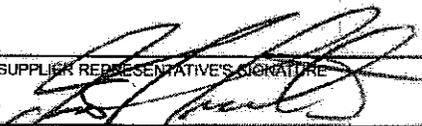


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435038</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/22/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>TEKAKWITHA NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>6 E CHESTNUT SISSETON, SD 57262</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 000	INITIAL COMMENTS  Stories: 1 Construction type: Type V (111) Constructed: 1959, 1979 addition K0180: Fully Sprinkled  Certified Beds: 62 Capacity: 62 Census: 55	K 000		
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to mark the means of egress as required.  Findings include:  On 5/22/14 two doors that lead to a patio were not marked with " No Exit " signs as required. The doors were likely to be mistaken for an exit as they led to the exterior of the building from a corridor and had glass windows viewed the the outside. The doors did not lead to an exit discharge.	K 022	Our walkthrough identified, five doors needing "No Exit" signs. The signs are ordered and will be applied to the doors. The safety committee will identify any doors in quarterly walkthroughs and will apply signage where needed. All concerns found by safety committee will be addressed at the quarterly Quality Assurance meeting.	7/10/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:  TITLE: Administrator/CEO (X6) DATE: June 19, 2014

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 022	Continued From page 1  The maintenance man acknowledged the finding when the deficiency was identified.  Failure to mark the means of egress as required increases the risk of death or injury due to fire.  The deficiency affected one of five smoke compartments.	K 022			
K 029 SS=D	Ref: 2000 NFPA 101 Section 19.2.10.1, 7.10.8.1 NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain hazardous areas as required.  Findings include:  On 5/22/14 the six doors that served the kitchen storage room were not self-closing as required.  On 5/22/14 the storage room in the basement	K 029	Identified six doors that need self-closers installed around the kitchen. Self-Closers are ordered and will be installed when received. The fire doors in basement will reapply the hardware. Safety Committee will do the quarterly walk through in June and identify any additional doors that require smoke resisting doors and others requiring self-closers on non-rated doors. Findings will be shared with Quality Assurance Committee and any concerns will be relayed to the respective departments.	7/11/14	

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K 029	Continued From page 2 adjacent to the elevators was being used as a storage room and did not have self-closing doors as required.  Storage rooms that exceed 50 sf in size and contain combustible materials are considered hazardous areas. Doors to hazardous areas are required to be self-closing.  The maintenance man 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 one of five smoke compartments.  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 5/22/14 the north entry door was found to be secured with a magnetic lock that released when	K 038	Aberdeen House of Glass is coming to facility on 7/20/14 to assess the needs of the 30 second delay egress for the north entry door. We will have the 30 second delay installed. The door by room 101, Maintenance Tech adjusted the doors and they open with minimal force. The Safety Committee will do quarterly walk-through and check doors to make sure they open with	7/29/14	

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K 038	Continued From page 3 a button located to the right hand side was pressed. Locks are required to be operable under all lighting conditions and are not permitted to require special knowledge or effort to operate. This locking arrangement did not meet these requirements.  Ref: 2000 NFPA 101, Section 19.2.2.2.1, 7.2.1.5.4  On 5/22/14 one of two leaves of a set of exit doors near room 101 would not open when pushed with over 50 lbs of force.  Ref: 2000 NFPA 101, Section 19.2.2.2.1, 7.2.1.4.5  The maintenance man 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 2 of 5 smoke compartments.	K 038	minimal force. Any findings will be shared at Quality Assurance Meeting.	
K 046 SS=F	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:	K 046		7/11/14

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K 046

Continued From page 4

On 5/22/14 no records could be produced that documented the required testing of battery powered light at 30 day intervals for 30 seconds or the annual 90 minute test. Testing is required at both intervals and durations, and records are required to be maintained for review.

Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3

On 5/22/14 records showed that the monthly exercise of the diesel generator loaded the generator to 20% of the name plate rating during the required monthly exercise. The facility did not perform an annual supplemental load exercise as required when diesel generators are not loaded to 30% of nameplate rating during the required monthly exercises.

Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 Section 6-4.2.2

On 5/22/14 the emergency generator was not functional due to a dead battery as reported by the maintenance man. Emergency generators are required to be maintained when used as a power source for emergency lighting.

Ref: 2000 NFPA 101 Section 19.2.9.1, 4.6.12.1

The maintenance man acknowledged the finding when the deficiency was identified.

Failure to maintain emergency lighting as required increases the risk of death or injury due to fire.

The deficiency affected the entire facility.

K 056

NFPA 101 LIFE SAFETY CODE STANDARD

K 046

We added the task of testing the battery powered lights every 30 days to the Maintenance Tech's list of duties. The two battery powered lights will be run for 30 seconds each month and they will be recorded on a spreadsheet.

On June 24, 2014 The Maintenance Shop will be doing the Annual Inspection on our generator, along with making the generator functional and adjusting the load to 30% of nameplate rating. It will be set up to run at or above 30% of nameplate rating going forward on a monthly exercise. The Maintenance Tech will record monthly checks on the hours and load rating of the generator. All concerns with generator will be addressed through quarterly Quality Assurance Meeting.

K 056

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K 056 SS=D	<p>Continued From page 5</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have an automatic fire sprinkler system as required.</p> <p>Findings include:</p> <p>On 5/22/14 the automatic fire sprinkler inspectors test connection serving located in the basement near the riser did not terminate in a smooth bore corrosion resistant orifice giving a flow equivalent to one sprinkler of a type having the smallest orifice installed on the particular system. The inspector test connection terminated to a hose connection. This was larger than the smallest sprinkler orifice observed in the building.</p> <p>The maintenance man acknowledged the finding when the deficiency was identified.</p> <p>Failure to provide an automatic fire sprinkler</p>	K 056	<p>NOVA Fire Protection will install a smooth bore corrosion resistant orifice near the riser, which will flow into floor drain. The Maintenance Tech will monitor for accuracy. The Quality Assurance Committee will address any additional issues with the maintenance department.</p> <p>7/29/14</p>

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K 056	Continued From page 6 system as required increases the risk of death or injury due to fire.  The deficiency affected one of twelve zones.  Ref: 2000 NFPA 101 Section 19.3.5.3, 9.7.1.1; 1999 NFPA 13 Section 5-15.4.2	K 056			
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  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  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test the automatic sprinkler system as required.  Findings include:  On 5/22/14 records indicated that required quarterly waterflow alarm devices testing on the dry and wet pipe systems were performed once in the past year on the annual inspection of 6/18/13. The sprinkler contractor annual test indicates that there were 12 zones. The fire alarm contractor conducted testing at 2 unidentified zones and as such was not considered a complete test.  Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.1.1; 1999 NFPA 13 Section 11-8.2, 12-1; 1999 NFPA 25 Section 2-3.3, 9-2.7  On 5/22/14 records indicated that required	K 062	Nova Fire Protection will be here to do annual inspection on 6/24/14. They will show our Maintenance Tech how to do the quarterly waterflow alarm testing. Maintenance Tech will keep a log of the quarterly testing. After visiting with both Johnson Controls and Nova, Nova reprogrammed the panel so there are only 3 zones (Basement, Garage & Nursing Home) because any flow switch in those designated areas will set off the alarm at one of the three flow switches named above.	7/11/14	

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K 062	Continued From page 7 semiannual valve tamper testing was performed once in the past year on the annual inspection of 6/18/13.  Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-3.4.3  Seven 2ft x 4ft ceiling tiles in the basement fire sprinkler riser room and an estimated twelve ceiling tile were missing in the garage. The tiles are a feature of the fire protection system that prevents smoke and heat from escaping to the space above the tiles and delaying the sprinkler response. As such they are required to be maintained.  Ref: 2000 NFPA 101 Section 4.6.12.1  The maintenance man acknowledged the finding when the deficiency was identified.  Failure to maintain the automatic sprinkler system as required increases the risk of death or injury due to fire.  The deficiency affected three of four required quarterly waterflow tests, one of two tamper tests, and one of two levels in the building.	K 062	The Maintenance Tech will be trained by Nova to do the semi annual valve tamper testing and document it in the records. Quarterly monitoring- see above with waterflow testing. The seven 2ft x 4ft tiles were replaced in the garage. The safety committee will do their quarterly walk through in June and will look for missing ceiling tile. Any ceiling tile concerns will be discussed at the Safety Meeting. Any additional concerns will be discussed at Quality Assurance Meeting.	
K 074 SS=E	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.	K 074	We identified 30 curtains that were not in compliance. We ordered and sprayed the closet curtains, dining room curtains and the east lobby curtains with Banfire which	6/23/14

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K 074	<p>Continued From page 8</p> <p>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</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to use permitted draperies.</p> <p>Findings include:</p> <p>On 5/22/14 the draperies in the activity room, the lobby and the resident rooms closets listed below were not flame resistant as required. No tags or other documentation was available to establish that the materials had been tested as required.</p> <p>Resident rooms: 101, 102, 104, 106, 108, 109, 113, 116, 125, 203, 214, 215, 216, 217, 218, 231</p> <p>The maintenance man acknowledged the finding when the deficiency was identified.</p> <p>Failure to use permitted draperies increases the risk of death or injury due to fire.</p> <p>The deficiency affected 16 of 48 resident rooms and 2 other locations.</p>	K 074	<p>meets the NFPA 701 standard.</p> <p>They will be sprayed annually and if washed. They were sprayed on 6/12/14 &amp; 6/13/14. The Safety Committee will do the walk through and find other curtains or material that do not have flame retardant tag. Any material identified will be immediately sprayed. The list of non compliance material will be discussed at our quarterly Quality Assurance meeting.</p> <p>Curtains in 101,102,104,106, 108,109,113,116,125,203,214, 215,216,217,218,231 were all sprayed with Banfire, a flame retardant spray.</p>	

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K 074	Continued From page 9 Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1	K 074		