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
	435105	A. BUILDING _____ B. WING _____	04/13/2022

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

(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: 45383 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/11/22 through 4/13/22. Wheatcrest Hills Healthcare Center was found not in compliance with the following requirement: F658.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Surveyor: 45383 Based on interview and record review, the provider failed to ensure one of one sampled resident (20) had received a thorough assessment that included application of oxygen, blood sugar check, and a determination by the physician how to transport prior to transfer to the emergency department. Findings include: 1. Review of resident 20's electronic medical record revealed licensed practical nurse (LPN) E documented on 10/12/21 at: *6:00 p.m.: -The resident had been complaining of chest pain, but no shortness of breath. -The vitals measurements of temperature: 98.7, pulse: 94, respiratory rate: 20, blood pressure (BP): 164/85, oxygen (O2) saturation 98% on room air (RA). *6:20 p.m.:	F 658	1. Unable to correct deficient practice noted during survey. All residents have the potential to be affected. 2. All licensed nursing staff will be educated prior to 5/20/22 on thorough assessment, including oxygen application, if appropriate, blood sugar check, if appropriate and other necessary interventions prior to transport to emergency department as well as validation on mode of transportation to emergency department by DNS or designee. All staff not in attendance will be educated prior to their next working shift by DNS or designee. 3. All transfers to emergency department will be audited monthly times six months for proper intervention and validation of transportation to emergency department by the DNS or designee. The DNS or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	5/20/22

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

Dru Fischgrabe | Executive Director | 4/29/22

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 658	Continued From page 1 -He had been complaining of shortness of breath, feeling dizzy and weak, and still complaining of chest pain. -The vitals measurements of B/P 181/97, pulse 122, respiratory rate 22, O2 saturation 86% on RA. *6:55 p.m.: -The resident was transported to the emergency department via facility van and two staff members. -There was no indication the physician had been consulted prior to transporting. Interview on 4/13/22 at 9:15 a.m. with director of nursing A regarding the above documentation revealed she: *Would had expected staff to apply oxygen since oxygen levels were below 90%. *Would had expected staff to have checked a blood sugar since the resident was diabetic. *Was unable to provide an order for transfer. *Stated that it was staff discretion if a resident was sent by ambulance or by facility van. Phone interview on 4/13/22 at 10:35 a.m. with medical director (MD) D regarding treatment revealed he would expect staff to: *Apply oxygen with saturations less than 90%. *Check a blood sugar if a resident was diabetic. *Transfer a resident to emergency department as quickly as possible. MD D would not comment if the resident was stable or unstable at the time of transfer. A copy for provider's vital sign policy had been requested. The provider reported they did not have a vital sign policy.	F 658		

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E 000	Initial Comments Surveyor: 06365 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 4/11/22 through 4/13/22. Wheatcrest Hills Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dru Fischgrabe
TITLE: Executive Director
(X6) DATE: 4/29/22

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	435105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2022**

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K 000	INITIAL COMMENTS Surveyor: 40506 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 4/12/22. Wheatcrest Hills Healthcare Center was found not in compliance with 42 CFR 483.90 (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 K222, K321 and K353 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222	1. The door in the therapy department was repaired with a proper locking mechanism. All doors checked for appropriate locking mechanism. All residents have the potential to be affected. 2. The maintenance director was educated by ED on proper locking mechanisms by 5/7/22. 3. The ED or designee will audit all doors weekly times four weeks and monthly times two month for proper locking function of the doors. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review and recommendation to continue or discontinue the audits.	5/20/22

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

Dru Fischgrabe | *Executive Director* | *4/29/22*

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MAY 03 2022

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	435105	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2022**

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 2 Surveyor: 40506 Based on observation, testing, and interview, the provider failed to provide egress doors as required at one of six locations (physical therapy exit). Findings include: 1. Observation on 4/12/22 at 11:00 a.m. revealed the exit door at the west wing, off the physical therapy room was locked with a twist lock on the lever door handle. The physical therapy room was occupied, and serving a patient during the survey. Interview at the time of the observation with the maintenance manager confirmed that condition. He agreed that a different locking mechanism for the emergency exit from physical therapy was necessary.	K 222		
K 321 SS=E	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 Area Automatic Sprinkler	K 321	1. All doors affected were repaired to close appropriately. All residents have the potential to be affected. 2. The maintenance director was educated by the ED by 5/7/2022 on proper function of enclosure to hazardous areas. 3. The ED or designee will audit hazardous areas weekly times four weeks and monthly times two month for proper door closure. The ED or designee will bring the results of these audits to the monthly QAPI committee for further review or recommendation to continue or discontinue the audits.	5/20/22

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K 321	Continued From page 3 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: 40506 Based on observation and interview, the provider failed to maintain three separate hazardous areas (storage room, boiler room, and soiled linen room) as required. Findings include: 1. Observation on 4/12/22 at 11:05 a.m. revealed the storage room at the bottom of the east basement stairwell was over 100 square feet and had large amounts of combustibles stored in it. The door closer did not latch. 2. Observation on 4/12/22 at 11:15 a.m. revealed the soiled lined room was over 100 square feet and had combustible soiled linen stored in it. The door was equipped with a closer that did not close and latch the door. 3. Observation on 4/12/22 at 11:25 a.m. revealed the boiler room was equipped with a closer that did not latch the door. Interview with the maintenance manager at the times of the observations confirmed those findings.	K 321		

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K 321	Continued From page 4 The deficiency affected two requirements for hazardous storage rooms and had the potential to affect 100% of the occupants of the smoke compartment.	K 321		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 40506 Based on record review and interview, the provider failed to continuously maintain automatic sprinklers in reliable operating condition (quarterly flow test not done for the past year). Findings include: 1. Record review on 4/12/22 at 2:15 p.m. revealed the required quarterly flow tests had not been performed in the past year. Annual testing	K 353	1. Quarterly flow test was conducted on 5/9/2022. All residents have the potential to be affected. 2. The ED and maintenance director were educated on 5/9/2022 by Rapid Fire Protection on how to conduct the quarterly flow test. 3. The ED or designee will bring the results of the quarterly flow test to the QAPI committee quarterly times 4 quarters for review.	5/20/22

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K 353	Continued From page 5 was performed under contract, but no quarterly testing. Interview with maintenance manager at the time of the record review confirmed that condition. He commented that he did not know it was necessary because it was not included in his computerized maintenance management system.	K 353		

South Dakota Department of Health

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S 000	Compliance/Noncompliance Statement Surveyor: 06365 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/11/22 through 4/13/22. Wheatcrest Hills Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 06365 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 4/11/22 through 4/13/22. Wheatcrest Hills Healthcare Center was found in compliance.	S 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dru Fischgrabe — TITLE: Executive Director — (X6) DATE: 4/29/22