

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435105	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/28/2024
NAME OF PROVIDER OR SUPPLIER Wheatcrest Hills Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 Vander Horck St Britton, SD 57430	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35121</p> <p>A. Based on South Dakota Department of Health (SD DOH) facility reported incident (FRI), record review, and interview the provider failed to follow the individualized care plan that reflected the removal of dentures for one of one sampled resident (1), who required evaluation and treatment at the emergency department. provide care as directed in the care plans for the following:</p> <p>Findings include:</p> <p>1. Review of the 3/2/24 SD DOH FRI involving resident 1 revealed:</p> <p>*He was observed making a whistling noise.</p> <p>*A small portion of his lower partial denture was visible in his mouth, and then was not visible.</p> <p>*The on-call provider was notified and orders were obtained to transfer him to the emergency department (ED) for evaluation.</p> <p>*The denture was removed in the ED and he returned to the facility.</p> <p>2. Further review of the provider's FRI investigation and interview with certified nursing assistant (CNA) A revealed:</p> <p>*She had not removed resident 1's dentures that evening.</p> <p>*She stated she was aware his dentures should have been removed, but she had forgotten to remove them.</p> <p>3. Review of resident 1's medical record revealed:</p> <p>*Was admitted on [DATE].</p> <p>*Had a diagnosis of Alzheimer's disease.</p> <p>*His care plan had been updated to include:</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 10/23/2023 the intervention the resident requires substantial assist by one staff with oral hygiene. Resident has dentures, staff to use denture adhesive provided by family to put dentures in for meals and take dentures out after meals. had been added to his care plan.</p> <p>-On 3/2/2024 the intervention Sign in room reminding staff to take dentures out after meals had been added to his care plan.</p> <p>4. Interview on 3/28/24 at 9:09 a.m. with the director of nursing (DON) B revealed she :</p> <p>*Expected all staff to follow each resident's individual care plan.</p> <p>*Confirmed the intervention to remove resident 1's dentures after meals was on his care plan prior to the incident on 3/2/2024.</p> <p>*Agreed CNA A had not followed resident 1's care plan.</p> <p>B. Based on interview, record review, and job description review revealed the provider failed to follow the individualized care plan for bathing for five of sixteen sampled residents (4, 5, 6, 7, and 8).</p> <p>Findings include:</p> <p>1. Interview on 3/27/24 at 4:20 p.m. with resident 4 revealed she:</p> <p>*Was scheduled to receive a bath weekly.</p> <p>*Stated she did not receive her bath one week, until two or three days later.</p> <p>2. Review of resident 4's bathing documentation revealed she was bathed on:</p> <p>*1/4/24 and did not get bathed again until 1/12/24, that was 8 days later.</p> <p>*2/16/24 and did not get bathed again until 2/27/24, that was 11 days later.</p> <p>*3/7/24 and did not get bathed again until 3/15/24, that was 8 days later.</p> <p>*There was no documentation of a sponge bath found.</p> <p>3. Review of resident 5's bathing documentation revealed:</p> <p>*She was bathed on 2/8/24 and did get bathed again until 2/16/24, that was 8 days later.</p> <p>*There was no documentation of a sponge bath found.</p> <p>4. Review of resident 6's bathing documentation revealed:</p> <p>*He was bathed on 2/12/24 and did not get bathed again until 2/28/24, that was 16 days later.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>*There was no documentation of a sponge bath found.</p> <p>5. Review of resident 7's bathing documentation revealed:</p> <p>*She was bathed on 2/12/14 and did not get bathed again until 2/28/24, that was 16 days later.</p> <p>*There was no documentation of a sponge bath found.</p> <p>6. Review of resident 8's bathing documentation revealed:</p> <p>*She was bathed on 2/12/24 and did not get bathed again until 2/29/24, that was 17 days later.</p> <p>*There was no documentation of a sponge bath found.</p> <p>7. Review of the care plans for residents 4, 5, 6, 7, and 8 revealed staff were to Provide sponge bath when a full bath or shower cannot be tolerated.</p> <p>8. Interview on 3/28/24 at 12:12 p.m. with DON B regarding bathing revealed she:</p> <p>*Stated there was no bathing policy.</p> <p>*Expected each resident to receive a weekly bath.</p> <p>*Stated staff were to try again or offer a sponge bath when a resident refused bathing.</p> <p>*Stated bathing was not monitored to ensure all residents received a weekly bath or a sponge bath.</p> <p>*Was not aware that some residents had gone more than seven days between bathing.</p> <p>*Stated residents who did not receive a scheduled bath should have been given a sponge bath.</p> <p>*Stated there was no documentation if sponge baths were given.</p> <p>9. Review of the provider's March 2012 CNA job description revealed a CNA:</p> <p>*Under general supervision performs a combination of following duties in caring for residents in the Center, consistent with the plan of care.</p> <p>*Provides assistance with bathing, dressing, toileting, and oral hygiene activities of daily living (ADLs).</p> <p>10. Review of the provider's January 2019 Baseline Plan of Care policy revealed it includes information regarding care and services sufficient to promote safe delivery of care.</p> <p>A comprehensive care plan policy was requested from the DON multiple times throughout the survey, but was not provided by the end of the survey.</p>		