

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

PRINTED: 12/17/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435120</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - <b>MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/04/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>PIONEER MEMORIAL NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070</b>
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(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
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K 000	INITIAL COMMENTS  Stories: 1 Construction type: Type III(200) Constructed: 1968, 1976, 1977 K0180: Fully Sprinkled  Certified Beds: 52 Census: 49	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain fire barriers as required.  Findings include:  On 12/04/13 one of two leaves of the double doors in the fire barrier in the long wing separating the assisted living from the long term care would not latch when closed. Fire doors are required to be maintained.  Ref: 2000 NFPA 101 Section 19.1.2.1(2), 8.2.3.2.3.1  On 12/04/13 conduit penetrations in the fire barrier were not sealed as required at the Villa	K 011	On 12/5/2013 a broken spring on the latching hardware was replaced so that the fire barrier doors latch when closed. All latching fire barrier doors will be added to the monthly preventive maintenance schedule to monitor for proper closure.	1/16/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Thomas R. Kuba, Chief Executive Officer</i>	TITLE  Chief Executive Officer	(X6) DATE  12/26/2013
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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 011	Continued From page 1 living room. In consort with the Director of Maintenance, this fire barrier was identified as the separation between the senior living area and the health care occupancy as the fire barrier near the laboratory was not equipped with the required fire doors.  Ref. 2000 NFPA 101 Section 19.1.2.1(2), 8.2.3.2.3.1  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to maintain fire barriers as required increases the risk of death or injury due to fire.  The deficiency affected two of three fire barriers on the first floor.	K 011	On 12/12/2013 all penetrations in the fire barrier separation between the senior living and the health care occupancy was patched with fire caulk. Any future penetrations through fire barrier walls by facility staff or independent contractors will be inspected to assure penetrations are properly sealed. The Maintenance Director will be responsible for the plan of correction.		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018			

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K 018	Continued From page 2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain corridor doors as required.  Findings include:  On 12/04/13 the corridor door to the visitor dining room was equipped with a roller latch. CMS as the authority having jurisdiction does not consider roller latches as an acceptable device to keep corridor doors closed as required.  On 12/04/13 the corridor door to CSR#2 was found not to latch as required.  On 12/04/13, the corridor double doors to the arbor room did not latch as required.  Ref: 2000 NFPA 101 Section 19.3.6.3.2  On 12/04/2013, the Dutch door to CSR#1 room did not have a rabbit, bevel or astragal as required.  Ref: 2000 NFPA 101 Section 19.3.6.3.6  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to maintain corridor doors as required increases the risk of death or injury due to fire.  The deficiency affected three of numerous corridor doors in the building.	K 018	On 12/10/2013 the roller latch to the visitor dining room was replaced with latching hardware. The corridor door to CSR#2 already has a door closure with latching hardware and a keypad. In a telephone call on 12/20/2013 the CMS Life Safety Engineer acknowledged this door was confused with the door cited in K029. During a telephone call on 12/20/2013 with the CMS Life Safety Engineer it was discovered the double doors to the Arbor room is required to swing in the direction of egress. A Time-limited Waiver request will be submitted to determine a plan of correction and arrange for a contractor to order the materials and complete the necessary work. On 12/12/2013 a strip of metal was fastened on both sides of the Dutch door going into CSR#1. The Director of Maintenance will be responsible for completion of the plan of correction.	1/31/2014

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K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas as required.</p> <p>Findings include:</p> <p>On 12/04/13, the door to the oxygen storage room was found to not be self-closing as required. Oxygen storage rooms are considered a hazardous area. Doors to hazardous areas are required to be self-closing.</p> <p>On 12/04/13, the door to the dietary storage room was found to have a kick down device on the corridor door. The storage area is considered a hazardous area. Doors to hazardous areas are required to be self-closing or automatic closing. The kick down prevents self-closing and as such is not permitted.</p> <p>On 12/04/13, a friction hold open device was installed to hold the door open to CSR#2. Doors to hazardous areas are required to be self-closing</p>	K 029	<p>Self-closing hardware will be installed on the oxygen storage room door. On 12/4/2013 the kick down device was removed from the dietary storage room door. On 12/11/2013 the friction hold open device was removed from the CSR#2 door and latching hardware was installed. The Director of maintenance will be responsible for completion of the plan of correction.</p>	1/16/2014

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K 029	Continued From page 4 or automatic closing. The friction hold open prevents self-closing and as such is not permitted.  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to maintain hazardous areas as required increases the risk of death or injury due to fire.  The deficiency affected three of numerous doors in the building.  Ref: 2000 NFPA 101 Section 19.3.2.1	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress as required.  Findings include:  On 12/04/13, doors through the means of egress from the short wing were locked with keypad controlled magnetic locks at the cross corridor doors leading to the Alzheimer ' s unit and at two exit doors from the Alzheimer ' s unit. These locked doors were in the means of egress from the non-clinical needs (not Alzheimer ' s) areas.	K 038	An office at the end of the short wing will be taken out of service and converted into an exit. Plans for the exit will be submitted to the South Dakota Department of Health for approval and Life Safety Code review. A Time-Limited Waiver will be requested to allow time for plan development, approval and completion. The Director of maintenance will be responsible for the plan of correction.	2/28/2014

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K 038	Continued From page 5 Locks are required to be operable without the use of a keys, tools, special knowledge or effort from the egress side. A latch or other fastening device on a door shall be provided with a releasing device having an obvious method of operation and that is readily operated under all lighting conditions. The keypad controlled magnetic locks failed to meet these requirements.  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to maintain the means of egress as required increases the risk of death or injury due to fire.  The deficiency affected one of four smoke compartments.  Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1, 7.2.1.5.4, 19.2.2.2.4	K 038		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency lighting as required.  Findings include:  On 12/04/13, the emergency generator supply power for emergency lighting did not to have the required emergency stop station located outside of the room housing the prime mover or located	K 046		

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K 046	<p>Continued From page 6</p> <p>elsewhere on the premises where the prime mover is located outside the building as required.</p> <p>Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 3-5.5.6</p> <p>On 12/04/13 the required battery operated lights at the emergency power transfer switch and outside of the medical records area did not light when the test button was depressed. Required equipment for code compliance is required to be maintained. In addition, there was no record of this light being tested monthly or annually as required.</p> <p>Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3, 4.6.12.1; 1999 NFPA 110 5-3.1</p> <p>Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3</p> <p>The Maintenance Supervisor acknowledged the finding when the deficiency was identified.</p> <p>Failure to provide emergency lighting as required increases the risk of death or injury due to fire.</p> <p>The deficiency affected two of numerous components in the emergency lighting system.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>SS=D</p> <p>There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have a fire plan as required.</p>	K 046	<p>An emergency stop station will be installed outside of the room housing the prime mover. A Time-Limited Waiver request will be submitted for a constructor to install the emergency stop station.</p> <p>On 12/5/2013 the battery was replaced in the battery operated light at the emergency power transfer switch and the light has been added to the monthly preventative maintenance schedule. The battery operated light outside medical records was tested and found to be working. The light will be tested weekly and then monthly as part of the preventive maintenance schedule. A Quality Improvement audit will be completed quarterly and reported to the Quality Improvement Committee for one year. The Director of Maintenance will be responsible for the plan of correction.</p>
K 048		K 048	1/31/2014

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K 048	Continued From page 7  Findings include:  On 12/04/13 the fire plan did not have the required provision for evacuation of smoke compartment.  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to have a fire plan as required increases the risk of death or injury due to fire.  The deficiency affected one of eight required provisions in a fire plan.  Ref: 2000 NFPA 101 Section 19.7.1.1, 19.7.2.2	K 048	The fire plan will be revised to include instructions on evacuation of the smoke compartment. The Safety Officer will be responsible for implementation of the plan of correction.	1/16/2014
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conduct fire drills as required  Findings include:	K 050		

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K 050	Continued From page 8 On 12/04/2013, fire drills records for the past year were found to indicate that the time condition was not varied. Fire drills are required to be conducted under varied conditions. The last four fire drills for the 7-3 shift were conducted at 10:30, 9:30, 10:30, and 10:45. Fire drills for the Pioneer shift were conducted at 6:15, 6:30, 6:00 and 5:45.  The Maintenance Technician acknowledged the finding when the deficiency was identified.  Failure to conduct fire drills as required increases the risk of death or injury due to fire.  The deficiency affected one of numerous conditions that could be varied.  Ref: 2000 NFPA 101 Section 19.7.1.2	K 050	Fire Alarms will be held at varied time conditions with fire drills held at least three hours apart from the previously held drill on any particular shift. A Quality Improvement audit will be completed quarterly and reported to the Quality Improvement Committee for one year. The Director of Maintenance will be responsible for implementation of the plan of correction.	1/16/2014
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4,	K 051		

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K 051	Continued From page 9 9.6  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test the fire alarm system as required.  Findings include:  On 12/04/13 the records indicated that required semiannual tamper switches tests had only been conducted once in the past year on 5/21/13. Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 Table 7-3.2 item 15.1.  On 12/04/13 the records indicated that required semiannual battery load voltage tests had only been conducted once in the past year on 5/21/13. Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 table 7-3.2 item 6.d.3.  The Director of Maintenance acknowledged the finding when the deficiency was identified.  Failure to test the fire alarm system as required increases the risk of death or injury due to fire.  The deficiency affected 2 of numerous required tests.	K 051	A test of the tamper switches and battery load voltage will be conducted and the preventive maintenance schedule will be revised to require tamper switch and battery load voltage tests semi-annually instead of annually. A semi-annual audit for testing of the tamper switches and battery load voltage will be completed and reported through the Performance Improvement Committee for one year. The Director of Maintenance will be responsible for implementation of the plan of correction.	1/16/2014

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K 051	Continued From page 10 Ref. 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-3.4.3	K 051		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install automatic fire sprinklers as required.  Findings include:  On 12/04/13 sprinklers were not provided in the following areas/ rooms in a building otherwise equipped with automatic fire sprinklers: First Floor: <ul style="list-style-type: none"> <li>· X ray</li> <li>· DON office</li> <li>· OR</li> <li>· CSR</li> <li>· Electric Room</li> <li>· Endoscopy</li> </ul>	K 056		

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NAME OF PROVIDER OR SUPPLIER  <b>PIONEER MEMORIAL NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>315 NORTH WASHINGTON ST POST OFFICE BOX 368 VIBORG, SD 57070</b>	
(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 056	<p>Continued From page 11</p> <p>O2 manifold Basement: Unconcealed pipe chase</p> <p>As of August 13, 2013 all long term care providers are required to be in buildings equipped with automatic sprinkler systems in accordance with 1999 NFPA 13. The areas without sprinklers are required to be equipped with automatic fire sprinklers.</p> <p>Ref: 42 CFR Part 483; 1999 NFPA 13 Section 5-1.1(1)</p> <p>On 12/04/13 combustible materials were found in the unsprinkled concealed noncombustible crawl space. Storage of materials in an unsprinklered concealed noncombustible crawl space is not permitted.</p> <p>Ref: 2000 NFPA 101 Section 19.3.5.3, 9.7.1.1; 1999 NFPA 13 Section 5-13.1.1 exception 10</p> <p>On 12/04/13, the alarm test connection did not terminate in an orifice giving a flow equivalent to one sprinkler of the smallest orifice in the installation.</p> <p>Ref: 2000 NFPA 101 Section 19.3.5.3, 9.7.1.1; 1999 NFPA 13 Section 5-15.4.2</p> <p>The Director of Maintenance acknowledged the finding when the deficiency was identified.</p> <p>Failure to install automatic sprinklers as required increases the risk of death or injury due to fire.</p> <p>The deficiency affected nine of numerous areas requiring sprinkler protection and one of</p>	K 056	<p>A sprinkler system with exposed piping attached to the walls will be installed in the following areas: x-ray, Director of Nursing office, operating room, central sterile processing, electric room, endoscopy, oxygen manifold and in the unconcealed pipe chase in the basement. A Time-Limited Waiver request is being requested to have a plan of correction approved by the South Dakota Department of Health and for a contractor to install the sprinkler system. On 12/16/2013 all combustible materials were removed from the concealed crawl space.</p> <p>A sprinkler head will be installed so that the alarm test connection will terminate with an orifice with a flow equivalent to one sprinkler of the smallest orifice. A Time-Limited Waiver is requested so work can be completed the same time the sprinkler system installation is completed.</p>	1/31/2014

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435120	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING: _____		(X3) DATE SURVEY COMPLETED  12/04/2013
NAME OF PROVIDER OR SUPPLIER  PIONEER MEMORIAL NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 315 NORTH WASHINGTON ST POST OFFICE BOX 388 VIBORG, SD 57070		
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K 056	Continued From page 12 numerous components of the sprinkler system.	K 056		