

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

ORIGINAL

PRINTED: 05/11/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435037	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/06/2015
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NAME OF PROVIDER OR SUPPLIER CLARKSON HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1015 MT VIEW RD RAPID CITY, SD 57702
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 32572 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 5/4/15 through 5/6/15. Clarkson Health Care was found in compliance.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

[Signature] Director of Operations 5/12/15

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 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 5/06/15. Clarkson Health Care was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities.</p> <p>The building will meet the requirements of the 2000 LSC for existing health care occupancies upon correction of deficiencies identified at K029, K038, and K143 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000	<p>Addendums noted with an asterisk per 5/11/15 telephone to facility administrator. CHISDDO/HMF</p>	
K 029 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain proper separation of one of four hazardous areas in one randomly observed area (kitchen pantry). Findings include:</p>	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director of Operations	(X6) DATE 5/27/15
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K 038	Continued From page 2 maintenance supervisor confirmed that finding. Interview with the maintenance supervisor at the above time revealed he had checked all the magnetic door locks recently, and they had all functioned correctly. The maintenance supervisor called the magnetic lock service provider to come in and check the device during the survey. Interview with the maintenance supervisor at 2:15 p.m. on 5/06/15 revealed the service provider determined the magnetic lock had failed. He stated a new lock had been ordered and would arrive by next day air delivery. The deficiency affected egress requirements for the Elm wing.	K 038	The weekly check has been added to the maintenance supervisor weekly preventative maintenance checklist.	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2	K 143		

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K 143	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the requirements for one of one liquid oxygen transferring room (one hour fire-rated construction and signage) for the receiving dock area. Findings include: 1. Observation beginning at 9:15 a.m. on 5/06/15 revealed the receiving dock area where liquid oxygen transferring was to take place had a bare concrete floor and vinyl floor tile in another portion of the room. The two liquid oxygen canisters were on casters and were situated on the bare concrete area of the floor. a) The door from the receiving dock into the kitchen pantry was labeled a twenty minute fire-rated door with a closer. Doors with a minimum forty-five minute fire resistive rating are required for a one hour fire barrier enclosure. b) The horizontal conduit chase at the ceiling by the emergency generator transfer switch in the receiving dock was not sealed. There was a gap approximately eighteen inches wide by two inches high where the conduits penetrated the brick wall at the juncture with the ceiling gypsum board. A one hour fire barrier may not have unsealed openings. c) There was no signage in the oxygen transferring area that would state that liquid oxygen transferring was occurring. d) There was a sign for the exhaust fan switch stating the exhaust must be turned on when	K 143	1. The two oxygen canisters have been secured by a chain barrier by the maintenance supervisor on to ensure canisters are stored in that area. a.) The door from the receiving dock into the kitchen pantry will be replaced on with a 1-hour rated door. b.) The gap will be filled with gypsum board and sealed with fire rated caulk on by the maintenance supervisor to ensure proper 1- hour fire barrier. c.) A sign that states, "Liquid Oxygen Transferring is Occurring" was installed by maintenance supervisor.	6-22-15
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K 143	<p>Continued From page 4</p> <p>transferring. No transferring was occurring during the survey, and the exhaust fan was switched off. Interview with the maintenance supervisor revealed the liquid oxygen containers remained on the receiving dock between transferring times. If liquid oxygen (a cryogenic liquid) were to leak from the cylinders, the flashpoint of vinyl floor tiles or other items kept in the room could be lowered (become more combustible). Areas of liquid oxygen storage must have continuous mechanical exhaust ventilation (no switch). Further interview with the maintenance supervisor revealed he was unaware the oxygen transferring area was not in compliance. It was not determined during the survey if transferring procedures were in place. Documentation for the training of staff for transferring liquid oxygen was not reviewed.</p> <p>The deficiency affected several requirements for liquid oxygen transferring and storage.</p> <p>Ref: 2000 NFPA 101 Section 19-3.2.4, 8-3.1.11.2(c)3(d), 4-3.2.1.1.2(b)4, 8-6.2.5.2</p>	K 143	<p>d.) The On/Off switch for the ventilation fan will be removed by STEL Electric and the fan will be wired to run continuously. Oxygen in service was completed on 5/19 during the nursing staff meeting to review equipment, use, and the transferring of oxygen.</p> <p><i>*The maintenance supervisor will monitor the completion of these items and report the results to AA. This equipment will be added to the preventive maintenance schedule.</i> CH/SDD/HMF</p>	

South Dakota Department of Health

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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 on 5/06/15. Clarkson Health Care was found not in compliance with the following requirement: S166.	S 000		
S 166	44:04:02:17(1-10) OCCUPANT PROTECTION The facility must take at least the following precautions: (1) Develop and implement a written and scheduled preventive maintenance program; (2) Provide securely constructed and conveniently located grab bars in all toilet rooms and bathing areas used by patients or residents; (3) Provide a call system for each...resident bed and in all toilet rooms and bathing facilities routinely used by...residents. The call system must be capable of being easily activated by the...resident and must register at a station serving the unit; (4) Provide handrails firmly attached to the walls on both sides of all resident corridors in nursing facilities; (5) Provide grounded or double-insulated electrical equipment or protect the equipment with ground fault circuit interrupters. Ground fault circuit interrupters must be provided in wet areas and for outlets within six feet of sinks; (6) Install an electrically activated audible alarm on all unattended exit doors in nursing facilities. Other exterior doors must be locked or alarmed. The alarm must be audible at a designated nurses' station and may not automatically silence when the door is closed; (7) Portable space heaters and portable halogen	S 166		

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

TITLE

STATE FORM

8899

N3E311

Director of Operations

RECEIVED	(X6) DATE 5/27/15
If continuation, sheet 1 of 2 MAY 28 2015	
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South Dakota Department of Health

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S 166	<p>Continued From page 1</p> <p>lamps may not be used in a facility; (8) Household-type electric blankets or heating pads may not be used in a facility; (9) Any light fixture located over a...resident bed, in any bathing or treatment area, in a clean supply storage room, any laundry clean linen storage area, or in a medication set-up area must be equipped with a lens cover or a shatterproof lamp; and (10) Any clothes dryer must have a galvanized metal vent pipe for exhaust.</p> <p>This Administrative Rules of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation, testing, and interview, the provider failed to maintain the electrically activated audible alarm for unattended doors in an active condition for two of six exterior doors (main entrance/exit and exit door at therapy). Findings include:</p> <p>1. Observation and testing beginning at 11:00 a.m. on 5/06/15 revealed the exterior exit door at the main entrance was equipped with a delayed egress magnetic lock. A code was posted beside the door that would release the magnetic lock and would also silence the audible alarm required for that location. That condition also existed at the exit door from the Willow wing adjacent to therapy rooms. The posted code would allow residents to input the code and leave the building without sounding the door alarm. Interview with the administrator at 3:00 p.m. on 5/06/15 confirmed that condition. He stated a wander management system was also in place for certain residents.</p>	S 166	<p>The facility has implemented a new process for the front entrance door. The code will remain posted during business hours while the receptionist is present. When the receptionist leaves for the day, the code will be relocated 10 feet away from the exit door. In the absence of the receptionist during business hours, other staff will be present to fill in for monitoring.</p> <p>The sign posting the code on the Willow exit door has been removed by the administrator and will remain removed going forward. Changes will be reviewed during monthly QA meeting.</p>	6-25-15
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