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
	435056	A. BUILDING ______ B. WING ______	08/24/2023

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 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 8/21/23 through 8/24/23. Winner Regional Healthcare Center was found not in compliance with the following requirements: F550, F584, F655, F657, F684, F688, F689, and F812.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	**F550 Resident Rights** WRH has a "Usage of Cell Phones and Other Personal Electronics Communication Devices" policy that states, "the use of cellular phones and other personal electronic communication devices including but not limited to Kindles, laptops, I-pads by employees is allowed only during designated breaks and only in Employee Dining room or outside the building." The Director of Nursing has educated that staff member on September 8, 2023, that violated the policy, and an employee in-service will be held on September 13, 2023, and September 21, 2023. In addition, WRH Care Center will also be educating travel staff upon their first day concerning our policies. WRH will also be doing quarterly in-service meetings in which the use of cell phones will be reviewed. WRH administrator, Director of Nursing, and social worker will continue to be observant for cell phone use violations and if the policy is violated, the issue will be addressed through the facilities	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brian Williams, CEO
TITLE
(X6) DATE: September 20, 2023

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and resident right's review, the provider failed to protect a resident's rights to privacy and a dignified existence during one of one observed resident care when certified nursing assistant (CNA) (T) was using her personal cell phone while one of one sampled resident (17) was using the bathroom. Findings include: 1. Observation on 8/24/23 from 9:23 a.m. to 9:32 a.m. in the special care unit (SCU) revealed: *CNA T was standing in resident 17's room. -The door to the bathroom was open, and her back was facing the bathroom. -Resident 17 was using the bathroom. *CNA T was on her personal cell phone. -Audio from videos and notification sounds from a messaging application was overheard. Interview at that time with CNA T about the above observation revealed: *She indicated that she had downloaded an application on her phone to answer and turn off call lights. -Her reason for doing that was because she had	F 550	**Update:** The correction will be completed on September 21, 2023, after the final All Staff meeting. The DON and Administrator will be actively monitoring the use of cell phone use daily during nursing hours and keep a log for 6 months to identify violations to the Cell Phone policy and bring the results to the QAPI committee. The DON will also address any cell phone violations immediately with that staff member	09/21/2023

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no radio or pager, and she was unsure where to have gotten one.
-She stated she had used her personal cell phone to message one of her coworkers about bringing "butt cream" for resident 17.
*She was a contracted travel CNA and had been at the facility for 13 weeks.
*When asked about the call light application and if other staff used it, she stated that she was unsure if other staff members had used the same application.

Interview on 8/24/23 at 9:56 a.m. with CNA P about how she communicated with staff revealed:
*She was primarily the bath aide, and she answered resident call lights on occasion.
*Staff used the radios to communicate with each other.
-At the beginning of a shift, each staff member was to obtain a radio and a pager to use for that shift.
-The equipment was in the employee charting room located behind the nurse's station.
*The pagers were used to have located an activated call light.
*It was the policy for staff not to have used a personal cell phone during working hours.
-Staff could have used their cell phones on their breaks, or in emergent circumstances.
*If she needed assistance from another staff member, they were to have used the provided radios.
*She confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 10:17 a.m. with CNA V about communication with other staff members revealed:
*Staff were to use the radios to communicate with

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each other.
*They were not allowed to use their personal cell phones during a shift, only on a break.
-They could have their cell phone with them, however.
*He confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 10:18 a.m. with activities assistant L about cell phone use and the provider's radios revealed she:
*Stated it was not appropriate for CNA T to have been using her personal cell phone while working with a resident.
*Confirmed they recently started using new radios earlier that week.
-CNA T had not known about the new radios.
*Confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 10:36 a.m. with licensed practical nurse R about communicating with other staff members revealed she:
*Expected staff to use the provider's radios to communicate with each other.
*Commented that it was not appropriate for CNA T to have used her cell phone to communicate with other staff members about a resident's care needs.
*Confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 10:44 a.m. with CNA N about communication with other staff members revealed:
*They were allowed to carry their cell phones with them while on duty.
*In "dire situations," it was acceptable for a staff member to use their cell phones, but using the

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radios was the preferred method of communication.
*She was the staffing coordinator.
-She confirmed that CNA T had not been on the schedule since the new radios were implemented.
*Usually there was a shift-to-shift report with updates about residents and any other pertinent information.
*She was unsure if CNA T had been informed of the new radios.
*She confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 10:59 a.m. with director of nursing (DON) B about staff communication expectations revealed:
*They recently started using new radios because the previous radios were outdated.
*She confirmed they had enough radios for each staff member on duty.
*When informed about CNA T using her cell phone while in a resident's room, she indicated that she was "disappointed."
-She recently had every staff member review and sign the cell phone use policy.
*She confirmed that it was not appropriate for CNA T to have been using her personal cell phone to watch videos, or to communicate with other staff members about a resident's care needs via a messaging application.
*She confirmed there was no cell phone application to answer or turn off call lights.

Interview on 8/24/23 at 1:17 p.m. with administrator A about staff communication expectations revealed:
*Cell phone use should have been limited to texting a provider or a manager.

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*Texting or calling from a cell phone was acceptable if the radios were not in reach of another staff member's radio.
-He tried to limit a staff member's cell phone use to work-related items only.
*His expectation was to not discuss a resident's identifying information over the radio.
*He stated the situation with CNA T's cell phone use was inappropriate.

Review of the provider's February 2020 "Usage of Cell Phones and Other Personal Electronic Communication Devices" policy revealed:
*Under the "Purpose" section:
-"1. To clarify the appropriate usage of cell phones and other personal communication devices by Winner Regional Healthcare Center employees."
-"3. To prevent the loss of productivity that results from frequent interruptions."
*Under the "Policy" section:
-"1. It is the policy of Winner Regional Healthcare Center that the use of cellular phones and other personal electronic communication devices including but not limited to Kindles, laptops, I-pads by employees is allowed only during designated breaks and only in the Employee Dining Room or outside the building."
--"Cellular phones and other personal communication devices are not to be used by employees in work areas unless authorized by the Department Manager."
-"2. Personal calls during working hours are strongly discouraged, regardless of phone used."
--"Cell phones are not to be carried on the job."
--"Cell phones are to be turned off, no vibration or low ring, before shift starts and as soon as breaks are over."
-"3. In the event of an emergency, employees

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F 550	Continued From page 6 may be contacted through the main switchboard." Review of the provider's undated document titled "The ABCs of Resident's Rights" revealed: *"Every resident has the right to the following:" -"Dignity, privacy, and respect. Every resident has the right to be treated with consideration and respect for personal dignity, including the right to privacy in their living arrangements, personal care, medical care, communications, visits, and meetings." -"Every resident has the right to exercise his or her rights without interference, coercion, discrimination, or punishment." -"Guard confidentiality. Every resident has the right to confidential treatment of his or her personal and medical records."	F 550		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584	**F584 Safe Environment** Residents who are unable to voice their preferences due to their impaired cognition, families will be asked during care conferences concerning the family's preference on the use of clothes protectors. The care plan will reflect the preferences by the families on the use of the clothes protectors. Cognitive intact residents will have the option of clothe protectors which will be in the center of the table or in the visitor dining room. If the resident would like a clothes protector, staff will assist the resident in obtaining one and placing it if the resident would like. The scheduled in-service training for September 13, 2023, and September 21, 2023. On September 18, 2023, the clothes protectors will be available in the center of the table for use if the resident so desires.	

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F 584	Continued From page 7 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review, the provider failed to provide a homelike experience in two of two dining rooms that had the potential to affect all residents. Findings include: 1. Observation on 8/22/23 at 11:49 a.m. in the special care unit dining room revealed that CNA W was placing clothing protectors on the residents without asking or explaining the process to the residents. 2. Observation on 8/22/23 at 12:12 p.m. in the main dining room revealed: *All residents, except one resident, were wearing clothing protectors. *Certified nursing assistant (CNA) V walked up to	F 584	Ongoing education will occur for new employees upon their job specific orientation. **Updated:** The correction to this occurred on September 18, 2023, and all clothe protectors have been placed in the middle of the table. The Social Worker will be monitoring this process during no fewer than 10 meals a week to ensure the process is being followed. This monitoring will be for a period of 6 months after which the 6 months monitoring, we will continue to monitor 10 meals a month for an additional 6 months. Violations will be discussed with employees immediately and the findings will be presented in our monthly QAPI meetings for a year starting in October of 2023.	**09/18/2023**

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the resident without a clothing protector on and asked if she wanted help putting it on.
*The resident explained she would use it if she needed to but had not wanted to put it on.

Observations on 8/23/23 at 11:20 a.m. revealed clothing protectors were setting on the dining room tables at each chair.

Observations on 8/23/23 at 11:20 a.m. revealed clothing protectors had been placed on the dining room tables at each chair.

Interview on 8/23/23 at 11:23 a.m. with dietary manager (DM) E revealed:
*She started two months ago as a new employee.
*Clothing protectors were routinely placed on the dining room tables before each meal.
*She would have liked to change the dining room appeal, including the use of clothing protectors for the residents.
*She felt the clothing protectors were not attractive.

Observation on 8/23/23 at 4:30 p.m. revealed the resident's clothing protectors were positioned on the dining room tables at each chair in the main dining room.

Interview on 8/23/23 at 5:30 p.m. with social worker (SW) H revealed:
*She had been employed as the provider's SW for 5 years.
*The clothing protectors were placed on the tables at each person's assigned seat prior to the residents arriving for the meal.
*There had been an attempt to remove the use of the clothing protectors a couple of years ago, but the "residents wanted them back."

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F 584	Continued From page 9 The provider was requested to provide a policy related to a homelike dining process. Review of the provider's policy, "Open Dining Within Long Term Care," date reviewed 03.2016, revealed: *Policy: "Residents will have choice related to what they are going to eat, when they are going to eat, and where and with whom they will be seated and served." *Procedure number 6: "When seating a Resident in the dining room, a staff member will first sanitize hands, then take their meal order, proceed to the serving line..." *There was no procedure regarding the use of the clothing protectors.	F 584		
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable.	F 655	**F655 Baseline Care Plan** An audit of all residents have/were admitted since July 1, 2023, for the Comprehensive Person-Centered Care Plan. Either the DON, Social Worker, or designee who will provide a written summary of the resident's baseline comprehensive care plan will conduct the audit. These care plans will be reviewed with the resident or POA. Until an ADON is hired, the Care Center Administrator will be responsible for ensuring that all residents have Comprehensive Care Plans within 48 hours of admission to the facility. Once the ADON is hired and on boarded this responsibility will return to DON to ensure Comprehensive Care Plans are occurring. Starting in November of 2023, Comprehensive Care Plans will be a QAPI project reported	

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F 655	Continued From page 10 §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the provider failed to ensure: *Three of six sampled residents recently admitted (29, 86, 136) had a baseline care plan established and reviewed with the resident, their representative, or their responsible family member. *One of six sampled residents recently admitted (33) had a baseline care plan established and reviewed within 48 hours of admission with the resident, their representative, or their responsible family member. Findings include: 1. Review of resident 29's electronic medical	F 655	**Update:** The correction of this item took place September 11, 2023, when we began reviewing the past due Baseline Care Plans. The DON will be responsible for ensuring all Baseline Care Plans are conducted within 48 hours of admission. The MDS company we have hired to assist us in MDS's will also be providing weekly reports on admitting of residence and the Baseline Care Plan. The administration will also be reviewing weekly the residents being admitted and will be admitted discussing the Baseline Care Plan to ensure they have been completed in addition to the audit by the MDS company. The DON will be responsible for reporting the findings to the QAPI Committee monthly for a period of 12 months beginning in October of 2023	**09/11/2023**

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F 655	Continued From page 11 record (EMR) revealed: *He was admitted on 6/13/23. *There was a "Baseline Care Plan" assessment from 6/13/23. -The only section that had been completed was the "Dietary / Nutritional Status." -The only staff person who had signed the assessment was the registered dietitian. Review of resident 86's EMR revealed: *She was admitted on 8/17/23. *There was no "Baseline Care Plan" assessment completed. *There was a care plan from a previous stay in February 2022, but there was no new care plan initiated since her readmission. Review of resident 136's EMR revealed: *She was admitted on 8/15/23. *There was no "Baseline Care Plan" assessment completed. *Her comprehensive care plan had been initiated on 8/18/23. Review of resident 33's EMR revealed: *She was admitted on 7/25/23. *There was a "Baseline Care Plan" assessment from 7/30/23. -There were no staff, resident, or resident representative signatures to indicate who had participated in developing the care plan. Interview on 8/23/23 at 2:08 p.m. with director of nursing (DON) B about the above baseline care plans revealed: *They used an assessment form for baseline care plans. *She confirmed there was no baseline care plan completed for residents 29, 86, or 136, and the	F 655		

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WINNER REGIONAL HEALTHCARE CENTER	805 E 8TH ST WINNER, SD 57580

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baseline care plan for resident 33 was completed late.
*She understood that the baseline care plans should have been completed and reviewed with the resident and their representative within 48 hours of a resident's admission.

Interview on 8/23/23 at 3:05 p.m. with social worker H about baseline care plans revealed:
*She had met with the administrator and the DON within the past two weeks and identified the issue with the baseline care plans and the comprehensive care plans.
*The previous Minimum Data Set (MDS) coordinator had been responsible for organizing the development of the care plans.
*It had been "several months" since the previous MDS coordinator had left.
-The current MDS coordinator worked remotely, and the responsibility for the care plans had fallen by the wayside.
-The nurses were to have been participating in the development of the care plans.
*Since the administrator and the DON were new to their positions within the past couple of months, she had been in "fight or flight mode" and care plans had not been prioritized.
*When residents were admitted to the facility, they would still sit down with the resident and their families to discuss the resident's goals and needs, however, those conversations had not been documented.

Review of the provider's February 2020 "Care Plans: Preliminary, Comprehensive and Reviews" policy revealed:
*Under the "POLICY" section:
-"1. Winner Regional Health LTC [long term care] shall assure each resident has a preliminary care

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F 655	Continued From page 13 plan developed at admission to address immediate care needs." *Under the "PROCEDURE for PRELIMINARY CARE PLAN AT ADMISSION" section: -"1. The interdisciplinary team reviews the attending physician's admission orders (e.g., diet, medications, treatment, etc.) and implemented a nursing care plan to meet the resident's immediate care needs." -"3. Preliminary care plans are used until the comprehensive care plan has been completed and address the following areas of care for the resident:" --"a. Problems - Any area of difficulty or concern that prevents the resident from reaching his/her fullest potential. Problems must be stated in behavioral and/or functional terms associated with the diagnoses or symptoms." --"b. Strengths - Any positive aspects of the resident's overall physical, social, emotional or spiritual functioning as it relates to the problem." --"c. Short/Long-term Goals - The desired outcome for the problem. Short/Long-term goals must be resident oriented, behaviorally stated, measurable, and include a time frame." --"d. Approach - The specific action(s) or intervention(s) that the staff will take to assist the resident in meeting/achieving the short/long-term goal(s)." --"e. Time Frame - The time limit assigned to meet each goal."	F 655		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657	**F657 Care Plan Conferences** The Care Center Administrator, DON, and Social Worker identified the lack of Care Conferences just prior to the survey. The team had developed a plan that would prioritize the Care Plan occurring each quarter.	

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F 657	Continued From page 14 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview, record review, observation, and policy review, the provider failed to: *Review and revise the care plans for 3 of 13 sampled residents (24, 27, and 29) whose care plans were reviewed. *Include the resident or the resident's representative in the care planning process for 3 of 10 sampled residents (2, 15, and 27) who were interviewed about participation in the care planning process. The findings include: 1. Interview on 8/22/23 at 11:05 a.m. with resident 2 revealed she had not been invited to a care	F 657	**F 657 Care Plan Conferences Cont.** All residents are divided into 3 groups to identify the month in that quarter in which the team will try to schedule a Care Plan Conference. The Social Worker will reach out the family to schedule a time for the Care Plan Conference towards the end of the month proceeding the month of the Care Plan Conference to schedule the day and time. A nursing designee will work with the off-site MDS Company to identify the residents who had changes in their health that would require a Care Plan Conference sooner than the scheduled quarterly conference. The Social Worker will track the monthly Care Plan Conferences to ensure that they are occurring at the appropriate time and report the findings to the QAPI Committee on the first month following the quarter. This QAPI project will last for 12 months from October 2023.	

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conference nor had talked with anyone about her care plan.

Review of the electronic medical record (EMR) for resident 2 revealed:
*Her admission date was on 11/17/21.
*The care conference summary appeared in the assessment list quarterly since 11/30/21.
*The assessment list for the care conference summary dated 11/10/22 displayed the status of "complete," but "attendance at meeting" had no checkmarks including the resident, and the only section completed was from dietary.
*Each of the care conference summaries dated 2/9/23, 5/4/23, and 6/1/23 displayed the status of "in progress."

Interview on 8/23/23 at 5:30 p.m. with social worker (SW) H revealed due to the absences of several director positions, including activities, dietary, and nursing, care plans had not been revised as needed and care conferences with the resident and/or family had not been held for quite some time.

Interview on 8/24/23 at 10:38 a.m. with director of nursing (DON) B revealed she:
*Started in the DON position less than two months ago.
*Had not had an opportunity to get involved with resident care planning.
*Was learning how to get into the EMR to view the care plans but had not yet learned how to enter care plan information.

2. Observations with resident 24 revealed:
*On 8/22/23 at 10:53 a.m. and at 3:09 p.m.:
-She was on her back in bed rubbing her arms up and down under a blanket.

Update: This was resolved September 11, 2023, as that is the date when WRH Long-Term Care started holding the Care Conferences. The scheduling coordinator is responsible for scheduling all the Care Conferences in coordination and the Social Worker will be responsible for reporting on a monthly basis to the Administrator the number of conferences held and the Social Worker will also report to the QAPI Committee monthly for 12 months on how the status of the Care Conferences.

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-The position of the bed was low to floor and a thick cushioned mat was on the floor beside the bed.
*On 8/23/23 at 3:41 p.m.:
-She was sitting up in a reclining wheelchair with her eyes closed and her arms and body covered with blanket.
-She was not arousable when her name was spoken.
-A hand splint was setting on the overbed table positioned on the left side of the resident.

Interview on 8/23/23 at 2:31 p.m. with DON B revealed resident 24 had not had a fall but the low bed and floor mat were implemented to prevent injury when she moved around in bed.

Interview on 8/23/23 at 4:40 p.m. with certified nursing assistant (CNA) U revealed:
*Resident 24 required total weight-bearing support of staff for bed mobility and transferring, and she did not move around in bed.
*Restorative staff were responsible for putting the hand splint on resident 24.

Review of resident 24's EMR revealed the care plan, last reviewed on 8/10/23, included the following focuses:
*Initiated on 5/25/21, monitor for seizures and injury related to seizure activity and at moderate risk for falls related to confusion, deconditioning, and gait/balance problems, with no interventions related to a low bed and floor mat beside the bed.
*Initiated on 3/2/22:
-Restorative range of motion (ROM) program, with interventions for the restorative nursing assistant (RNA) to "notify nurse if gentle ROM exercise causes [name] pain," and "skills training and practice 15-30 minutes per day."

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-"Restorative (splinting)" for a "hand cone to the left hand," with interventions for the RNA and CNA to "encourage her to participate in Range of Motion exercises," "Look for red areas when splint is removed," and "trim [name] nails regularly." Refer also to F688, finding 1.

Interview on 8/23/23 at 5:30 p.m. with SW H revealed she could not remember why the low bed and floor mat were put into place for resident 24.

3. Observation and interview on 8/22/23 at 10:17 a.m. with resident 27 revealed:
*Multiple deep dark purple bruises on both of her front forearms and hands.
*She would like to "walk more in the hallway," but when staff answer her call light, "some staff don't come back to walk with me."
*She thought staff talked with her daughter about her care plan, but it "would be nice" for them to meet with her, too.

Review of resident 27's EMR revealed:
*The most recent progress note "communication - with family" was dated 3/1/23.
*The 6/7/23 quarterly Minimum Data Set (MDS) assessment coded her brief interview mental status as a score of 12, which indicated no cognitive impairment.
*A health status note dated 7/24/23 indicated the resident returned from the hospital to the facility with the daughter.
*A nursing note dated 7/27/23 indicated the daughter was informed of an order for therapy.
*Four "Plan of Care" notes dated 8/2/23 by social worker H stated, "Care plan has been reviewed and remains appropriate."
*A "Care Conference Summary" dated 8/2/23 was

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noted as "In Progress." There were no checkmarks to indicate "Attendance At Meeting," including the resident and family,

Review of resident 27's care plan, last reviewed on 8/3/23, included:
*A focus of "at risk for unintentional injuries" related to a diagnosis of Parkinson's, but did not address interventions related to bruises. Refer also to F684, finding 1.
*Two focuses of "physical mobility impaired" related to weakness and Parkinson's Disease, but had not included interventions related to walking mobility. Refer also to F688, finding 2.

Interview on 8/23/23 at 6:09 p.m with DON B revealed she would contact the MDS contractor when there was new or changed information about a resident from the "24-hour report" so that the contractor could update the care plan.

4. Observation on 8/22/23 at 12:29 p.m. of resident 29 during lunch in the special care unit (SCU) revealed:
*When he was finished with his meal, he wheeled himself back to his room.
*There was a loud alarm-like beeping noise that came from his room.
*CNA W ran to his room and shut the door behind her.
*The beeping then stopped.

Observation on 8/22/23 at 5:14 p.m. in the SCU revealed that resident 29 had a pressure alarm affixed to his wheelchair.

Interview on 8/23/23 at 9:49 a.m. in the SCU with CNA N about pressure alarms revealed:
*Staff would put a pressure alarm on a resident's

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F 657	Continued From page 19 wheelchair, chair, or in the bed if a resident had no safety awareness or if the resident was "constantly trying to get up from their wheelchairs." *They would have gotten a physician's order prior to implementing the pressure alarm. *Generally, they would discontinue the pressure alarm "once a resident became less mobile." Interview on 8/23/23 at 3:11 p.m. with SW H about resident 29's pressure alarm revealed: *His physician ordered the "chair alarm" due to "his impulsivity and dementia." *He had not had any falls since implementing the pressure alarm. *She confirmed the pressure alarm had not been documented on his care plan. Review of resident 29's EMR revealed: *He was admitted on 6/13/23. *He experienced a fall on 6/20/23. *There was a signed physician's order for a "chair alarm" on 6/20/23. *His care plan had not been updated to include the use of a pressure alarm. Review of the provider's June 2023 "Bed and Chair Alarms" policy revealed: *The policy statement read, "Alarms will be utilized for residents based on their individual care plans." *The purpose statement had read, "Purpose: To provide guidelines for staff regarding the use of bed alarms and chair alarms." *Under the "Scope" section: -"Patients with confusion and dementia who may get out of a chair or bed without assistance." -"Patients who demonstrate a potential for falling."	F 657		

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F 657	Continued From page 20 -"Patients who have a history of falling." -"Patients that have scored moderate to high fall risk should be assessed for the need for alarm." 5. Interview on 8/22/23 at 2:53 p.m. with resident 15's father about communication with the provider revealed: *Staff used to call him about once per month to provide an update about his daughter, but that had since stopped *He was unable to visit the facility due to his physical limitations. *He relied on updates and phone calls from the provider due to his daughter's inability to communicate. *No staff from the facility had spoken with him in several months. The last time he remembered someone had called him about a medication change, and he had wondered if the change in medication had taken effect yet. *The staff had previously assisted resident 15 make a video call with him, but that was "a year or two ago now." Interview on 8/23/23 at 3:18 p.m. with SW H about communicating with a resident's family revealed: *The nursing department would call the family with medical updates. *Care conferences had not been prioritized in the past several months due to staffing shortages. -They had been in "fight or flight mode." *It was their policy to chart conversations with a resident's family or representative in the resident's EMR. Review of resident 15's EMR revealed: *The last time resident 15's father/power of attorney was contacted about his daughter was	F 657		

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on 3/9/23.
*On that day, social worker H had called him about the excess funds in resident 15's account and asked for consent to initiate a burial trust.

Review of resident 15's care plan revealed the interventions related to communication with family were as follows:
*"Notify family of changes to medication regime."
*"Provide instruction to resident and family about their rights and how to address concerns."
*"Discuss with resident/family concerns or feelings regarding communication difficulty."
*"Communicate with the resident/family/caregivers regarding residents capabilities and needs."
*"Discuss concerns about confusion, disease process, NH placement with resident/family/caregivers."
*"Educate the resident/family/caregivers regarding expectations of treatment, concerns with side effects and potential adverse effects, evaluation, maintenance."
*"During the facilities visitor limitations make sure resident has access to phone calls from family and visitors, can do electronic visits as desired and has one on one activities offered and supported by the activities department."

6. Review of the provider's February 2020 "Care Plans: Preliminary, Comprehensive and Reviews" policy revealed:
*Under the "Policy" section:
-"2. Following a comprehensive resident assessment, a comprehensive care plan shall be developed for each resident that includes measurable short term and long term goals and timetables to meet the resident's ongoing medical, nursing, activity, therapy and

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F 657	Continued From page 22 psychosocial needs." -"3. The comprehensive care plan is developed within seven (7) days of the completion of the resident assessment or within twenty-one (21) days after the resident's admission, whichever occurs first." -"4. Care plans shall be reviewed at least quarterly and with any change in the resident's condition." *Under the "Procedure for comprehensive care plan" section: -"1. An interdisciplinary team, in coordination with the resident and his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident." -"2. ...PointClickCare shall always have the most updated care plan for each resident." -"4. Care plans are revised as changes in the resident's condition dictates and reviewed at least quarterly." -"5. The comprehensive care plan is designed to:" --"a. Incorporate identified problem areas and associated risk factors;" --"d. Reflect treatment goals and objectives in measurable outcomes; and" --"e. Enhance the optimal functioning of the resident." -"6. The resident and family are encouraged to participate in the development of his/her care plan." *Under the "Procedure for Periodic Review of Care Plans" section: -"1. The Care Planning Committee/Team is responsible for keeping care plans on a current status and for periodic review and updating of care plans:" --"a. When there has been a significant change in the resident's condition;" --"b. When the resident is admitted to facility;"	F 657		

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F 657	Continued From page 23 --"c. 90, 180, 270, 360 days thereafter; and at least quarterly." -"2. A 'significant change' is a decline or improvement in a resident's status that:" --"c. Requires interdisciplinary review and/or revision of the care plan." -"3. Resident/family/legal representative is invited by phone or in person to attend care plan meetings." -"4. Clinical record reflects resident/family/legal representative participation with signature in clinical record plan or social progress note." -"6. A list of residents scheduled for care plan updates is published at the beginning of each month; meetings are limited to 90 minutes in length and are held on specific days/times of the week." -"7. All disciplines are encouraged to update their progress notes prior to care plan meetings."	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to assess injuries of unknown origin for one of seventeen sampled residents (27) screened for non-pressure related skin injuries. The findings	F 684	**684 Quality of Care** Skin observations will be conducted on all residents during each bath time. Nursing staff will document any wounds/bruises identified during the assessment or during any type of care. The findings of these assessments will be charted in the resident's chart. Audits to ensure that the skin assessments are occurring will be performed will be conducted weekly and results will be presented to the QAPI Committee starting in November 2023, and concluding January 2024.	

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F 684	Continued From page 24 include: 1. Observation and interview on 8/22/23 at 10:17 a.m. with resident 27 revealed: *Multiple deep dark purple bruises on both of her top forearms and the back of her hands. *She thought they had developed when she hit her arms and hands. *She then motioned with her left hand and arm towards her chair armrest and the overbed table that was positioned on the left side of her chair. *She said her bruises don't hurt and denied that they were the result of staff causing the bruises. Review of resident 27's electronic medical record (EMR) revealed documentation regarding the risk for or presence of bruises on her arms or hands were not found in: *All progress notes documented between 7/24/23 and 8/22/23. *The care plan focuses or interventions, last reviewed on 8/3/23, including a focus of "At risk for unintentional injuries" related to a diagnosis of Parkinson's. *Three separate skin observation assessments completed by nurses on 8/10/23, 8/14/23, and 8/17/23. Further review of resident 27's EMR revealed: *Diagnoses of Parkinson's Disease and unspecified atrial fibrillation (A-fib). *A consultant pharmacist review dated 8/17/23 noted she received aspirin 81 milligrams (mg) every morning, and "Based on discussions with family at time of diagnosis of A-fib, it was felt that risks > [were greater than] benefits of full anticoagulation due to her fall risk. Interview on 8/24/23 at 10:28 a.m. with director of	F 684	**Update:** *A complete skin assessment of resident 27 was completed and charted on September 18, 2023, by an RN and verified by the DON. The RN on duty will have performed a complete skin assessment on all residents by September 21, 2023, and the DON will verify the charting on the skin assessments are completed and addressed appropriately. The nurse on duty will complete a skin assessment on all residents during their first bath of the week and the DON conducts a weekly audit to ensure all residents skin assessments are completed and addressed. The DON will present the findings in the monthly QAPI meeting starting in October QAPI Meeting for a period of 12 months.*	***09/21/2023***

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F 684	Continued From page 25 nursing (DON) B revealed: *The presence of bruises should have been noted on the weekly skin observation assessments. *There had not been any risk management reports completed related to the bruises. *The DON had recently started doing "audits" of the skin observation assessments every week because they were not getting done. Review of the provider's "Incident Reporting Guidelines" policy, last reviewed 10.2021, revealed: *"Incidents of unusual nature, suspected abuse...or an accident that causes injury to a resident shall be recorded." *"The facility must have evidence that all alleged violations of abuse are thoroughly investigated..." *"Nurse's notes shall document the incident in sufficient details..." *"The following detail shall be recorded in the nurse's notes...b. Resident's physical condition identifying the presence/absence of swelling, bruises, lacerations, etc. [et cetera]." *"It may be appropriate to take photographs of bruises, abrasions, and lacerations as a legal protection for the nursing facility."	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of	F 688	***F688 Mobility*** WRH Long Term Care has a restorative CNA starting on October 2, 2023. The restorative CNA will work with the DON and therapy department regarding restorative care. The DON or designee will review with the restorative care CNA weekly the residents and their progress. The statistics of number of residents using restorative care will be taken to the monthly QAPI meeting for a period of 6 months starting November 2023.	

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F 688	Continued From page 26 motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to provide restorative nursing services for two of seventeen sampled residents (24, 27) reviewed for concerns related to limited range of motion and/or decreased mobility. The findings include: 1. Observations with resident 24 revealed: *On 8/22/23 at 10:53 a.m. and at 3:09 p.m., she was on her back in bed rubbing her arms up and down under a blanket. *On 8/23/23 at 3:41 p.m., she was sitting up in a reclining wheelchair with her eyes closed and her arms and body covered with a blanket. She was not arousable when her name was spoken. A hand splint was setting on the overbed table positioned on the left side of the resident. Interview on 8/23/23 at 4:40 p.m. with certified nursing assistant (CNA) U revealed: *Resident 24 required total weight-bearing support of staff for bed mobility and transferring. *Restorative staff were responsible for putting the hand splint on resident 24. Interview and observation on 8/24/23 at 8:14 a.m. revealed: *As CNA P slowly lifted Resident 24's fingers	F 688	**Updated:** On September 20, 2023, this issue will be corrected, as that is when a CNA will start for restorative care. This individual will be dedicated to restorative care full time and will work with the Therapy Department to ensure individuals identified by them are worked with and proper documentation is charted in the resident's chart. Resident 24 received a hand cone on September 19, 2023, and on September 12, 2023, the staff was educated that resident 27 is a walk to dine resident. Resident 27 has refused to walk to dine however, resident 27 has been walking in their room to the bed, restroom, and recliner with 1 assist since September 12, 2023, and has completed 7 out of 7 days. The DON will perform chart reviews to ensure restorative care is occurring on residents who are care planned for this care and report monthly for 6 months to the QAPI committee.	**09/20/2023**

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away from the palm of her contracted left hand, she flinched and moaned several times.
*The hand was clean and dry, but her nails were long and one had a broken jagged edge.
*CNA P reported she had bathed resident 24 yesterday and had placed a washcloth in the palm of her hand when she was done. The washcloth was not in place, and CNA P glanced around the room to see if it was laying somewhere.
*Two different styles of hand splints were on the overbed table next to the resident in the room.
*CNA P reported that the restorative staff would put those splints in place after the range of motion exercises.
*There had not been any restorative staff "for quite some time," but resident 24's contracted hand had "not gotten any worse."

Interview on 8/24/23 at 10:33 a.m. with director of nursing (DON) B revealed:
*A new restorative nurse was hired and would be start employment soon.
*There had not been any staff assigned to the restorative nursing program during the position vacancy.
*Nail care should have been done during the resident's bathing.

Review of resident 24's electronic medical record (EMR) revealed:
*The most recent "restorative program note" was dated 2/28/2022.
*The Minimum Data Set (MDS) assessments on 4/28/23 and 7/25/23 revealed :
-Resident 24 required extensive weight-bearing support of two persons for bed mobility and transferring.
-She had a functional limitation in range of motion

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(ROM) of upper and lower extremities on both sides of her body.
-No restorative minutes were recorded for ROM or splint/brace assistance.
*The care plan, last reviewed on 8/10/23, included the focuses of:
-Restorative ROM program, initiated on 3/2/22, with interventions for the restorative nursing assistant (RNA) to "notify nurse if gentle ROM exercise causes [name] pain," and "skills training and practice 15-30 minutes per day."
-"Restorative (splinting)" for a "hand cone to the left hand," with interventions for the RNA and CNA to "encourage her to participate in Range of Motion exercises," "Look for red areas when splint is removed," and "trim [name] nails regularly."
*There was "no data found" in the past 30 days since 8/23/23 for the restorative tasks of ROM and "Splint/Brace Assistance (Left Hand) Wear PRN [as needed] AM [morning] and PM [afternoon]."
*The bathing task was documented as completed on 8/23/23.

2. Observation and interview on 8/22/23 at 10:17 a.m. with resident 27 revealed she would have liked to "walk more in the hallway," but when staff answer her call light, "some staff don't come back to walk with me."

Review of resident 27's EMR revealed:
*The admission MDS assessment dated 7/28/23 coded her as:
-Needing one staff person to provide weight-bearing support when walking in her room or in the corridor.
-Believing she was capable of increased independence with activities of daily living. Direct

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care staff was coded as believing she was capable of increased independence.
*The care plan, last reviewed on 8/3/23, included two focuses of "physical mobility impaired" related to weakness and Parkinson's Disease, but there were no interventions related to the resident's walking mobility.
*There was "no data found" for the restorative walking task in the past 30 days since 8/23/23.
*The "walk in room" task was documented as completed 22 out of 30 days since 8/23/23.
*The "walk in corridor" task was documented as completed 19 out of 30 days since 8/23/23.

Interview on 8/24/23 at 10:33 a.m. with DON B revealed she was looking forward to starting a "walk to dine" program with the new restorative nurse.

3. Review of the provider's policy, "Restorative Nursing Policy," reviewed on 02.2020, revealed:
*"It is the policy of this facility that a resident is given the appropriate treatment and services to maintain or improve his or her abilities, as indicated by the resident's comprehensive assessment, to achieve and maintain the highest practicable outcome."
*The procedures included:
-"General restorative nursing care is that which does not require the use of a qualified professional therapist."
-"Nursing personnel are trained in restorative nursing care."
-"Restorative nursing care is performed according to the resident's functional assessment. Such a program includes, but is not limited to:"
--"Assisting residents with ambulation."
--"Assisting resident with their routine range of motion exercises."

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the provider failed to ensure the safety of one of one sampled resident (18) prior to pushing the resident in her wheelchair without placing foot pedals to elevate her feet off the floor, and that resulted in the resident falling out of the wheelchair and fracturing her left arm. Findings include: 1. Observation and interview on 8/22/23 at 10:25 a.m. with resident 18 revealed: *She had a cast on her left arm. *When asked about how she got the cast, she stated that she had fallen and broke her arm. *She winced in pain when moving her arm and stated it was quite painful at times. -She indicated she had just taken some pain medication and was waiting for it to start working. -The pain was manageable with the help of her pain medication. Interview on 8/24/23 at 10:35 a.m. with licensed practical nurse R about resident 18's fractured left arm revealed: *Resident 18 usually propelled herself throughout the building in her wheelchair. *She had not witnessed the fall, but she had	F 689	**F 689 Free of accidents** WRH Long Term Care Wheelchair Transports (8/22/2023) states that 1. Residents will have wheelchair bags for pedals to be placed into. 2. Occupational Therapy when assessing the individuals for appropriate wheelchair will also assess for correct wheelchair pedals. If individual is self-propelled, pedals will be placed in the pedal bag. 3. When patients are being transported via wheelchair, foot pedals must be in place and utilized. WRH Long Term Care is in the process of receiving the foot pedal bags and installing them on the residents' wheelchairs. An in-service for all staff will be held on September 13, 2023, and September 18, 2023. New employees will be trained concerning wheelchair pedals upon hire.	

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F 689	Continued From page 31 received a report of the incident. Interview on 8/24/23 at 10:47 a.m. with CNA N about resident 18's fall revealed she: *Was not working when the incident occurred. *Confirmed that after the fall, therapy was consulted. *Therapy recommended a certain style of foot pedals for the wheelchair resident 18 was using. Interview on 8/24/23 at 10:56 a.m. with director of nursing B about resident 18's incident revealed: *Resident 18 was usually independent with propelling herself in her wheelchair, and that was the reason she had not been assessed for the use of wheelchair foot pedals. *The fall happened on 8/12/23. *On that day, CNA S noticed that resident 18 was taking longer than usual to propel herself back to her room after the evening meal. -CNA S asked the resident if she wanted a "ride" back to her room. -There were no foot pedals available for the resident to rest her feet on. -Resident 18 lifted her legs up so they would not drag on the floor. -While CNA S was pushing the resident back to her room, resident 18 suddenly put her feet down. -Resident 18's feet were pulled underneath the wheelchair, and she fell face-forward out of her wheelchair to the floor. -She braced herself with her arms. *After the fall, the staff had completed the following: -Assessed her using the fall protocol. -Confirmed she was not experiencing pain. -Contacted the resident's physician and family members. -Initiated neurological checks per protocol.	F 689	**Update:** The corrective action for resident 18 occurred on August 13, 2023, and the involved employee was addressed on August 14, 2023, and at the huddle that day education was provided to the entire staff. All self-propelled residents had already been identified as self-propelled by therapy and the bags will be installed on the wheelchairs on September 21, 2023. The Administrator will monitor the use of pedals during mealtime travel to and from the dining hall at 7 meals a week for 1 month and then for 5 months the Administrator will monitor during the same timeframe for 10 meals a month. The results will be presented to QAPI monthly for a period of six months.	09/21/2023

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*Several hours after the fall, staff noted that resident 18's left hand and forearm were swollen, and she experienced pain upon movement.
-At that time, she was taken to the emergency room for assessment.
*X-rays confirmed she had broken her arm.
*DON B confirmed that prior to the incident, they had no policy regarding safety protocols when pushing a resident in a wheelchair.
*She had since created a wheelchair foot pedal policy.
*She ordered new bags to have been placed on the back of all wheelchairs to store the foot pedals when not in use.
*She re-educated all staff during the daily huddles about the new policy, and what procedures staff had to do prior to pushing a resident in a wheelchair.
*She had not documented who had attended the daily huddles to ensure each staff member was educated.
*She had not initiated any audits to ensure staff were compliant with the new policy.

Interview on 8/24/23 at 12:26 p.m. with DON B and social worker H about resident 18's incident revealed:
*Occupational therapists (OT) would recommend types of foot pedals for a resident's wheelchair.
*They confirmed resident 18 had not been assessed by OT prior to her accident because she had propelled herself independently in her wheelchair.
-The staff had not wanted to always leave the foot pedals on her wheelchair due to the risk of residents or staff tripping over them or causing damage to walls.
-They had no storage bags for all the resident's foot pedals but had ordered them for all the

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residents who used wheelchairs.
*When asked how they were monitoring for compliance that all the residents had foot pedals in place when being pushed, they stated that resident 18 was the only one they were monitoring.

Review of resident 18's electronic medical record revealed:
*Her care plan had not been updated to include the use of foot pedals while assisting the resident with locomotion in her wheelchair.
*Her most recent Brief Interview for Mental Status score was assessed at 4, indicative of severe cognitive impairment.
*A progress note from 8/12/23 read, "Per CNA assigned to resident, as resident was being pushed in wheelchair from supper, legs got caught under wheelchair and resident fell forward out of her chair. Abrasion to forehead and nose. VSS [vital signs stable], resident denied pain when asked. Neuro-checks initiated. MD [medical doctor] and DON notified. Attempted to contact POA [power of attorney] [name redacted] but no answer and voicemail full."
*A progress note from 8/13/23 at 3:36 a.m. read, "Resident has a edematous bruise on her L [left] hand at the middle finger."
*Another progress note from 8/13/23 at 11:42 a.m. read, "Resident with noted swelling to left wrist. Warm to to the touch and tender when palpated. Limited ROM [range of motion]. Call placed to on call provider in ER [emergency room] and resident sent over for X-ray."
*8/13/23 progress note from 2:07 p.m. read, "X-ray revealed closed fracture of distal end of left radius ..."
*There was a therapy note from 8/14/23 which read, "OT put pedals on [resident 18's] w/c

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[wheelchair] this morning as unable to find any in her room. Pedals should always be used when pushing any resident."
*Another therapy note from 8/18/23 read, "OT placed a calf board on resident's w/c due to recent fall incident as she is having more difficulty keeping her feet on the pedals and putting her feet on the ground when being pushed was the cause of her fall. Will monitor response. Resident was very receptive to this change as she has not been propelling her own w/c due to the cast on her arm."

Review of the provider's Department of Health "Required Healthcare Facility Event Reporting" revealed:
*In the final report and investigation submitted, the provider indicated that the DON "has educated [CNA S] and all staff regarding utilizing foot rests when transporting a resident."
-"Occupation Therapy added foot rests to [resident 18's] wheelchair ...[Resident 18] did not usually have foot rests on her wheelchair as she self propels herself often.
-"[Resident 18's] care plan did not address the foot pedals."
-"There was a not a policy in place regarding wheelchair foot pedals prior to this incident, there is now a new policy moving forward that all residents need to have foot pedals on their wheelchair if they are pushed."

Review of the provider's 8/22/23 "Wheelchair Transports" policy revealed:
*The policy had not addressed:
-The need for therapy to assess the resident for the type of foot pedal.
-The use of the foot pedal storage bags.
-The procedure for installing the foot pedals.

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F 689	Continued From page 35 -The procedure for ensuring resident safety prior to staff pushing the resident in a wheelchair. *The purpose of the policy was "to provide safe transports via wheelchair." *Under the "Equipment" section: -"1. Wheelchair" -"2. Footrest Pedals" *Under the "Procedure" section: -"1. When patients are being transported via wheelchair, foot pedals must be in place and utilized."	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the provider failed to prevent potential cross-contamination by improper glove use and hand hygiene when	F 812	**F 812 Food Procurement** An in-service will be held for food service workers the week of September 21, 2023, to educate staff on the proper use of gloves while preparing and handling of food. This in-service will be followed up by regular observations by our IP to ensure the proper use of gloves during the handling of food. Any findings will be brought to the attention of the DON and Dietary Manager to be addressed with the employee.	

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F 812	Continued From page 36 handling ready-to-eat foods by two of two employees (dietary manager E and dietary assistant K) during one of one meal service observation. 1. Observation on 8/23/23 from 5:13 p.m. to 5:46 p.m. of supper meal service revealed: * Dietary assistant K was serving supper. *She put on a pair of clean gloves. She wore the same pair of gloves throughout the entire supper observation. *Several times throughout the meal service, she would touch serving utensil handles, refrigerator door handles, product packing from the refrigerators, plates, cart handles, and other potentially soiled surfaces. -She also went back and forth between the kitchen and the serving area without performing hand hygiene or changing her gloves. -She would use those same potentially soiled gloves to touch slices of bread that was then served to residents. *At one point during the supper service, dietary manager (DM) E came to the serving area with gloves already donned, grabbed two slices of bread and a plate and went back to the kitchen. -With those same gloved hands, she touched a container of peanut butter, a refrigerator door handle, and a bottle of jelly. -Without changing those gloves or performing hand hygiene, she used a clean knife to prepare a peanut butter and jelly sandwich that was served to a resident. Interview on 8/23/23 at 5:46 p.m. with DM E about the above observations revealed she: *Initially thought that it was acceptable to touch ready-to-eat foods if that person was wearing gloves.	F 812	**Update:** Education for preparing and safe food handling employees E and K took place on September 8, 2023. The dietary manager has implemented a process so that utensils are available and used for all prepared food in the serving area. The Dietician/IP who is familiar with Procurement will be performing weekly checks on the food service line starting September 19, 2023, to ensure safe food handling practices are used. This report will be brought to the monthly QAPI committee starting in October 2023, for a period of 6 months. The Dietary Manager will also be training all new dietary workers concerning safe food handling when they are hired and will discuss safe food handling at each staff meeting for a period of 6 months meeting.	**09/08/2023 In-service held** **09/19/2023**

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 ______	08/24/2023

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 812	Continued From page 37 *Had not thought about the potential for cross-contamination due to touching multiple objects and surfaces prior to touching the food with those same gloved hands. *Agreed that she and dietary assistant K should have used a utensil to handle the bread.	F 812		

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435056	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 08/24/2023

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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E 000	Initial Comments 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 8/21/23 through 8/24/23. Winner Regional Healthcare Center was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 9/8/23

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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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
	435056	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**08/23/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINNER REGIONAL HEALTHCARE CENTER	**805 E 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) COMPLETION DATE
K 000	INITIAL COMMENTS A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 8/23/23. Winner Regional Healthcare Center was found in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: COO — (X6) DATE: 9/8/23

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.

SEP 13 2023
SD DOH-OLC

PRINTED: 09/06/2023
FORM APPROVED

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 ____	08/24/2023

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 000	Compliance/Noncompliance Statement A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 8/21/23 through 8/24/23. Winner Regional Healthcare Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement 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 8/21/23 through 8/24/23. Winner Regional Healthcare Center was found in compliance.	S 000		

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

TITLE CEO

(X6) DATE 9/8/23

STATE FORM 6899 E6BG11 If continuation sheet 1 of 1