

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

PRINTED: 02/01/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>435105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/22/2016</b>
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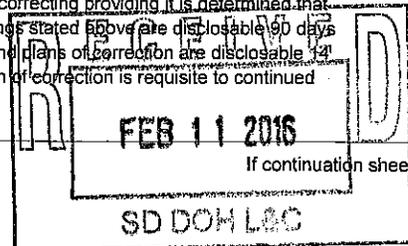
NAME OF PROVIDER OR SUPPLIER  <b>WHEATCREST HILLS HEALTHCARE COMMUNITY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1311 VANDER HORCK POST OFFICE BOX 939 BRITTON, SD 57430</b>
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K 000	INITIAL COMMENTS  42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1965 K7 SURVEY UNDER: 2000 Existing K8 SNF/NF Type of Structure: One (1) story with a basement, (1965), Type II (000), unprotected noncombustible construction with five (5) smoke compartments and a complete automatic wet sprinkler system. A Comparative Federal Monitoring Survey was conducted on 01/22/16, following a State Agency Annual Survey on 12/21/15 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Wheatcrest Hills Healthcare Community was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000	Submission of this response and plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the administrator or any employees, agents or other individuals who draft or may be discussed in this response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of correction is submitted as the facility's credible allegation of compliance.	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8  This STANDARD is not met as evidenced by: Based on observations and interview, the facility	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Lawsonne Turman* TITLE: Administrator (X6) DATE: 2-9-16

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 120 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 045	<p>Continued From page 1</p> <p>failed to provide illumination of means of egress. The deficient practice affected three (3) of five (5) smoke compartments, staff and 34 residents. The facility has the capacity for 56 beds with a census of 45 on the day of survey.</p> <p>Findings include:</p> <p>1. Observation during the building inspection tour on 01/22/16 at 10:15 am revealed the designated exit discharge located adjacent to the Physical Therapy area had a one (1) bulb light fixture installed. If the one (1) bulb failed the area would be left in darkness. Interview on 01/22/16 at 10:16 am with the Maintenance Supervisor revealed the facility was not aware of the illumination requirements for exit discharge.</p> <p>2. Observation during the building inspection tour on 01/22/16 at 11:18 am revealed the designated exit discharge located adjacent to Resident Room #103 had a one (1) bulb light fixture installed. If the one (1) bulb failed the area would be left in darkness. Interview on 01/22/16 at 11:19 am with the Maintenance Supervisor revealed the facility was not aware of the illumination requirements for exit discharge.</p> <p>The census of 45 was verified by the Administrator on 01/22/16. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on -01/22/16.</p> <p>Actual NFPA Standard, NFPA 101, 19.2.8</p>	K 045	<ol style="list-style-type: none"> <li>1. Two light fixtures have been ordered, each containing 2 (two) light bulbs, and will replace the fixture on the exit adjacent to the Physical therapy area, and also the exit adjacent to room 103.</li> <li>2. All residents are at risk.</li> <li>3. NFPA standard for egress illumination has been reviewed by maintenance director and Administrator for compliance.</li> <li>4. Each light replaced will be monitored by maintenance director or designee one time per week for 4 weeks. Audits will be discussed by the maintenance director in monthly Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation /discontinuation of audit.</li> </ol>	2/28/16
	<p>Illumination of Means of Egress. Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>Actual NFPA Standard: NFPA 101, 7.8.1.1.</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs,</p>			

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K 045	Continued From page 2 aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way. Actual NFPA Standard: NFPA 101, 7.8.1.2. Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units. Actual NFPA Standard: NFPA 101, 7.9.2.2*. The emergency lighting system shall be arranged to provide the required illumination automatically in the event of any of the following: (1) Interruption of normal lighting such as any failure of a public utility or other outside electrical power supply (2) Opening of a circuit breaker or fuse (3) Manual act(s), including accidental opening of a switch controlling normal lighting facilities Actual NFPA Standard: NFPA 101, 7.8.1.4. Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. Actual NFPA Standard: NFPA 101, 7.8.2.1*. Illumination of means of egress shall be from a	K 045		

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K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly per shift. The deficient practice affected five (5) of five (5) smoke compartments, staff, and all residents. The facility has the capacity for 56 beds with a census of 45 on the day of survey. Findings include:</p> <p>1. Record review of the facility's fire drill records for the 12 month period prior to the survey on 01/22/16 at 09:30 am revealed the facility failed to conduct fire drills on the following:</p> <ul style="list-style-type: none"> <li>· The first (1st) quarter of 2015 on the second (2nd) shift.</li> <li>· The first (1st) quarter of 2015 on the third (3rd) shift.</li> </ul> <p>Interview on 01/22/16 at 09:31 am with the Maintenance Supervisor revealed the facility was going through personnel changes at that time and was unaware the fire drills were missed. The census of 45 was verified by the</p>	K 050	<ol style="list-style-type: none"> <li>1. Monthly fire drill (each shift one time per quarter) has been highlighted on monthly maintenance duties.</li> <li>2. All residents are at risk.</li> <li>3. The Administrator and maintenance director reviewed policy and findings from the cited deficiency were reviewed. Education was provided to maintenance director on proper procedure.</li> <li>4. Maintenance director or designee is to monitor monthly for three (3) months and report findings to Quality Assurance Process Improvement (QAP) for review and recommendations of continuation discontinuation of audit.</li> </ol>	2/28/16

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K 050	Continued From page 4 Administrator on 01/22/16. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on -01/22/16. Actual NFPA Standard: NFPA 101, 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to protect cooking equipment. The deficient practice affected one (1) of five (5) smoke compartments, staff and residents in the Dining Room. The facility has the capacity for 56 beds with a census of 45 on the day of survey. Findings include: Observation during the building inspection tour on 01/22/16 at 09:45 am revealed the fire suppression pull was located on the back side of the stove in the corner of the Kitchen farthest from the nearest egress path.	K 069	1. The fire suppression pull has been relocated (2/5/16) to the wall adjacent to the exit door, which is a path of egress. 2. All residents are at risk. 3. The Administrator and maintenance director reviewed NFPA standards regarding a manual hood suppression pull, and our compliance to same. 4. The manual hood suppression pull will be monitored weekly X four (4) by maintenance director or designee, for compliance with these standards. Results will be reported to Quality Assurance Process Improvement (QAPI) for review and recommendations of continuation /discontinuation of audit.	2/28/16

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K 069	Continued From page 5 Interview on 01/22/16 at 09:46 am with the Maintenance Supervisor revealed the facility was not aware the manual hood suppression pull was to be located in the egress path. The census of 45 was verified by the Administrator on 01/22/16. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on -01/22/16. Actual NFPA Standard: NFPA 96, 7-5.1 A readily accessible means for manual activation shall be located between 42 in. and 60 in. (1067 mm and 1524 mm) above the floor, located in a path of exit or egress, and clearly identify the hazard protected. The automatic and manual means of system activation external to the control head or releasing device shall be separate and independent of each other so that failure of one will not impair the operation of the other. Exception No. 1: The manual means of system activation shall be permitted to be common with the automatic means if the manual activation device is located between the control head or releasing device and the first fusible link. Exception No. 2: An automatic sprinkler system.	K 069			