for the second and fourth quarter and for the night shift fourth quarter 2019). Findings include: 1. Record review at 12:05 p.m. on 2/11/20 revealed there was no documentation of evening shift fire drills for quarter two (April, May, and June) or quarter four (October, November, and December) 2019. Additionally, there was no documentation of night shift fire drills for quarter four (October, November, and December) 2019. The only fire drills in that quarter occurred during the day shift. Interview with the maintenance supervisor at the time of the record review confirmed those findings. He was aware of the minimum number of fire drills but was not aware of the requirement of one per shift per quarter. When asked how many drills were required; he stated, "One per month". The deficiency had the potential to affect 100% of the occupants of the building.	K 712	K 712 System correction: Maintenance director was re-educated on 02/11/2020 on regulations for fire drills needing to be completed at least quarterly on each shift. The information from the fire drill check off sheets will be entered into a grid spreadsheet to make sure all shifts are covered per quarter. Evening and night shift drill will be conducted on 03/04/2020 to ensure 1st quarter drills are in compliance for each shift. System monitoring: Fire drill check off sheets and grid will be monitored by the maintenance director and administrator or designee on a monthly basis to ensure compliance. Results will be reported at the monthly QAPI meetings by the maintenance director or designee.	03/04/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	435094	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/11/2020**

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South Dakota Department of Health

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	10701	A. BUILDING: _____ B. WING _____	02/13/2020

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S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 2/11/20 through 2/13/20. Wakonda Heritage Manor was found not in compliance with the following requirements: S157 and S195.	S 000		
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: 27198 Based on observation and interview, the provider failed to maintain exhaust ventilation for two randomly observed rooms (shower room and whirlpool room). Findings include: 1. Observation at 2:45 p.m. on 2/11/20 revealed the shower room was not provided with any exhaust ventilation. That room had a musty odor, and there was a visible mold like substance on the walls and ceiling. Interview with the environmental services manager at the time of the observation confirmed that finding. He stated he was not aware of the requirement for exhaust ventilation in that room. 2. Observation at 3:01 p.m. on 2/11/20 revealed the whirlpool room was not provided with any exhaust ventilation.	S 157	S 157 Correction to system: Exhaust ventilation fan was installed in the shower room on 02/20/2020. Exhaust ventilation fan was installed in the whirlpool room on 02/28/2020. All exhaust systems are fully functioning. Monitoring of system: Maintenance director or designee will perform audits for all exhaust ventilation systems in the facility 1x per week x 4 weeks, then monthly x 3 months and then quarterly x 2. All results from audits will be reported at monthly QAPI meetings by maintenance director or designee.	02/28/2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robin R. Stockland — TITLE: Administrator — (X6) DATE: 03/02/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10701	A. BUILDING: _____ B. WING _____	02/13/2020

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S 157	Continued From page 1 Interview with the environmental services manager at the time of the observation confirmed that finding. He stated he was not aware of the requirement for exhaust ventilation in that room.	S 157		
S 195	44:73:03:02 General Fire Safety Each facility covered under this article shall be constructed, arranged, equipped, maintained, and operated to avoid undue danger to the lives and safety of its occupants from fire, smoke, fumes, or resulting panic during the period of time reasonably necessary for escape from the structure in case of fire or other emergency. The fire alarm system shall be sounded each month. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on record review and interview, the provider failed to sound the fire alarm monthly (seven out of twelve months) for calendar year 2019. Findings include: 1. Record review of fire drill documentation at 12:05 p.m. on 2/11/20 revealed the fire alarm had not been sounded for seven of twelve months for calendar year 2019. The fire alarm was required to be sounded monthly. Interview with the maintenance director at the time of the record review confirmed that finding. He revealed he was unaware the alarm was required to be sounded monthly.	S 195	S 195 Correction to system: The fire alarm system will be activated on a monthly basis during monthly fire drills, except for those drills conducted at night. In order to keep resident disruption to a minimum, the fire alarm will be sounded the next day and will be documented on the fire drill check off sheet with date and time of activation. Monitoring of system: Fire drill check off sheets will be monitored by the maintenance director, administator and/or designee on a monthly basis to ensure compliance. Results will be reported at monthly QAPI meetings by maintenance director or designee.	02/28/2020
S 000	Compliance/Noncompliance Statement Surveyor: 18560	S 000		

South Dakota Department of Health

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	10701	A. BUILDING: _____ B. WING _____	02/13/2020

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S 000	Continued From page 2 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 2/11/20 through 2/13/20. Wakonda Heritage Manor was found in compliance.	S 000		