STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A103	A. BUILDING _____ B. WING _____	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KADOKA NURSING HOME	605 MAPLE ST W KADOKA, SD 57543

(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
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 on 4/14/25. Kadoka Nursing Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiency identified at E004 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	E 000		
E 004 SS=C	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following:	E 004	The Chief Operating Officer reviewed the organizational flow chart on 4/15/2025. The Director of Nursing was updated to the new Director of Nursing within 6 months of role position. The administrator remains current. The Chief Operating Officer will monitor the organizational flow chart monthly for 3 months and report to the quality assurance process improvement team for further recommendations.	5/31/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maureen Cadwell
TITLE: CEO/Administrator
(X6) DATE: 05/08/2025

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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E 004	Continued From page 1 * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to update the emergency preparedness plan organizational flow chart for 2025. Findings include: Record review on 4/14/25 at 3:15 p.m. revealed no documentation that the provider's current emergency preparedness plan organizational flow chart had been updated. A former administrator and former nurse listed on the chart were no longer employed with the provider. Interview with the chief operating officer on 4/14/25 at 5:00 p.m. confirmed those findings.	E 004		

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	43A103	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/14/2025**

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KADOKA NURSING HOME	**605 MAPLE ST W** **KADOKA, SD 57543**

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K 000	INITIAL COMMENTS A recertification survey was conducted on 4/14/25 for compliance with 42 CFR 483.90 (a)&(b), requirements for Long Term Care facilities. Kadoka Nursing Home was found not in compliance. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K341 and K712 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 341 SS=C	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to maintain the fire alarm system	K 341	The fire alarm system was reviewed on 4/17/2025. The Chief Operating Officer contacted the contracting fire alarm system supplier on 4/17/2025. The dialer and automatic third party notification system is scheduled to be installed on 5/13/2025. The Chief Operating Officer or designee will monitor the operation of the dialer on the fire alarm system monthly for 3 months and report to the quality assurance process improvement team for further recommendations.	5/31/2025

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

Maureen Cadwell | CEO/Administrator | 05/08/2025

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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K 341	Continued From page 1 as required (no signal dialer and no monitoring of the fire alarm). Findings include: 1. Record review on 4/14/25 at 2:25 p.m. revealed there was an annual fire alarm inspection and testing performed on 1/27/25. There was no documentation the fire alarm signal was transmitted to a monitoring agency. The fire drill reports did not document that a signal had been received by a monitoring agency. The fire alarm panel did not have a dialer to transmit a signal to a monitoring location. 2. Interview with the plant operations supervisor at the time of the review confirmed that finding. He stated the fire alarm signal was not transmitted to any location. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency had the potential to affect 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11)	K 341		
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted	K 712	The Chief Operating Officer reviewed the monthly Fire Drill Policy on 4/28/2025. The Chief Operating Officer will educate the maintenance director and all staff on the monthly and quarterly fire drill process by 5/31/2025.	5/31/2025

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K 712	Continued From page 2 between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the provider failed to: *Conduct fire drills for a minimum of one per shift per quarter for April 2024 through March 2025 for all three shifts. A total of eleven fire drills were documented. No fire drills were held for the first shift during the first quarter (January, February, and March) of 2025. *Hold fire drills at varying times for each shift. *Document transmission of the fire alarm signal during the fire drills. Findings include: 1. Record review on 4/14/25 at 4:15 p.m. revealed the nursing home had three scheduled staff shifts: First shift: from 6:00 a.m. to 2:30 p.m.; Second shift: from 2:00 p.m. to 10:30 p.m.; Third shift: from 10:00 p.m. to 6:30 a.m. The fire drills held for April 2024 through March 2025 were documented as follows: *4/1/24: 10:00 a.m. *5/8/24: 3:10 p.m. *6/13/24: 11:30 p.m. *7/9/24: silent, 1:00 a.m. *8/8/24: 9:20 a.m. *9/17/24: 4:30 p.m. *10/22/24: 10:30 a.m. *11/21/24: silent, 12:45 a.m. *12/9/24: 4:15 p.m. *2/27/25: silent, 1:00 a.m. *3/24/25: 2:45 p.m. 2. Interview with the plant operations supervisor	K 712	Continued from previous page The Chief Operating Officer or designee will monitor the monthly fire drill process and operation x 3 months then quarterly x 3 months and report to quality assurance process improvement for further recommendations.	5/31/2025

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K 712	Continued From page 3 on 4/14/25 at 4:45 p.m. confirmed those findings. The deficiency had the potential to affect 100% of the building occupants.	K 712		