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

ORIGINAL

PRINTED: 08/03/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435084 | | 07/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAULKTON SENIOR LIVING | 1401 PEARL ST<br>FAULKTON, SD 57438 |

| (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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| F 000 | INITIAL COMMENTS<br><br>Surveyor: 23059<br>A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/20/15 through 7/22/15. Faulkton Senior Living was found not in compliance with the following requirements: F318 and F514. | F 000 | Addendums noted with an asterisk per 9/1/15 telephone to facility Administrator.<br>NS/SOOOH/JJ | |
| F 318<br>SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 32332<br>Based on record review, interview, and policy review, the provider failed to ensure restorative services and treatment had been offered to prevent further decline in activities of daily living for 1 of 11 sampled residents (7). Findings include:<br><br>1. Review of resident 7's medical record revealed she had diagnoses of dementia (loss of mental functioning) and chronic lymphoma (a type of slow-progressing cancer). Review of her Minimum Data Set (MDS) assessments had revealed:<br>*Her ability to transfer between surfaces had declined from assistance of one staff to two staff | F 318 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 08/13/2015

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| F 318 | Continued From page 1<br>assistance on the 2/1/15 MDS.<br>*Her ability to walk had declined:<br>-From limited assistance to extensive assistance of one staff on the 11/9/14 MDS.<br>-From extensive assistance of one staff to only once or twice weekly with one assistance on the 2/1/15 MDS.<br>-From once or twice weekly on 2/1/15 to not walking on the 4/26/15 and the 7/17/15 MDS.<br><br>Interview on 7/22/15 at 1:50 p.m. with restorative aide A revealed:<br>*She provided passive exercises to one resident.<br>*Resident 7 had displayed declines in her status.<br>*She had not provided passive or active exercises for resident 7.<br><br>Interview on 7/22/15 at 3:15 p.m. with the MDS coordinator revealed:<br>*She and the director of nursing worked together to implement restorative programs for the residents.<br>*She agreed resident 7 had displayed gradual overall declines in her functioning over the last several months.<br>*She had not offered restorative services to resident 7, because she had severe dementia and was expected to die.<br>*She was not receiving hospice services.<br>*Her functional abilities had changed day-to-day and were sometimes better, sometimes worse.<br>*Restorative services were discussed in interdisciplinary team (IDT) meetings, but she had not known if it had been discussed with her family.<br>*She had not known when an IDT discussion would have taken place.<br><br>Interview on 7/22/15 at 4:15 p.m. with the director | F 318 | **F 318**<br>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:<br>1. [redacted] * Resident 7 was NS/SDOH/JJ reviewed by the MDSC (Minimum Data Set Coordinator) and DNS (Director of Nursing Services). NS/SDOH/JJ Family was contacted and agreed to try a restorative program which includes passive ROM (range of motion) NS/SDOH/JJ MDSC reviewed other residents showing a decline and referred to appropriate therapy as indicated.<br>2. MDSC and IDT (interdisciplinary team) NS/SDOH/JJ team were educated on 8-13-2015, by the | |

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| F 318 | Continued From page 2<br>of nursing revealed:<br>*She agreed the restorative services should have been offered when resident 7 had declines in functioning.<br>*She had already identified an under-utilization of restorative services earlier in the week.<br><br>Review of the provider's updated February 2013 Restorative Nursing Care policy revealed:<br>*"Mobility is critically important to our residents and functional decline can lead to depression, withdrawal, social isolation and complications."<br>Restorative care programs might have been started upon admission, when restorative needs arose, or upon discontinuation of formal therapy. | F 318 | DNS on the Restorative Nursing Program and the potential benefits of this program for the residents. The IDT team will discuss any declines in ADL's (activities of daily living) NS/SDOOH/JJ at regularly scheduled NS/SDOOH/JJ meetings.<br>3. Any residents the IDT team discussed due to declines will be reviewed by the MDSC and/or DNS for appropriate referrals to therapy and/or Restorative with documentation in residents chart as to the outcome. The MDSC and DNS will review the Restorative Program and participants weekly. | 08/13/2015 |
| F 514<br>SS=E | 483.75(l)(1) RES<br>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.<br><br>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.<br><br>This REQUIREMENT is not met as evidenced by:<br>Surveyor: 35121<br>Based on record review, interview, and policy review, the provider failed to maintain complete | F 514 | The DNS/designee will present data collected to the Quality Improvement/Quality Assurance meeting [redacted] monthly times 2 and await their NS/SDOOH/JJ further recommendations regarding system monitoring and documentation. NS/SDOOH/JJ | |

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| F 514 | Continued From page 3<br>and accurate documentation of meals for three of three sampled residents (3, 8, and 9) with a history of weight loss. Findings include:<br><br>1. Review of resident 3's dietary intake records (amount of food eaten) revealed:<br>*She had a ten pound weight loss from April 9, 2015 (98 pounds) to July 13, 2015 (88 pounds).<br>*There were undocumented meals for:<br>-Five meals in April.<br>-Four meals in May.<br>-Nine meals in June.<br>-Three meals from July 1 through July 20.<br><br>2. Review of resident 8's dietary intake records revealed:<br>*She had an eight and a half pound weight loss from March 12, 2015 (160.5 pounds) to April 9, 2015 (152 pounds).<br>*Her historical weight on October 23, 2014 was 179 pounds.<br>*There were undocumented meals for:<br>-One meal in March.<br>-Three meals in April.<br>-Four meals in May.<br>-Nine meals in June.<br>-Three meals from July 1 through July 20.<br><br>3. Review of resident 9's dietary intake records revealed:<br>*She had a 16 pound weight loss from June 11, 2015 (142 pounds) to July 21, 2015 (127 pounds).<br>*There were undocumented meals for:<br>-Three meals from July 1 through July 21.<br><br>Interview on 7/22/15 at 2:20 p.m. with the dietary manager (DM) revealed:<br>*The dietary staff were to have documented meal | F 514 | **F 514**<br>This facility denies that the alleged facts as set forth constitute a deficiency under interpretations of Federal and state law. The preparation of the following plan or correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction was prepared solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:<br>* Residents 3, 8, and 9<br>1. [redacted] NS/SDOH/JJ<br>and all other residents' intakes were reviewed by DNS/Dietary Manager.<br>2. Staff education will be provided on or before August 19, 2015 on the Policy for accurate and timely documentation of all intakes. | |

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| F 514 | Continued From page 4<br>intakes for residents not needing assistance with meals.<br>*The certified nurse aides (CNA) were to have documented meal intakes for residents they assisted with meals.<br>*It was her responsibility to ensure the charting had been done.<br>*The cook was responsible to ensure charting had been done on the days the DM was gone.<br>*It was the facility's policy to document meal intakes for each resident, each meal, each day.<br>*She agreed:<br>-There were multiple meals not documented for the above residents.<br>-Those residents had a history of unplanned weight loss.<br>-The staff had not been following their policy for documenting meal intake.<br><br>Review of the provider's 2008 Recording Percent of Meal Consumed policy revealed the staff were to document the percentage of each meal consumed for each individual on a daily basis. | F 514<br><br>will make<br>NS/SDDOH/JJ | 3. The Dietary Manager or her designee will audit dietary intake documentation and weight changes on 6 residents weekly times two months. Dietary Manager will meet with DNS weekly.<br>4. Dietary Manager or Designee will present data collected at Quality Assurance meeting and the committee will make further recommendations regarding system monitoring and documentation.<br>NS/SDDOH/JJ | 08/19/2015 |

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 18087<br>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/20/15 and 7/22/15. Faulkton Senior Living (Building 01) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K011, K038, K050, K062, and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 011<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to maintain the fire-resistive characteristics of the two hour fire-rated separation wall between the nursing home and the assisted living building at one randomly observed location (connecting corridor door). Findings include: | K 011 | | |

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| K 011 | Continued From page 1<br>1. Observation at 8:45 a.m. on 7/22/15 revealed the ninety minute fire-rated door in the two hour fire-rated separation wall between the nursing home and the assisted living buildings was not equipped with positive latching hardware (striker was missing, but the strike plate was in place in the door frame). The door was equipped with a closer and a magnetic door locking device at the top of the door. The door was not a designated exit.<br><br>Interview with the administrator at the time of the observation confirmed that finding. She stated the striker and door had sustained damaged from occupants using the door, so the striker had been removed, since it was kept magnetically locked.<br><br>The non-latching ninety minute fire-rated door affected one of several required components of fire-resistive separation wall characteristics. | K 011 | K011<br>The Environmental Services Director (ESD) ordered positive latching hardware on 8/12/2015. Hardware will be installed by 9/10/2015. The Environmental Services Director or designee will report outcome and any recommendations to Quality Improvement Quality Assurance Committee meeting for further recommendations regarding system changes and continued monitoring. | 09/10/2015 |
| K 062<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to maintain unobstructed space adjacent to the sprinkler deflector, so the water discharge was not interrupted in two randomly observed resident rooms (111 and 204). Findings include: | K 062 | K062<br>The Environmental Services Director made adjustments to the privacy curtain tracks to eliminate the sprinkler discharge pattern from possibly penetrating two privacy curtains in rooms 111 and 204 on 7/27/2015. All other double occupancy rooms were audited, and corrections were made on 7/27/2015.<br>Environmental Services Director or designee will report outcomes and any recommendations to Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring. | 07/27/2015 |

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| K 062 | Continued From page 2<br>1. Observation beginning at 5:45 p.m. on 7/20/15 revealed a single sprinkler in the ceilings of resident rooms 111 (in the west wing) and 204 (in the south wing). The rooms were double-occupancy rooms with two privacy curtains. The sprinkler was situated so the discharge pattern would have to penetrate both curtains (in one direction) if both were closed at the same time. Interview with the maintenance supervisor at the time of the observation confirmed that finding. He stated he was unaware of the second curtains possible interruption of the sprinkler discharge pattern.<br><br>The deficiency affected two of numerous resident room locations required to be equipped with unobstructed fire sprinkler protection. | K 062 | | |
| K 144<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to install a remote stop button for one of one generator. Findings include:<br><br>1. Observation at 9:00 a.m. on 7/22/15 revealed | K 144 | K144<br>Electrician contacted on 8/11/2015 to relocate the emergency stop button from inside the generator enclosure to the exterior by 9/10/2015. Environmental Services Director or designee will report outcome and any recommendations to Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring. | 09/10/2015 |

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| K 144 | Continued From page 3<br>there was not an emergency stop button installed for the generator. Interview with the maintenance supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator.<br><br>All Level 2 installations shall have a remote manual stop station of a type similar to a break-glass station. The stop shall be located outside the room housing the prime mover or located elsewhere on the premises where the prime mover is located outside the building (National Fire Protection Association 110, Chapter 3-5.5.6, 1999 Edition).<br><br>The deficiency affected a single location required to be equipped with remote emergency stops. | K 144 | | |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 435084 | MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING | DATE SURVEY COMPLETE 7/22/2015 |
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| K 038 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 18087<br>A. Based on observation, testing, and interview, the provider failed to ensure exits were readily accessible at all times (main entrance). The magnetically locked door would not release when tested Findings include:<br><br>1. Observation at 8:00 a.m. on 7/22/15 revealed the main entrance (exit) was a magnetically locked door. When tested by exerting force from the inside of the building(to simulate exiting) at the time of the observation, the door magnet would not release.<br><br>Interview with the maintenance supervisor at the time of the observation revealed the door was a delayed egress type door. The proper signage designating the door as delayed egress was not in place as required Further testing of the door and magnet by the maintenance staf revealed the magnet's plate (on the door itself) was loose and needed adjustment. The door then functioned properly as a delayed egress type door.<br><br>The improper functioning of the delayed egress door could affect all occupants of the building in an emergency.<br><br>B. Based on observation and interview, the provider failed to ensure exits were readily accessible at all times (main entrance). The magnetically locked door was not equipped with the required delayed egress signage Findings include:<br><br>1. Observation at 8:00 a.m. on 7/22/15 revealed the main entrance (exit) was a magnetically locked door.<br><br>Interview with the maintenance supervisor at the time of the observation revealed the door was a delayed egress type door. The door was not equipped with the required delayed egress signage.<br><br>The lack of labeling of the delayed egress door affected one of several requirements for delayed egress doors. |
| K 050 | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 |

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The above isolated deficiencies pose no actual harm to the residents

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| K 050 | Continued From Page 1 |

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:
Surveyor: 18087
Based on record review and interview, the provider failed to conduct quarterly fire drills at varied times each quarter for the twelve month period beginning July2014. Findings include:

1. Fire drill record review revealed drills had been held for July, August, October 2014, and January, April, May 2015 between 2:00 p.m. and 3:30 p.m on the days of the drills. Interview with the maintenance supervisor revealed the staffing shift change occurred during that time period and allowed for a greater exposure of staff to the fire drill procedure.

Exit interview with the administrator at 11:30 a.m. on 7/22/15 revealed she was unaware fire drills needed to be held at varied times.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435084 | | 07/22/2015 |

NAME OF PROVIDER OR SUPPLIER: FAULKTON SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 PEARL ST, FAULKTON, SD 57438

| (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<br><br>Surveyor: 18087<br>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/22/15. Faulkton Senior Living (Building 02) was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.<br><br>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of the deficiencies identified at K050 and K144 in conjunction with the provider's commitment to continued compliance with the fire safety standards. | K 000 | | |
| K 144<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 18087<br>Based on observation and interview, the provider failed to install a remote stop button for one of one generator. Findings include:<br><br>1. Observation at 9:00 a.m. on 7/22/15 revealed there was not an emergency stop button installed for the generator. Interview with the maintenance | K 144 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: BMZ | TITLE: Executive Director | (X6) DATE: 8/13/2015

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.

AUG 17 2015
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 435084 | A. BUILDING 02 - BUILDING 02<br>B. WING _____ | 07/22/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| FAULKTON SENIOR LIVING | 1401 PEARL ST<br>FAULKTON, SD 57438 |

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|---|---|---|---|---|
| K 144 | Continued From page 1<br>supervisor at the time of the observation revealed he was unaware of the remote stop requirement for the generator.<br><br>All Level 2 installations shall have a remote manual stop station of a type similar to a break-glass station. The remote stop shall be located outside the room housing the prime mover or located elsewhere on the premises where the prime mover is located outside the building (National Fire Protection Association 110, Chapter 3-5.5.6, 1999 Edition).<br><br>The deficiency affected a single location required to be equipped with remote emergency stops. | K 144 | K144<br>Electrician contacted on 8/11/2015 to relocate the emergency stop button from inside the generator enclosure to the exterior by 9/10/2015. Environmental Services Director or designee will report outcome and any recommendations to Quality Improvement Quality Assurance meeting for further recommendations regarding system changes and continued monitoring. | 09/10/2015 |

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 435084 | MULTIPLE CONSTRUCTION A. BUILDING: 02 - BUILDING 02 B. WING | DATE SURVEY COMPLETE: 7/22/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER FAULKTON SENIOR LIVING | STREET ADDRESS, CITY, STATE, ZIP CODE 1401 PEARL ST FAULKTON, SD | | |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| K 050 | 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:
Surveyor: 18087
Based on record review and interview, the provider failed to conduct quarterly fire drills at varied times each quarter for the twelve month period beginning July2014. Findings include:

1. Fire drill record review revealed drills had been held for July, August, October 2014, and January, April, May 2015 between 2:00 p.m. and 3:30 p.m on the days of the drills. Interview with the maintenance supervisor revealed the staffing shift change occurred during that time period and allowed for a greater exposure of staff to the fire drill procedure.

Exit interview with the administrator at 11:30 a.m. on 7/22/15 revealed she was unaware fire drills needed to be held at varied times.

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 disclosable90 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 disclosable14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

031099

South Dakota Department of Health

ORIGINAL

PRINTED: 08/03/2015
FORM APPROVED

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 10619 | | 07/22/2015 |

NAME OF PROVIDER OR SUPPLIER: FAULKTON SENIOR LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE: 1401 PEARL ST, FAULKTON, SD 57438

| (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) COMPLETE DATE |
|---|---|---|---|---|
| S 000 | Initial Comments<br><br>Surveyor: 18087<br>A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:04, Medical Facilities, requirements for nursing facilities, was conducted from 7/20/15 through 7/22/15. Faulkton Senior Living was found in compliance. | S 000 | | |

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

TITLE: Executive Director

(X6) DATE: 08/13/2015

STATE FORM 6899 7N1S11 If continuation sheet 1 of 1

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