

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

ORIGINAL

PRINTED: 05/12/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2014
NAME OF PROVIDER OR SUPPLIER TEKAKWITHA NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Surveyor: 26180 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 4/29/14 through 4/30/14. Tekakwitha Nursing Center was found not in compliance with the following requirements: F221, F323, F332, F371, F425, F431, and F441.	F 000	addendums noted with an asterisk per w/initial telephone to facility DON F221 CS/SDOH/HMF	5/30/14
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, record review, interview, and policy review, the provider failed to ensure side rail assessments had been completed for five of five sampled residents (1, 3, 4, 10, and 11) who had side rails on their beds. Findings include: 1a. Observation on 4/29/14 at 1:30 p.m. revealed resident 1 laying on his bed with two side rails up on the top half of his bed. Review of resident 1's medical record revealed: *No assessment had been completed for the use of the side rail *There was no physician's order for the side rails. *The side rails had not been care planned. Surveyor: 34030 Preceptor: 18560	F 221	On 5/22/2014, All Staff were in-serviced on the proper assessing of restraints. MDS Nurse will do an assessment at admission and quarterly thereafter. A restraint assessment was done on resident #1, 3, 4, 10, and 11. There will be a standing order to use top side rails for mobility upon admission and if determined they are a restraint, then will be assessed per restraint protocol. The comprehensive care plan and policy were updated. IDT will evaluate each resident utilizing *side rails or physical restraints on their quarterly Resident Assessment. The DON will monitor the medical record of all new admissions to ensure completion of restraint assessments for ninety days and results brought to the QA meetings quarterly.	

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

TITLE

(X6) DATE

[Signature]

[Signature]

5/27/14

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 45 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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If continuation sheet Page of 20
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F 221	<p>Continued From page 1</p> <p>b. Random observations on 4/29/14 and 4/30/14 from 7:30 a.m. to 6:30 p.m. revealed one side rail up on the top half of resident 3's bed.</p> <p>Review of resident 3's entire medical record revealed: *No assessment had been completed for the use of the side rail. *There was no physician's order for the side rail. *The side rail had not been care planned.</p> <p>c. Random observations on 4/29/14 and 4/30/14 from 7:30 a.m. to 6:30 p.m. revealed two side rails up on the top half of resident 10's bed.</p> <p>Review of resident 10's entire medical record revealed: *No assessment had been completed for the use of the side rails. *There were no physician's orders for the side rails. *The side rails had not been care planned. Surveyor: 32331</p> <p>d. Observation on 4/30/14 at 9:35 a.m. of resident 11 revealed she was laying on her bed with two quarter side rails up on the top half of her bed.</p> <p>Review of resident 11's medical record revealed: *No assessment had been completed for the use of the side rails. *There were no physician's order for the side rails. *The side rails had not been documented on the care plan.</p> <p>e. Observation on 4/30/14 at 9:45 a.m. of resident 4 revealed she was laying on her bed with two quarter side rails up on the top half of her bed.</p>	F 221			

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F 221	Continued From page 2 Review of resident 4's medical record revealed: *No assessment had been completed for the use of the side rails. *There were no physician's order for the side rails. *The side rails had not been documented on the care plan. f. Interview on 4/30/14 at 11:00 a.m. with the director of nursing regarding side rails on resident beds revealed: *Side rails were not being assessed "unless they were full side rails." *No assessments were being done on quarter or half rails. *She was not aware all side rails needed to be assessed. Review of the provider's December 2002 Restraints-Physical policy revealed: *Physical restraints were defined as: -Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body. -Resident could not remove easily. -Restricted freedom of movement or normal access on one's body. *Each resident was to have been assessed for the appropriateness of any type of physical restraint, including half side rails, on admission and at least quarterly throughout their stay.	F 221	F 323 All staff were in-serviced on May 22, 2014, of the importance of recognizing safety practices. We will update the policy to identify safety issues throughout facility. On May 21, 2014 the Maintenance Technician removed the shower bench frame from the wall and on May 28, 2014 a contractor will be here to repair the fiberglass shower stall. The Maintenance Department will check each nurse station daily (Monday – Friday) for maintenance request forms filled out. The Administrator will monitor completion of the maintenance requests monthly for 90 days. Additionally, the Safety Committee will do a safety walk through quarterly to identify safety issues. <i>*The administrator will report to the QA committee quarterly. (S/05/04/14)MF</i>	6/6/14
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	<p>Continued From page 3 prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 A. Based on observation and interview, the provider failed to ensure safety for all residents who took showers from potential accident hazards in one of two shower rooms (east). Findings include:</p> <p>1. Observation on 4/29/14 at 4:40 p.m. in the east shower room revealed: *A shower stall that contained a wall mounted fold-down shower bench that was not securely mounted to the fiberglass wall. *One of two hinges was loose. *The hinge attached to the fiberglass was starting to split from the wall in approximately a quarter-sized piece. -It was cracked in three other locations around the hinge. *The shower bench seat cover was separated from the bench frame along the sides.</p> <p>Interview on 4/29/14 at the above time and location with certified nursing assistant I revealed residents took showers in the east shower room.</p> <p>Observation and interview on 4/29/14 at 5:00 p.m. with the administrator in the east shower room regarding the shower bench revealed he: *Agreed the bench was a potential accident hazard. *Agreed the bench could come off the wall if a resident was:</p>	F 323		

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F 323	<p>Continued From page 4</p> <p>-Seated on the bench and could cause the resident to fall and receive an injury. *Stated the bench was not to be used in its current condition. *Stated the shower bench had deteriorated due to water exposure.</p> <p>Interview on 4/29/14 at 6:00 p.m. with the administrator regarding the shower bench in the east shower room revealed he had: *Removed the bench from the frame. *Informed staff not to use that shower area until further notice.</p> <p>Interview on 4/30/14 at 1:50 p.m. with the director of nursing revealed there was no policy on maintenance of the shower bench.</p> <p>B. Based on observation and interview, the provider failed to maintain an environment free from potential accident hazards in one of one resident area (activity room) involving a stove located in that area. Findings include:</p> <p>1. Observation on 4/29/30 at 12:13 p.m. in the activity room revealed: *A stove's shut off switch had not been turned off. *The indicator light on the stove's front panel became red when this surveyor turned the dials to the high setting, and each burner had become hot to the touch. *A typed sign was taped to the front of the stove below the dials with the following: "Remember to shut off the Circuit Breaker after use!!!!!"</p> <p>Interview on 4/29/14 at 12:35 p.m. with the activity director regarding the stove revealed: *The activity room was available to residents at all times.</p>	F 323		

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F 323	<p>Continued From page 5</p> <p>*It was not a locked area.</p> <p>*The stove's shut off switch was to have been turned off when not in use and not attended by staff.</p> <p>*The shut off switch was located in the basement.</p> <p>*The activity department had last used the stove for a baking activity in October 2013.</p> <p>*The therapy department used the stove with residents to train on stove safety prior to discharge.</p> <p>*She agreed it could have been a hazard to residents and/or visitors if the burners had been turned on and had not been monitored by staff.</p> <p>Interview and observation on 4/29/14 at 1:45 p.m. with the activity director in the basement regarding the stove revealed:</p> <p>*The stove's shut off switch was located inside a gray panel box attached to the wall.</p> <p>*The shut off switch was in the off position.</p> <p>*The shut off switch with the word "OFF" was barely visible and had been rubbed off.</p> <p>*She agreed that it would be difficult to know if the shut off switch was off unless it was double checked.</p> <p>*She confirmed it was now in the off position as it had been checked by the administrator.</p> <p>Interview on 4/29/14 at 3:45 p.m. with the maintenance director regarding the stove in the activity room revealed:</p> <p>*He had not been routinely checking the stove to ensure if it was off.</p> <p>*He agreed it could have been a hazard to residents and/or visitors if the burners had been turned on and had not been monitored by staff.</p> <p>Interview on 4/30/14 at 8:20 a.m. with occupational therapist E regarding the stove</p>	F 323			

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F 323	Continued From page 6 revealed: *The shut off switch was to have been put in the off position when it was unattended by staff. *It was used by the therapy departments for educating residents on safety with turning the stove off and on when working with meal preparation goals prior to discharge. *She was aware there was a switch in the basement to shut off the stove. *Her occupational therapy assistant was the staff person that used the stove with residents. Interview on 4/30/14 at 1:00 p.m. with certified occupational therapy assistant F regarding the stove revealed: *She had not used the stove with a resident for over three months. *She was aware there was a switch in the basement to shut off the stove. *She agreed the shut off switch needed to have been turned off. *She agreed it could have been a hazard to residents and/or visitors if the burners had been turned on and had not been monitored by staff. Interview on 4/30/14 at 3:40 p.m. with the activity director revealed the provider had no policy on the stove.	F 323	The stove will be shut off by breaker when not in use. A new policy will be written for use of stove. A log sheet will be placed beside the stove. It will need to be signed as the stove is turned "on" and "off". Also, the activity department will do five times a week monitoring-signature in the book that stove was checked in the morning. The Activity Department will present stove checklist to Administrator monthly. The checklist will be reviewed by the Administrator the first month and then quarterly. Administrator will report the results to the QA Meeting each quarter.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by:	F 332			

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F 332	<p>Continued From page 7 Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to ensure a less than 5 percent (%) medication error rate for 2 of 28 resident's (7 and 15)observed medication administrations. Findings include:</p> <p>1. Observation and interview on 4/29/14 at 3:36 p.m. with licensed practical nurse (LPN) A for the administration of Systane eye drops (an eye lubricant) to both eyes for resident 7 revealed: *She had given two drops in the left eye and three drops in the right eye. *The physician's order was prescribed for one drop to be administered to both eyes twice daily. *She stated she "sometimes squeezes the applicator bottle too hard" and administered more than the one prescribed drop to each eye. *She agreed the above was a medication administration error.</p> <p>2. Observation on 4/29/14 at 4:10 p.m. and interview at 5:30 p.m. with registered nurse (RN) B regarding the administration of resident 15's Omeprazole (medicine to reduce acid in the stomach) revealed: *The prescribed physician's order was Omeprazole 20 milligrams (mg) one tablet twice daily, thirty minutes to one hour before meals. *She had administered Omeprazole 20 mg at 4:10 p.m. to resident 15. *Resident 15 had yet to receive her dinner tray at 5:30 p.m. *RN B agreed it had not been administered within the prescribed time frame.</p> <p>Review of the provider's undated Medication Administration Guideline's revealed: **Medications are to be administered within sixty</p>	F 332		

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F 332	Continued From page 8 minutes of scheduled time, except before or after meals, which are administered precisely as ordered." **Medications are administered in accordance with the written order."	F 332	F 332 The nursing department was in-serviced on May 6, 2014 on the medication administration policy and procedure. The areas discussed included proper dosage and proper administration time. The medication checklist was created and will be used to do medication audits on each nurse and medication aide over the next 30 days by Director of Nursing and randomly by Pharmacy Consultant A. The checklists results will be trended and shared at QA Meeting quarterly for 90 days.	5/30/14
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Surveyor: 18560 Based on observation, interview, and policy review, the provider failed to ensure food temperatures were appropriately obtained and documented prior to meal service for two of two meal service observations. Findings include: 1. Observation on 4/29/14 at 10:55 a.m. of cook G revealed she jammed different thermometers through the tinfoil covering the pans of food. She went from one food item to the next to take the food temperatures. The tinfoil had not been a clean surface. She had not sanitized the thermometers between food items to prevent cross-contamination. Observation on 4/29/14 at 4:45 p.m. of cook H	F 371	* Medication error reports were completed on residents 7 and 15. * by the Director of Nurses CSKDDDH/MF	

** medication error reports completed on residents 7 and 15. CSKDDDH/MF*

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F 371	Continued From page 9 revealed she had not taken the temperatures of the food items. She stated she normally had not taken the food temperatures, because "it's hot coming out of the oven." She confirmed she had not been regularly recording the food temperatures. Interview on 4/30/14 at 10:30 a.m. with the certified dietary manager confirmed thermometers should not have gone through the tinfoil. The thermometers should have been sanitized between each food item. She further agreed food temperatures needed to be taken and documented for each meal served. Review of the provider's Maintaining Proper Food Temperature policy dated 2000 revealed food temperatures would be taken and recorded for all hot and cold items at all meals.	F 371	F371 The Dietary Staff were in-serviced on May 23, 2014 about using proper technique to monitor and record food temperatures. The policy and procedures were revised. The temperature log is on the reach-in refrigerator. The cooks have been shown the proper way of lifting the tinfoil to get temperature, using an alcohol swab to clean thermometer after each temp is taken. CDM will observe five meal services per week for four weeks. After four weeks, each cook will be observed two times monthly by the CDM for correct food temping.	6/18/14
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425	Audits will be reviewed by Dietary Manager and the findings from the audits will be brought to the Quality Assurance Committee monthly for three months.	

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F 425	<p>Continued From page 10 on all aspects of the provision of pharmacy services in the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, record review, and policy review, the provider failed to ensure expired insulin was discarded and not administered after the expiration date for three of three observed insulin vials (resident 18 and two unidentified residents). Findings include:</p> <p>1. Medication administration observation on 4/29/14 at 11:25 a.m. in the east dining room of registered nurse (RN) D regarding resident 18 revealed: *She had pulled the resident into the large bathroom next to the dining area and administered insulin in his right arm. *RN D had drawn up the insulin at the nurses station prior to the medication observation.</p> <p>Observation and interview with RN B on 4/30/14 at 10:15 a.m. regarding insulin stored in the drug cabinet at the east nurses station for residents 16, 17, and 18 revealed: *Three Novolin R insulin vials for the above residents in the cabinet had opened dates listed as 3/16/14, 3/21/14 and 3/24/14. *No expiration dates were written on the label by staff. *The insulin vials were expired on 4/13/14, 4/18/14, and 4/21/14. *RN B stated the above insulin had currently been administered to the above residents for whom it</p>	F 425		

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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
F 425	Continued From page 11 had been prescribed. Interview with the director of nursing (DON) on 4/30/14 at 10:30 a.m. regarding the above expired insulin vials revealed: *It had been her expectation that insulin would be discarded after twenty-eight days of being opened. *She stated nursing staff should not have administered the expired medication. *She agreed that was a medication administration error. Phone interview on 4/30/14 at 3:00 p.m. with pharmacy supervisor K regarding the above mentioned insulin vials revealed: *Manufacturer's guidelines were explicit in discarding opened vials of insulin after twenty-eight days of use. *The sterility (absence of germs) could not be guaranteed after that time. *Her expectation was nursing staff should have written the expiration dates on the bottles once opened and discarded them on the appropriate date.	F 425	<i>*The outdated insulin for resident 116, 17 and 18 was disposed of by the nurses at the time of the finding.</i> F425 The nursing department was in-serviced on May 6, 2014 on making sure medications are checked for expiration dates prior to administration. Omnicare provided an insulin chart that shows the guidelines on all insulin types and outdates. The overnight nurse will check for outdated medications three times a week prior to reordering medications. The insulin will be checked by each nurse prior to each medication administration. Director of Nursing and Pharmacy consultant will audit medication administration of each nurse over next 30 days. The results will be reviewed by Director of Nursing and concerns will be brought to the QA meeting quarterly until QA committee advises to discontinue.	6/18/14
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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F 431	<p>Continued From page 12</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on observation, interview, and policy review, the provider failed to have a system for accounting for as needed (PRN) narcotic (used to treat pain) medication stored in two of two medication carts.</p> <p>1. Observation and interview on 4/30/14 at 1:20 p.m. with licensed practical nurse (LPN) A regarding the north nurses station medication cart revealed: *Various narcotic PRN medication blister packs (individual pills would be in a plastic pop out on a</p>	F 431		

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F 431	<p>Continued From page 13</p> <p>card) were stored in the medication cart. *PRN medications in the cart included but were not limited to: -Hydrocodone (narcotic pain reliever). -Ativan (an anti-anxiety medication). -Alprazolam (an anti-anxiety medication). -Clonazepam (an anti-anxiety medication) -Robitussin with Codeine (narcotic cough syrup) *She could not verify how much PRN narcotic medication was to have been in the facility for individual resident use. *She stated nurses documented on the medication administration record (MAR) when they gave the PRN narcotic medication *The provider would have no way of knowing if it had been missing or how much should have remained.</p> <p>Interview on 4/30/14 at 1:30 p.m. with the director of nursing (DON) regarding the PRN narcotic medication stored in the above medication cart revealed: *She stated they had been advised by their pharmacy they did not have to account for narcotic as needed medication dispensed or stored in the facility. *Although they had drug diversion (theft of drugs) in the past she stated they had no problems at the current time. "We would notice it (the narcotic medication) missing eventually." *There had been no system in place for accurate accounting of PRN narcotic medications.</p> <p>2. Observation and interview on 4/30/14 at 2:00 p.m. with registered nurse (RN) C regarding the east nurses station medication cart revealed: *Various narcotic PRN medication blister packs were stored in the medication cart. *PRN medications in the cart included but were</p>	F 431		

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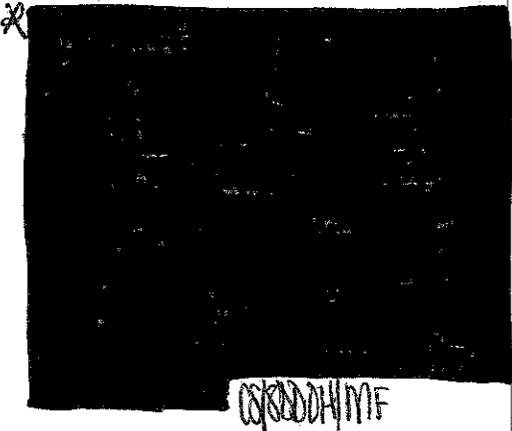
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F 431	Continued From page 14 not limited to: -Hydrocodone (narcotic pain reliever). -Ativan (an anti-anxiety medication). -Alprazolam (an anti-anxiety medication). -Clonazepam (an anti-anxiety medication). -Robitussin with Codeine (narcotic cough syrup) *She could not verify how much PRN narcotic medication was to be in the facility for individual resident use. *She also stated nurses documented on the medication administration record (MAR) when they gave the PRN narcotic medication. They would have no way of knowing if it had been missing or how much should have remained. Review of the provider's January 2005 Omnicare Controlled Substances policy revealed: *Controlled substances ordered by the physician shall be dispensed in easily accountable quantities. *Information to record includes date of receipt, name and strength of medication, and quantity.	F 431	F-431 The nursing department was in-serviced by Consultant Pharmacist on May 6, 2014, "Best Practices in Preventing Drug Diversion." A new policy was written and reviewed with nurses. Upon receipt C3, C4, and C5 substances, a narcotic record will be completed with (name, Medication, prescription #, Pharmacy name, amount received and date received). Each PRN card for controlled substances will be dated when received. On MAR listed "Amount remaining" and doing a count with every dose given. A running count will be on the MAR for all controlled PRN drugs. All discrepancy will be immediately reported to the Director of Nursing. Director of Nursing will reconcile counts from MAR and card monthly. The reconciling audit will be brought to Pharmacy Consultant. All concerns will be shared with QA Committee quarterly.	6/6/14
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

CSISADDHIME

*by the Director of Nurses
CSISADDHIME*

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F 441	<p>Continued From page 15</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, product information review, manufactures' recommendation review, and policy review, the provider failed to ensure appropriate sanitary practices were followed for: *One of one whirlpool tub and chair disinfection between residents use in the east hall shower room. *One of one laundry room separating clean linen from dirty laundry. Findings include:</p>	F 441		

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F 441	<p>Continued From page 17 between residents. *Stated the product was to have been left on the interior of the tub for at least one minute. *Scrubbed the interior of the tub with a hand brush that had been located on the wall next to the tub. *Rinsed the interior of the tub with a hand-held hose after she turned a dial to "Rinse" which were located inside the cabinet on the back of the tub. *Turned on the jets on the whirlpool tub during the rinse. *Stated she would have disinfected the shower chair by spraying it with the Hepacide Quat II and leaving the disinfectant on the chair for one minute. *Would have then rinsed the chair with water.</p> <p>c. Record review of the provider's posted procedure in the shower room on the east hall for disinfecting the whirlpool tub revealed: **Remove the 'Disinfecting Wand' from the cabinet. *Turn the 'Disinfecting Valve' to 'Disinfect'. *Spray the interior of the tub. You may use a brush or sponge to clean the walls of the tub. *Turn off the disinfecting system by turning the 'Disinfecting Valve' to off. *Let the disinfecting solution remain on the surface of the tub for the recommended bacteria killing time given by on the Rane disinfectant solution you are using. See the distributor for product information. *Turn 'Disinfecting Valve' to rinse. Turn on Air Spa while rinsing to blow disinfectant out of jets. When finished turn the 'Disinfecting Valve' to the off position. Recoil the hose back into the cylinder container. Lock the 'Disinfecting Cabinet' door. Turn off Air Spa."</p>	F 441	<p>Both clean linen carts in the path of dirty linen will be removed. The bedmaking cart will be relocated to the clean laundry folding area and the other cart will be eliminated. Administrator will audit linen cart location weekly for 90 days to assure prevention of cross contamination of clean linen doesn't happen. The compliance will be monitored in the quarterly departmental infection control audit. Any concerns of noncompliance will be presented to monthly Infection Control Committee and quarterly to the QA Committee* by the Administrator. CS/SDDH/MF</p>	

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F 441	<p>Continued From page 18</p> <p>Interview on 4/30/14 at 12:50 p.m. with a customer service representative of the Rane Bathing System regarding the Rane Neutral Lemon Disinfectant Spray contact time revealed the contact time was to have been ten minutes.</p> <p>Review of product label information of the Hepacide Quat II Disinfectant Cleaner revealed a contact time of "Leave surfaces wet for 10 minutes."</p> <p>Observation and interview on 4/30/14 at 1:50 p.m. with the director of nursing (DON) regarding the cleaning of the whirlpool tub and chair revealed: *The contact time for the disinfectant products needed to have been for ten minutes. *The manufacturer's instructions for disinfecting the whirlpool tub and chair between residents' baths had not been followed.</p> <p>Review of the provider's undated Disinfection of the Shower-Tubs revealed: *The tub was to have been properly disinfected after use. *Manufacturer's instructions for whirlpools and tubs were to have been followed.</p> <p>2. Observation and interview on 4/30/14 at 8:25 a.m. with the laundry supervisor in the laundry room revealed: *Two washing machines were located in close proximity to two uncovered clean linen carts that contained the following clean items: -Towels. -Soaker pads (used on resident beds for absorption of bodily fluids). -Bed linen. -Aprons.</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>-Gowns.</p> <p>*She agreed there was no barrier between the dirty laundry that went into the washing machines and the clean linen carts.</p> <p>*She agreed there was a possibility of cross-contamination between the dirty laundry and the clean linen located on the uncovered carts in the current location.</p> <p>*She confirmed the linen carts should be moved to an area in the laundry room that was located away from the dirty laundry area.</p> <p>Interview on 4/30/14 at 1:50 p.m. with the DON revealed she agreed there needed to be a separation between dirty laundry and clean linen in the laundry area.</p> <p>Review of the provider's 2010 Handling Clean Linen policy revealed the purpose was to have provided clean, fresh linen to each resident and to have prevented contamination of the clean linen.</p>	F 441			

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 4/29/14. Tekakwitha Nursing Center was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2000 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 4/30/14 upon correction of the deficiencies identified below. Please mark an "F" in the completion date column for those deficiencies identified as meeting the FSES to indicate the provider's intent to correct the deficiencies identified at K038, K062, and K074 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and record review, the	K 033		F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE <i>Administrator</i>	(X6) DATE 5/27/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disposable 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 disposable 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.

MAY 28 2014
If continuation sheet Page 1 of 7
SD DOH L&C

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K 033	Continued From page 1 provider failed to maintain a one hour fire rated protected path of egress from a stair enclosure to the exterior of the building for three randomly observed stairways (north, basement, and second floor). Findings include: 1. Observation at 10:45 a.m. on 4/29/14 revealed the north stairway from the basement discharged into a main level vestibule. The vestibule was not separated by a one hour fire resistive construction. Further observation at 11:15 a.m. revealed the basement and second floor stairways to the pre-school areas discharged into the main level corridor system. Review of previous survey data indicated that condition was part of the original construction. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 033		
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: Surveyor: 18087 Based on observation and interview, the provider failed to ensure exits were readily accessible at all times. Two randomly observed doors (family room and kitchen) were provided with double-action latching hardware. Findings	K 038	K038 The doors on the family room and (2) doors exiting the kitchen to dock were replaced with a "classroom" style door handset. The Maintenance Department will do a walk through to identify all double-action locksets that need to be replaced and will replace them. The report from the walk through will be reviewed by the Administrator after the first month and then quarterly. Administrator will report the results to the Quality Council each quarter.	6/18/14

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K 038	Continued From page 2 include: 1. Observation and interview beginning at 11:00 a.m. on 4/29/14 revealed the door for the family room and the west door from the kitchen were provided with double-action hardware. The double-action hardware would impede opening the doors in a fire emergency. Interview with the administrator at 3:30 p.m. on 4/29/14 revealed the double-action latching hardware would be replaced as soon as possible with the appropriate single-action hardware.	K 038		
K 040 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and record review, the provider failed to maintain clear door widths of at least 32 inches for one randomly observed set of exit access doors (double-door number 7). Findings include: 1. Observation at 1:15 p.m. on 4/29/14 revealed the leaves for double-door number 7 between the stairwell and the corridor were only 30 inches wide. They did not provide a clear opening width of 32 inches. Review of the previous survey report confirmed the doors were part of the original construction. The building meets the FSES. Please mark an	K 040		F

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K 040	Continued From page 3	K 040		
K 062 SS=D	<p>"F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to verify the required maintenance of the sprinkler system (backflow preventer, 5 year internal inspection, and hydraulic information signage) had been performed. Findings include:</p> <p>1. Review of the provider's sprinkler maintenance records on 4/29/14 revealed no documentation the required annual testing of the backflow preventer had been performed. Interview with the administrator at 3:00 p.m. on 4/29/14 revealed that testing was not on the services agreement proposed by the sprinkler inspection contractor.</p> <p>2. Review of the provider's sprinkler maintenance records on 4/29/14 revealed no documentation the required 5 year internal obstruction inspection of the sprinkler system had been performed. Interview with the administrator at 3:00 p.m. on 4/29/14 revealed that testing was not on the services agreement proposed by the sprinkler inspection contractor.</p>	K 062	<p>K062</p> <p>The Sprinkler Inspection Company has been contacted and the work order has been signed and returned to include the backflow preventer inspection, 5 – year internal inspection and a hydraulic information signage in the June 2014 inspection.</p> <p>The Maintenance Tech will follow the inspection vendor around to assure the above inspections are done. These inspections will be added to the Maintenance Tech's schedule as a reminder to get these done when needed. The noncompliance will be reported to the Quality Council quarterly until advised to discontinue.</p>	6/18/14

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

PRINTED: 05/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2014
NAME OF PROVIDER OR SUPPLIER TEKAKWITHA NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
(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 062	Continued From page 4 3. Observation at 2:30 p.m. on 4/29/14 revealed no hard sign with the sprinkler system hydraulic design information at the sprinkler riser. Interview with the maintenance supervisor at the time of the observation confirmed that finding. The deficiencies affected multiple components of the building's automatic fire sprinkler system required annual maintenance. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7	K 062		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Surveyor: 18087	K 074	K074 The curtains will be replaced within the next 9 months, in the interim, we will spray them with a fire retardant spray. The Maintenance Tech and Administrator did a walk through on May 22, 2014 and found other curtains that aren't flame resistant and will spray them with a flame retardant spray.. Our findings will be replaced and presented to the Safety Committee. The Safety Committee will do a quarterly walk. The Safety Committee will give the Administrator a copy of the monthly walk through and the Administrator will report the non-compliance findings to the Quality Assurance Committee each quarter.	6/18/14

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K 074	Continued From page 5 Based on observation and interview, the provider failed to verify the required flame resistant qualities of draperies and curtains in the dining room. Findings include: 1. Observation at 1:30 p.m. on 4/29/14 of draperies and curtains in the dining room revealed no factory installed tags stating the items were flame resistant in accordance with National Fire Protection Association (NFPA) 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. Interview with the maintenance supervisor at the time of the observation revealed the draperies and curtains had not been treated with an approved fire retardant material. The deficiency affected a single component of the building's required criteria regarding furnishings, bedding, and decorations. Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1	K 074		
K 130 SS=C	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation, measurement, and interview, the provider failed to maintain exit and exit access, so a dead-end corridor did not exceed thirty feet. Findings include: 1. Observation and measurement at 2:30 p.m. on 4/29/14 of the south corridor from the south,	K.130		F

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K 130	Continued From page 6 east-west corridor to resident rooms 207, 208, 209, and 210 was not provided with an exit. The dead-end corridor measured seventy-two feet in length. Interview with the director of maintenance at the time of the observation revealed during a remodel of that area the exterior door had been removed. The building meets the FSES. Please mark an "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 130		

SOUTH DAKOTA DEPARTMENT OF HEALTH

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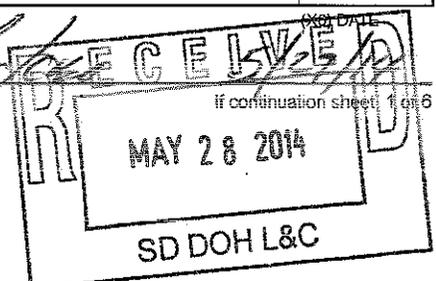
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S 000	Initial Comments Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 4/29/14 through 4/30/14. Tekakwitha Nursing Center was found not in compliance with the following requirements: S210, S236, S376, and S398.	S 000	<i>Addendums noted with an asterisk per 6/1/14 telephone to facility DON. CSKDDOH/ME</i>	
S 210	44:04:04:06 EMPLOYEE HEALTH PROGRAM The facility must have an employee health program for the protection of the...residents. All personnel must be evaluated by a licensed health professional for freedom from reportable communicable disease which poses a threat to others before assignment to duties or within 14 days after employment including an assessment of previous vaccinations and tuberculin skin tests. The facility may not allow anyone with a communicable disease, during the period of communicability, to work in a capacity that would allow spread of the disease. Personnel absent from duty because of a reportable communicable disease which may endanger the health of...residents and fellow employees may not return to duty until they are determined by a physician or the physician's designee to no longer have the disease in a communicable stage. This Rule is not met as evidenced by: Surveyor: 26180 Based on review of employee health files and interview, the provider failed to ensure three of five new employees (L, M, and N) were evaluated by a health professional for freedom from communicable diseases. Findings include:	S 210	S210 A pre-employment health statement is included with the job application. The employee (L,M,N) have been signed and placed in their respective employee file. The employee and the D.O.N. or his designee will check and sign the statement indicating they are free of communicable diseases. Human Resources will check all employee files to assure the statement is in each new employees health file now and ongoing indefinitely. Human Resources will inform Administrator of any files missing pre-employment statements. The Administrator will present findings to the Quality Assurance Committee for six months.	6/1/14

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

TITLE

(X6) DATE



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S 210	Continued From Page 1 1. Review of employee L's personnel file revealed her date of hire was 12/17/13. Her employee health statement regarding freedom from communicable diseases had not been evaluated by a health professional. 2. Review of employee M's personnel file revealed his date of hire was 10/17/13. His employee health statement regarding freedom from communicable diseases had not been evaluated by a health professional. 3. Review of employee N's personnel file revealed her date of hire was 11/22/13. His employee health statement regarding freedom from communicable diseases had not been evaluated by a health professional. 4. Interview on 4/30/14 at 1:15 p.m. with the human resources director revealed: *She was unfamiliar with that requirement. *She acknowledged their employee health statement required a health professional review and signed document. -That had not been done on those three employees. *She was unable to find a policy regarding that procedure.	S 210	<i>* All residents have been reviewed to ensure compliance with the TB policy.</i> S236 CS/SDDCH/MEF A chest x-ray and exam is scheduled for 5-28-14 for resident 9. Past history reveals completion of INH therapy in 1996. The TB policy was reviewed with the admission nurses. The MDS/admission nurse will review the resident's medical history upon admission to determine status of diseases and ensure that a 2 Step TB is given when indicated or a chest x-ray and exam is completed to verify no active disease. Health Information will audit all new admission records for completion of TB requirements. Any discrepancies will be reported to the DON immediately. TB audits will be shared with Infection Control Committee and QA quarterly.	6/1/14
S 236	44:04:04:08.01 TUBERCULIN SCREENING REQUIREMENTS Tuberculin screening requirements for healthcare workers or residents are as follows: (1) Each new healthcare worker or resident shall receive the two-step method of Mantoux skin test to establish a baseline within 14 days of	S 236		

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S 236	<p>Continued From Page 2</p> <p>employment or admission to a facility. Any two documented Mantoux skin tests completed within a 12 month period prior to the date of admission or employment shall be considered a two-step. Skin testing is not necessary if documentation is provided of a previous positive reaction of ten mm induration or greater. Any new healthcare worker or resident who has a newly recognized positive reaction to the skin test shall have a medical evaluation and a chest X-ray to determine the presence or absence of the active disease;</p> <p>This Rule is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and policy review, the provider failed to ensure one of two recently admitted residents (9) received a chest x-ray who had a history of a positive Tuberculin (a contagious respiratory disease) test and active cough. Findings include:</p> <p>1. Record review of resident 9's medical record revealed: *He was readmitted to the facility in February 2014. *His history and physical assessment revealed active coughing prior to admission to the facility. *Nurses Notes revealed he had a positive (PPD) tuberculosis screening test on 3/29/96. *He had been given a Mantoux (tuberculin screening test) in the hospital prior to discharge and before admission to the facility.</p> <p>Interview on 4/30/14 at 1:30 p.m. with the director of nursing (DON) and registered nurse (RN) B regarding resident 9 revealed: *No chest x-ray had been performed. *It had been her expectation a chest x-ray would be performed on any resident with a history of a</p>	S 236		

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S 236	Continued From Page 3 positive PPD upon entry into the facility. *RN B stated she had not notified the provider of the existing positive PPD and had not requested a chest x-ray. Review of the provider's December 2002 Admission of Resident policy revealed newly admitted residents would receive a two-step Mantoux unless they had previously tested positive skin test. At that time, nursing staff would then "Obtain M.D. (medical doctor) order for chest x-ray."	S 236		
S 376	44:04:13:16 Fire Extinguisher Equipment Fire extinguisher equipment must be installed and maintained by the following minimum standards: (1) Portable fire extinguishers must have a minimum rating of 2-A:10-B:C; (2) Fire extinguisher equipment must be inspected monthly and maintained yearly; (3) Approved fire extinguisher cabinets must be provided throughout the building with one cabinet for each 3000 square feet (278.7 square meters) of floor space or fraction thereof. The fire resistance rating of corridor walls must be maintained at recessed fire extinguisher cabinets. The glazing in doors of the fire extinguisher cabinets must be wire glass or other safety glazing material. Fire extinguisher cabinets must be identified with a sign mounted perpendicular to the wall surface above the cabinet; and (4) Halon chemical extinguishers may be installed and used only in those remote areas that do not present a hazard to staff...or residents. This Rule is not met as evidenced by:	S 376	S376 Maintenance Tech and Administrator did walk-through and found 15 recessed cabinets. The Maintenance department will identify the 15 recessed cabinets and place a sign mounted perpendicular above the fire extinguisher. The Safety Committee will double check the signage on the monthly walk through for 90 days. The Administrator will report the findings to the Quality Council Committee.	6/18/14

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S 376	Continued From Page 4 Surveyor: 18087 Based on observation and interview, the provider failed to mark the locations for one randomly observed fire extinguisher mounted in a recessed wall cabinet in the corridor (by room 107). Findings include: 1. Random observation at 10:45 a.m. on 4/29/14 revealed the location of one fire extinguisher located in a recessed cabinet in the corridor wall (by room 107). It was not marked with a sign mounted perpendicular to the wall surface above the cabinet. Interview with the maintenance supervisor at the time of the observation confirmed that finding.	S 376		
S 398	44:04:13:35 Vacuum Breakers Antisiphon devices or backflow preventers must be installed on hose bibs and on all fixtures to which hoses or tubing can be attached such as laboratory and janitors' sinks, bedpan flushing attachments, handheld showers...Antisiphon devices or backflow preventers must be installed on all plumbing and equipment where any possibility exists for contamination of the potable water supply. This Rule is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to install vacuum breakers on the hand-held hoses at the showers in two of two shower rooms (by door 7 and by the east entrance). Findings include: 1. Observation beginning at 9:00 a.m. through 10:30 a.m. on 4/29/14 revealed the three hand-held hoses in the shower room by door 7	S 398	S398 The vacuum breakers will be installed on the North and East Wing Shower hoses. The Maintenance department will do an audit of all plumbing to assure there is no contamination from any water sources in the facility. Will monitor all new water sources repaired or replaced and install vacuum breakers in the line. The Safety Committee will check these on the monthly walk through for three months and then quarterly thereafter and will give the report to the Administrator. The Administrator will report the findings to the Quality Council Committee.	6/18/14

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S 398	Continued From Page 5 and the hand-held hose in the shower room by the east entrance were not equipped with vacuum breakers. Interview with the maintenance supervisor at the time of the observations confirmed those conditions.	S 398		