

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

ORIGINAL

PRINTED: 08/02/2016
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 07/20/2016
NAME OF PROVIDER OR SUPPLIER TEKAKWITHA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
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F 000	INITIAL COMMENTS Surveyor: 33488 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for long term care facilities, was conducted from 7/18/16 through 7/20/16. Tekakwitha Living Center was found not in compliance with the following requirements: F225, F279, F281, F283, F323, F371, F431, F441, and F456.	F 000	*Addendums noted with an asterisk per 8/29/16 per telephone with facility administrator. NPN/SDDO/HJEL	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		

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

Mary Beth Grase LVAH

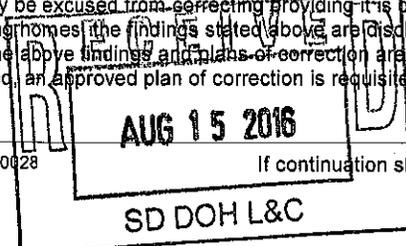
TITLE

Administrator

(X6) DATE

8-12-16

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 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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F 225	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on record review and interview, the provider failed to ensure five of five newly hired employees (A, B, C, D, and E) were safe to work with the residents. Findings include: 1. Review on 7/20/16 of new employee records revealed: *Two of the employees (A and B) were dietary aides. *Three of the employees (C, D, and E) were nursing staff. *No information on convictions had been obtained. Interview on 7/20/16 at 12:35 p.m. with the director of human resources regarding the above employee records revealed: *The administrator had directed her to stop doing background checks on new employees in September 2015 due to cost. -The administrator was not at the facility during the survey. *After that date she would just ask any new employees if they had ever been convicted of a crime.	F 225	F225 * All new hires will be checked through the National Sex Offender Registry and the Office of Inspector General Websites for abuse and/or neglect with all new hires. *A state background check will be completed with the Clerk of Courts at our local Courthouse to check for violations. *This will be completed by the Human Resources department during orientation process and discussed in the employee handbook and with checklist included in the hiring process of 100% of employees. *Checklist to be reviewed at QA quarterly times 3 <i>*Human resources to provide QA with checklist. Employees A, B, C, D, and E had background checks completed. NPN/SDDOH/EL</i>	08-03-16	

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F 225	Continued From page 2	F 225		
F 279 SS=D	<p>Interview on 7/20/16 at 4:20 p.m. with the director of nursing (DON) regarding the review of new employees revealed: *She was unaware background checks were not being done. *She agreed new employees had not been adequately reviewed to determine if they were safe to work with the residents.</p> <p>A policy was requested from the DON but had not been received by the time of exit. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced</p>	F 279		

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F 279	Continued From page 3 by: Surveyor: 32331 Based on interview, record review, and policy review, the provider failed to ensure one of five sampled residents (7) with depression had the care plan updated and revised as changes occurred. Findings include: 1. Review of resident 7's medical record revealed she had: *A diagnosis that included a major depressive disorder. *A fall on 6/9/16 resulting in a fracture and hospitalization. Interview on 7/19/16 at 8:52 a.m. with resident 7 revealed she had: *Her right arm in a sling. *A recent fall with complaints of pain in her shoulder. *Been feeling a "little down" since the fall. Review of 6/15/16 and 6/20/16 clinical psychologist's reports for resident 7 revealed: *She had been receiving treatment for depression. *She had a depressed mood and signs of depression were present. Review of resident 7's 6/30/16 significant change Minimum Data Set (MDS) assessment in section D revealed she had increased in symptom frequency of feeling down, depressed, or hopeless. Review of resident 7's revised 7/7/16 care plan revealed: *She had sustained a right humerus fracture and right rib fracture after a fall.	F 279	<i>*NPN/SPRUTHEL</i> F279 [REDACTED] *Review care plan policy for measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are to be identified in their assessment. *This will be monitored by the interdisciplinary team during the care planning process on new admission, readmissions and quarterly or when changes occur in residents status. * Resident #7 has been updated to include depression diagnosis, problems, goals and approaches. * Interdisciplinary team to audit resident care plans during MDS assessment period with checklist to ensure all diagnosis are addressed on the care plan. *DON to monitor compliance weekly for 90 days and report findings to QA. <i>*update care plans for all residents by MDS coordinator and interdisciplinary team. Education done at mandatory all staff meeting on 8/16/16 and 8/17/16.</i>	8-18-16

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F 279	Continued From page 4 *There was no documentation she had depression including any established goals and interventions for it. Interview on 7/20/16 at 11:00 a.m. with the director of nursing regarding resident 7 revealed: *Depression had not been on her care plan. *She confirmed depression along with goals and interventions had needed to have been on her care plan. *Interventions should have been on her care plan. Interview on 7/20/16 at 2:45 p.m. with the MDS coordinator regarding resident 7 revealed: *She agreed her most recent MDS assessment section D results had increased in symptom frequency of feeling down, depressed, or hopeless. *Depression had not been on her care plan. *She agreed depression along with goals and interventions had needed to have been on her care plan. *Interventions should have been on her care plan. *It was the responsibility of the MDS coordinator and social services to have included that on her care plan. Review of the provider's undated Care Plans policy revealed: *"The care plan must include measurable goals and time tables to meet a resident's medical, nursing, and psychological needs as identified in the assessment." *It was the responsibility of all staff to have kept it updated with: -Current information. -Changes in the plan of care and goals.	F 279			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			

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F 281 SS=D	<p>Continued From page 5 PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on record review, interview, and policy review, the provider failed to ensure professional standards were followed for submitting required incident reports regarding reporting of injuries of a serious nature and an elopement to the South Dakota Department of Health (SD DOH) for: *Two of two sampled residents (7 and 12) with a fall resulting in major injury. *One of one sampled resident (4) with an elopement. Findings include: Surveyor: 34030 1. Review of resident 7's medical record revealed on 6/9/16 a fall resulting in a fracture had occurred.</p> <p>Review of the provider's incident reports revealed SD DOH had not been notified of resident 7's fall on 6/9/16 resulting in major injury.</p> <p>Surveyor: 32331 Review of resident 7's medical record revealed she had a fall on 6/9/16 resulting in a fracture and hospitalization.</p> <p>Interview on 7/19/16 at 8:52 a.m. with resident 7 revealed she had: *Her right arm in a sling. *A recent fall with complaints of pain in her</p>	F 281	<p>F281 ██████████ *NPN/SDDOH/EL</p> <p>*Revise mandatory reporting policy by Administrator and DON by 08-17-16 to provide training to all staff on policy for mandatory reporting. *Investigation to be completed by nursing staff and SSD *New hires to watch presentation from DOH on website for mandatory reporting using checklist through HR. *All events will be reviewed by QA as they occur. *Findings brought to QA NPN/SDDOH/EL quarterly meetings *indefinitely. *Findings brought to QA by DON. NPN/SDDOH/EL</p>	8-17-16

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F 281	<p>Continued From page 6 shoulder.</p> <p>Review of resident 7's 6/30/16 significant change Minimum Data Set (MDS) assessment in section J revealed she had one fall with major injury since her 4/6/16 quarterly MDS assessment.</p> <p>Review of resident 7's 6/9/16 Event Report revealed she had: *Fallen in the hallway in a witnessed fall. *Been unresponsive after the fall. *Complained of severe right arm and shoulder pain. *Been taken by the ambulance to the emergency room.</p> <p>Review of resident 7's revised 7/7/16 care plan revealed she had sustained a right humerus fracture and right rib fracture after a fall.</p> <p>Interview on 7/20/16 at 11:00 a.m. with the director of nursing and at 2:45 p.m. with the MDS coordinator regarding resident 7 revealed: *Both agreed SD DOH should have been notified of resident 7's fall on 6/9/16 resulting in major injury. *A fall that involved injury of a serious nature should have been reported to the SD DOH.</p> <p>Surveyor 34030 2. Review of resident 12's 9/25/15 initial incident report to the SD DOH revealed: *An unwitnessed fall with injury had occurred on 9/24/15 at 9:00 p.m. *The time the incident was reported had not been recorded.</p> <p>Closed record review for resident 12 revealed: *He had dementia.</p>	F 281	<p>F281 *NPN/SDDOH/EL</p> <p>*Revise mandatory reporting policy by Administrator and DON by 08-17-16 to provide training to all staff on policy for mandatory reporting. *Investigation to be completed by nursing staff and SSD *New hires to watch presentation from DOH on website for mandatory reporting using checklist through HR. *All events will be reviewed by QA as they occur. *Findings brought to QA quarterly meetings</p>	8-17-16

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F 281	<p>Continued From page 7</p> <p>*His 8/28/15 Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) assessment was three indicating severe mental impairment.</p> <p>*He was at a high risk for falls.</p> <p>*He was unable to walk on his own and used a wheelchair. He would wheel around the facility by himself.</p> <p>*He wore a TABS alarm.</p> <p>*On 9/24/15 after a fall down some stairs he was sent to the hospital. They called at 11:17 p.m. to report he had a broken right arm along with bumps and bruises.</p> <p>*He had died on 11/16/15.</p> <p>*The provider had not notified the SD DOH in the required time frame of two hours for a fall with a serious injury.</p> <p>3. Review of resident 4's 4/25/16 initial incident report revealed:</p> <p>*The resident had left the building without the staff's knowledge on 4/23/16.</p> <p>*Her roommate went with her.</p> <p>*SD DOH had been notified on 4/25/16.</p> <p>*Notification should have been completed within twenty-four hours.</p> <p>Review of resident 4's medical record revealed:</p> <p>*She was admitted on 4/22/16 the day before her elopement.</p> <p>*She had dementia with confusion.</p> <p>*Her 4/28/16 MDS BIMS assessment was four indicating severe mental impairment.</p> <p>*The resident's sister called the facility to let them know she was at her house.</p> <p>*The facility was unsure of how long resident 4 and her roommate had been gone.</p> <p>Interview on 7/19/16 at 11:25 a.m. with the social service designee regarding the above incidents</p>	F 281	<p><i>*NPN/SDDOH/EL</i></p> <p>F281 [REDACTED]</p> <p>*Review elopement policy at mandatory staff meeting by 08-17-16</p> <p>*MDS coordinator and SSD to compile elopement risk assessment on admission, quarterly and resident change of status</p> <p>*Staff being alerted to the possibility of elopement through communication book and care plans.</p> <p>*Elopement risk assessment added to MDS checklist → <i>*Will be completed on all residents going forward and has been performed on at-risk residents currently in facility.</i></p> <p>*DON to monitor MDS checklist weekly through 90 days and report findings to QA quarterly</p> <p><i>*Policy did not change staff educated on reporting guidelines at mandatory staff meeting 8/16/16 and 8/17/16.</i></p> <p><i>NPN/SDDOH/EL</i></p>	8-17-16

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F 281	<p>Continued From page 8 revealed:</p> <ul style="list-style-type: none"> *Either she or the director of nursing (DON) were responsible for reporting and investigating incidents. *She thought all reportable incidents needed to be reported within twenty four hours. *She was unaware of the two hour time frame for some incidents. *She agreed the above incidents had not been reported to the SD DOH in a timely manner. <p>Interview on 7/20/16 at 4:30 p.m. with the DON confirmed she agreed the above incidents had not been reported in a timely manner as required.</p> <p>Review of the provider's undated Abuse policy revealed:</p> <ul style="list-style-type: none"> **"There are two limits for reporting [to the SD DOH] depending on the seriousness of the event. If the event causes reasonable suspicion resulting in serious bodily injury to a resident, staff must report the suspicion immediately, but not later than 2 hours". **"If the events do not result in a serious bodily injury to a resident the report must be not later than 24 hours". <p>Surveyor: 32331 Review of Patricia A. Potter and Anne Griffin Perry, Fundamentals of Nursing, 8th Ed., p. 358, St. Louis, MO, 2013 revealed:</p> <ul style="list-style-type: none"> **"An incident or occurrence was any event that was not consistent with the routine operation of a health care unit or routine care of a patient. *Examples of incidents include patient falls. *Follow agency policy when making an incident report. *These reports are an important part of quality improvement. 	F 281	<p>F281 [REDACTED]</p> <ul style="list-style-type: none"> *Revise mandatory reporting policy by Administrator and DON by 08-17-16 to provide training to all staff on policy for mandatory reporting. *Investigation to be completed by nursing staff and SSD *New hires to watch presentation from DOH on website for mandatory reporting using checklist through HR. *All events will be reviewed by QA as they occur. *Findings brought to QA quarterly meetings <p><i>*Policy did not change staff educated on reporting guidelines at mandatory staff meeting 8/16/16 and 8/17/16. NPN/SDDOH/EL</i></p>	8-17-16	

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F 281	Continued From page 9 *The overall goal is to identify changes needed to prevent future recurrence. *File the report with the appropriate risk-management department of the agency."	F 281	<i>*NPN/SDDOT/EL</i> F283 [REDACTED]	
F 283 SS=D	Surveyor: 34030 483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Surveyor: 33488 Based on record review, interview, and policy review, the provider failed to have an appropriate discharge summary that included a recapitulation (summary statement) that included a review of the resident's stay for one of one sampled resident (14) who was discharged home. Findings include: 1. Review of resident 14's 3/25/16 Discharge Planning-Discharge Summary form revealed: *That was the form completed upon discharge from the facility for the resident. *A section in that form was labeled Recapitulation of Stay and was filled out as follows: **"Rehabilitation services: PT/OT"	F 283	*Review discharge policy with nursing at nurses meeting on 08-15-16. *Review completion process of the discharge which recaps resident stay to include improvement information throughout stay, where being discharged to and with what services if any were provided. *DON to monitor completion for all discharges for 90 days and findings to QA quarterly. <i>* X2</i> <i>*Process to be completed going forward.</i> <i>*Nursing staff educated on 8/15/16 at nurses meeting.</i> <i>*Recap of resident 14 was completed and placed in chart. (Electronic)</i>	8-15-16 <i>NPN/SDDOT/EL</i> <i>NPN/SDDOT/EL</i> <i>NPN/SDDOT/EL</i>

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F 283	<p>Continued From page 10</p> <p>*"Final diagnosis/condition upon discharge: Healing of humerus fracture."</p> <p>*Significant changes in condition, outstanding events, and hospitalizations were left blank.</p> <p>*There was a progress note made by nursing staff that denoted "resident discharged home via private vehicle accompanied by husband, med list, and instructions sent with. Home Health to follow."</p> <p>Interview on 7/20/16 at 9:30 a.m. with the director of nursing regarding resident 14's discharge summary revealed:</p> <p>*There was no other documentation to show a summary statement was made to reflect the resident's life and care while at the facility.</p> <p>*She was unaware they needed a thorough discharge summary.</p> <p>*She agreed the limited information that was included in the above summary had not appropriately reflected the resident's life.</p> <p>Review of the current undated Discharge of a Resident policy revealed no procedure requiring staff to enter a summary statement describing the resident's life while at the facility.</p>	F 283		
F 323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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 prevent accidents.</p>	F 323		

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NAME OF PROVIDER OR SUPPLIER TEKAKWITHA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
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F 323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Surveyor: 34030 Based on observation, interview, record review, and policy review, the provider failed to: *Secure an exit door leading into a child daycare area resulting in a fall with major injury for one of one (12) sampled resident. *Alarm two exit doors (numbers four and six) and secure one of one courtyard gate resulting in an elopement for one of one (4) sampled resident. *Secure or alarm one of one elevator leading to a basement door that lead outside to the employee parking lot. *Ensure four randomly observed resident's (16, 17, 18, and 19) beds were free from entrapment hazards. Findings include: 1. Review of a 9/25/15 event report to the South Dakota Department of Health (SD DOH) regarding resident 12 revealed: *He was missing on 9/24/15 at approximately 9:00 p.m. *He was found with his wheelchair at the bottom of a stairwell in the child daycare area of the building. *He had opened two doors to get to the stairs. *He was taken to the hospital and found to have a broken arm. *"A lock has been placed on the day care door." Closed record review for resident 12 revealed: *He had dementia. *His 8/28/15 Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) assessment was three indicating severe mental impairment. *He was at a high risk for falls. *He was unable to walk on his own and used a	F 323	F323 Resident #12 *Revise/review policy for alarmed/secure doors to include all staff training by 08-17-16. Coded lock placed on day care door with keypad entry for parents and staff only. *No access to this area by residents related to code needed to enter. *Maintenance to check compliance while completing rounds and finding to be discussed at monthly Safety committee meetings	8-18-16

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F 323	<p>Continued From page 12</p> <p>wheelchair. He would wheel around the facility by himself.</p> <p>*He wore a TABS alarm.</p> <p>*On 9/24/15 after a fall down some stairs he was sent to the hospital. They called at 11:17 p.m. to report he had a broken right arm along with bumps and bruises.</p> <p>*He had died on 11/16/15.</p> <p>Observation on 7/18/16 during the initial tour of the East wing and dining hall revealed a door leading from the dining hall into the daycare that had a keypad with the numbers posted on it.</p> <p>Observation on 7/19/16 at 3:00 p.m. of the same daycare door revealed:</p> <p>*It opened into a child daycare after pressing the keypad number.</p> <p>*After entering the daycare a hallway to the right ended with another door leading to a stairway to the outside. That door currently had a bolt lock at the top of it.</p> <p>*Those were the two doors resident 12 had gone through before falling down the stairs.</p> <p>Observation on 7/19/16 at 3:40 p.m. of an unidentified staff member revealed:</p> <p>*He walked through the daycare door without punching in the numbers into the keypad.</p> <p>*There was a faint chiming noise heard as he went through the door.</p> <p>Interview immediately afterward with daycare worker H revealed both of the above doors were unlocked during the day. They were locked at 5:30 p.m. when they left for the day.</p> <p>Interview on 7/20/16 at 4:30 p.m. with the director of nursing (DON) and the social service designee</p>	F 323		

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F 323	<p>Continued From page 13 regarding the above doors and the event with resident 12 revealed: *The doors had not been locked. *The doors had not been alarmed at the time of the incident to prevent his fall with a major injury.</p> <p>2. Review of a 4/25/16 event report to the SD DOH regarding resident 4 revealed: *She and her roommate were missing on 4/23/16 at approximately 7:00 p.m. *They were found at a relative's home in a neighborhood away from the facility.</p> <p>Review of resident 4's medical record revealed: *She was admitted on 4/22/16 the day before her elopement. *She had dementia with confusion. *Her 4/28/16 MDS BIMS assessment was four indicating severe mental impairment.</p> <p>Surveyor 35625 Observation and interview on 7/18/16 at 4:20 p.m. at exit number four revealed: *The alarm to the door had been switched off. *An unidentified staff member stated it had been turned off when a resident went out to smoke, and it should have been turned back on. *The door led to a fenced courtyard with a gate at one end. -Testing of the gate revealed it could be unlatched without difficulty.</p> <p>Surveyor 34030 Observation and interview on 7/19/16 at 9:15 a.m. with licensed practical nurse (LPN) I revealed: *Exit doors number four and six were in the East wing near resident 4's room. *Those doors were used by resident smokers to</p>	F 323	<p>F323 *NPN/SSDOT/EL [REDACTED]</p> <p>*Review elopement policy at mandatory staff meeting by 08-17-16 *MDS coordinator and SSD to compile elopement risk assessment on admission, quarterly and resident change of status *Staff being alerted to the possibility of elopement through communication book and care plans. *Elopement risk assessment added to MDS checklist *DON to monitor MDS checklist weekly through 90 days and report findings to QA quarterly</p>	8-18-16	

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F 323	<p>Continued From page 14</p> <p>go outside the facility to smoke. *The alarms currently went off when they left and when they come back in.</p> <p>Interview that same day at 3:05 p.m. with LPN I regarding exit doors four and six revealed: *She had been working the day resident 4 and her roommate had eloped. *Both doors alarms had been turned off, so the smokers could go in and out without setting off the alarms.</p> <p>Interview on 7/20/16 at 3:00 p.m. with a family member of resident 4 who did not want to be identified revealed: *She was aware of resident 4's elopement. *Resident 4's current roommate had been her roommate at her previous residency. *She had told them (provider) the day the resident was admitted she would try to elope.</p> <p>Interview on 7/20/16 at 4:30 p.m. with the director of nursing (DON) and the social service designee regarding the above elopement revealed they had been unaware exit doors 4 and 6's alarms had been turned off.</p> <p>Review of the provider's undated Exterior Door Alarms policy revealed: **"East door/day care door - daycare will set daily." **"All exterior doors will be alarmed at all times unless there is direct supervision of that door."</p> <p>Surveyor: 35625 3. Observation on 7/20/16 at 8:33 a.m. in the east dining room revealed: *There was a door that exited the nursing facility into an attached childrens daycare center. *An adult and small child used the door to enter</p>	F 323	<p>F323 *NPN/SDDO/H/EL [REDACTED]</p> <p>*Review and revise policy on alarmed/secure doors and all staff training by 08-17-16.</p> <p>[REDACTED]</p> <p>*NPN/SDDO/H/EL *All direct exterior doors will be alarmed at all times unless there is direct supervision of that door. The alarm panel is located at the east wing nurses station. East wing nurse needs to assure that alarm panel is on at all times. Alarm disable when direct supervision of exterior door observed. Maintenance checklist for daily rounds. Findings of checklist to safety committee monthly. TO QA quarterly x 1 year. NPN/SDDO/H/EL</p>	8-18-16

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F 323	<p>Continued From page 15</p> <p>the daycare center from the nursing home. *No code was entered or alarm sounded when they passed through the door.</p> <p>Observation on 7/20/16 at 12:10 p.m. in the east dining room revealed: *A daycare center staff member exited through the above door. *It did not alarm, and no code had to be entered.</p> <p>On 7/20/16 at 12:15 a.m. testing of the east dining room exit door revealed: *The door did not alarm when this surveyor passed through the door. *The dining room exit door led to an entry way into the daycare center. *There were two additional doors after passing into the entry way. -An unlocked and unalarmed door led to the outside of the building. -At the end of the hallway there was a door that led down a flight of stairs. -A bolt latch was on the upper portion of the basement door, but it was not in place.</p> <p>Interview on 7/20/16 at 9:00 a.m. with the maintenance supervisor regarding the east dining room exit door revealed: *The alarm in place sounded at the door but was not wired into the facility alarm system. *He acknowledged the alarm to the daycare had been "acting up" for approximately one week. *He verified it was not alarmed at this time. *He was unable to supply documentation regarding a work order or alert status on the door.</p> <p>Interview on 7/20/16 at 4:45 p.m. with the director of nursing (DON) revealed: *There was no wander monitoring device or wired</p>	F 323	<p>F323 *NPN/SDDOT/EL [REDACTED] *Item #1 NPN/SDDOT/EL</p> <p>*Revise/review policy for alarmed/secure doors to include all staff training by 08-18-16 17-16. Coded lock placed on day care door with keypad entry for parents and staff only.</p> <p>*No access to this area by residents related to code needed to enter.</p> <p>*Maintenance to check compliance while completing rounds and finding to be discussed at monthly Safety committee meetings.</p> <p>*clarification - door to daycare is not an exit door or fire exit door. Maintenance checklist to include daycare door on daily rounds and taken to safety committee monthly x 3 months. Daycare door coded lock door to remain locked at all times. Lock code must not be posted at any time. Maintenance to add to preventative maintenance checklist.</p>	8-18-16 NPN/SDDOT/EL NPN/SDDOT/EL

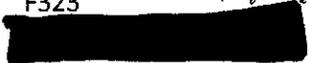
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F 323	<p>Continued From page 16</p> <p>alarm on the east dining room exit door. *An company had been contacted regarding safeguarding the exit doors and stated that it would be unable to be modified.</p> <p>Review of the provider's undated Exterior Door Alarms policy revealed: **"East door/day care door - daycare will set daily." **"All exterior doors will be alarmed at all times unless there is direct supervision of that door."</p> <p>4. Observation and interview on 7/20/16 at 9:50 a.m. of the elevator and basement exit door with the maintenance supervisor revealed: *The elevator was used to travel from the first floor to the basement. *There was a door at the end of the hall that led outside to the staff parking lot. *The elevator and exit door were unlocked at this time. *He stated "It does get locked at night" when referring to the exit door. *He was unable to give specifics on the time or duration that the door was locked.</p> <p>Interview on 7/20/16 at 4:45 p.m. with the DON regarding the elevator and basement exit door revealed: *There was no wander monitoring device on either door. *She verbalized staff would sometimes lock the elevator at night. -That was based on staff preference and was not a consistent practice or per policy. *She acknowledged there were no safeguards in place to prevent a resident from taking the elevator to the basement and exiting out the door.</p> <p>Review of the provider's undated Exterior Door</p>	F 323	<p><i>F323</i></p> <p>4) *New policy for has been established for locking of the elevator which will be locked when not in use. *Policy for elevator reviewed and presented at all staff mandatory meeting by 08-17-16</p> <p><i>*Long term is to utilize employee badge for elevator access *Placed on checklist for maintenance daily rounds with findings to CA quarterly *X2 NPN/SDDOHT/EL *Locking gate ordered forelevator and to be put in place by 9/8/16. Education to all staff at mandatory in-service on 8/16/16 and 8/17/16. NPN/SDDOHT/EL</i></p>	<p><i>*NPN/SDDOHT/EL</i></p> <p><i>*NPN/SDDOHT/EL</i></p>

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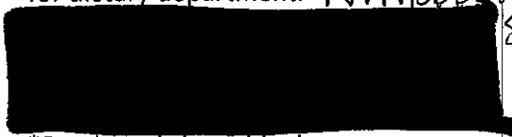
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F 323	Continued From page 17 Alarms policy revealed, "All exterior doors will be alarmed at all times unless there is direct supervision of that door." 5. Observation on 7/20/16 from 3:30 p.m. to 3:45 p.m. regarding side rails revealed: *There were four residents with half side rails that had three spindle-like openings with each measuring 8 inches in length by 8 inches in height. -Resident 17, 18 and 19 had one upper side rail that fit the above dimensions. -Resident 16 had both upper side rails with the above dimensions. Interview on 7/20/16 at 3:50 p.m. with the DON, maintenance supervisor, and environmental services supervisor revealed: *They were unaware those above side rails were in place. *They acknowledged the side rails were an entrapment hazard. *They placed spacer modifications on each of the side rails listed above during the survey to fix the issue. Review of the provider's November 2007 Accident/Incident Prevention Environmental policy revealed: *"Accident hazards are defined as physical features in the environment that can endanger a resident's safety." *"The facility should undertake an environmental assessment to modify the environment to improve mobility and safety, including, but not limited to...individualizing resident room with appropriate bed, toilet/chair height."	F 323	<i>*NPN/SDDOT/EL</i> F323  *Revise side rail policy to include all side rails to be monitored before put to use. *Bedmaker to monitor all bed rails meeting standard measurement weekly then monthly using checklist. *Housekeeping supervisor will monitor and report finding to QA for 90 days. <i>All staff mandatory meeting 08-17-16</i> <i>*Every bed checked by 07/20/16. NPN/SDDOT/EL</i> <i>*Housekeeping supervisor (bedmaker supervisor) will monitor bedmaker findings and report to QA for 90 days. NPN/SDDOT/EL</i>	<i>8-17-16</i>
F 371	483.35(i) FOOD PROCURE,	F 371		

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F 371 SS=E	<p>Continued From page 18 STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 32331 Based on observation, interview, record review, and policy review, the provider failed to ensure sanitary conditions were maintained in the kitchen for: *Three of three drawers that contained utensils. *Seven of seven window sills with uncleanable surfaces. Findings include:</p> <p>1. Observation on 7/18/16 in the kitchen from 4:16 p.m. through 4:50 p.m. revealed: *Three drawers containing serving spoons, spatulas, food whips, tongs, and scoops used for preparing and serving resident food had: -Duct tape that covered the ends of each of the partitioned liners inside the drawers. -Those covered ends ranged from five inches (in) by four in and three in by two in wide. *Seven window sills with: -Three windows located behind a three-tiered shelving unit that contained cleaned pots, pans, trays, bowls, lids, buckets, and baking sheets. -Each of the above window sills had a moderate</p>	F 371	<p>F371 *Review of policy and procedure of cleaning schedule for dietary department. <i>*NPN/SD/DH/EL 8-3-16</i></p> <p></p> <p>*Purchased cleanable drawers for storage of utensils until stainless steel table arrives *Windows have been caulked and painted so now cleanable surface. *Fiberglass reinforced panel placed over windows with surface now cleanable. *Checklist for cleaning of dietary surfaces to be maintained by dietary staff and reviewed by dietary manager monthly. *Findings taken to QA quarterly <i>*by dietary</i> <i>*All staff mandatory meeting manager for education 8-17-16</i></p> <p><i>*POC revised: stainless steel table not approved. Utensils being stored in three drawer cleanable rubbermaid container.</i> <i>NPN/SD/DH/EL</i></p>	
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F 371	<p>Continued From page 19</p> <p>amount of built-up grease with scarred and chipped surfaces.</p> <p>-Four windows located behind the two-compartment sink that contained the sanitizing bucket used for sanitizing the food preparation and equipment areas.</p> <p>-Those above windows had a moderate amount of peeling paint with scarred and chipped surfaces.</p> <p>*Those above windows sills had uncleanable surfaces.</p> <p>Interview on 7/19/16 at 10:00 a.m. with the maintenance director regarding the utensil drawers' partitioned liners that contained duct tape and the window sills revealed:</p> <p>*He agreed the drawer liners needed to have been replaced.</p> <p>*He agreed the windows sills in the kitchen needed to have been cleaned, sealed, and repainted.</p> <p>*He confirmed the above areas were not cleanable surfaces.</p> <p>Observation on 7/19/16 at 11:10 a.m. by cook J revealed:</p> <p>*She obtained a spatula from one of the drawer's partitioned liners that contained duct tape.</p> <p>-That spatula's handle had been touching the duct tape.</p> <p>*She used the above spatula in the blender for preparing residents' pureed cornbread.</p> <p>Interview on 7/20/16 at 8:45 a.m. with the certified dietary manager regarding the drawers' partitioned liners and the window sills revealed:</p> <p>*The cook was responsible for cleaning the drawers.</p> <p>*She agreed the utensil drawers' liners with the</p>	F 371	<p>F371</p> <p>*Review of policy and procedure of cleaning schedule for dietary department. *NPN/SDDOH/EL</p> <p>[REDACTED]</p> <p>*Purchased cleanable drawers for storage of utensils [REDACTED] *NPN/SDDOH/EL</p> <p>*Windows have been caulked and painted so now cleanable surface.</p> <p>*Fiberglass reinforced panel placed over windows with surface now cleanable.</p> <p>*Checklist for cleaning of dietary surfaces to be maintained by dietary staff and reviewed by dietary manager monthly.</p> <p>*Findings taken to QA quarterly *by dietary manager x 90 days. NPN/SDDOH/EL</p> <p>*POC revised → stainless steel table not approved. Utensils being stored in three drawer cleanable rubbermaid container. *NPN/SDDOH/EL</p>	8-3-16

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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 371	Continued From page 20 duct tape covering the ends were no longer cleanable surfaces. *The window sills were not on a cleaning schedule. *She confirmed those sills were located above: -Cleaned pots, pans, trays, bowls, lids, buckets, and baking sheets. -The sanitizing bucket used for sanitizing the food preparation areas and equipment. *She agreed the sills were no longer cleanable surfaces. Review of the provider's undated cleaning schedule revealed: *The above drawers were to have been cleaned every Friday. *Window sills had not been on the cleaning schedule. Review of the provider's 2000 Dish, Utensil, and Equipment Storage and Cleaning Procedures policy revealed: *Drawers must not be used unless the material used was cleanable. *All equipment, counters, tables, drawers, and shelves must be maintained in a clean condition at all times.	F 371			
F 431 SS=D	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.	F 431			

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F 431	<p>Continued From page 21</p> <p>Drugs and biologicals used in the facility must be 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, record review, and policy review, the provider failed to: *Ensure blank physician's medication prescriptions were not stored in one of one medication awaiting destruction box. *Ensure the medication awaiting destruction key was not left unsecured hanging on the wall in one of one medication room. *Ensure two of two medication refrigerators were maintained frost free to ensure critical medication</p>	F 431		

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F 431	<p>Continued From page 22 was not frozen. Findings include:</p> <p>1. Observation and interview on 7/19/16 at 9:00 a.m. with licensed practical nurse (LPN) F in the medication room revealed: *A medication awaiting destruction box was mounted on the wall. *Beside that box were numerous keys hanging up on a key rack. *LPN F was asked if the medication awaiting destruction key was hanging on the key rack. *LPN F replied it was, and she proceeded to remove the key from the rack and open the medication box. *Inside the medication box was narcotic medication waiting for destruction by a nurse and the pharmacist and a large pad of blank medication prescriptions. *Those blank prescriptions were the property of one of the physicians who provided care for residents at the facility. *He had accidentally left them there and asked staff to lock them up for him. *She was unaware how many blank prescriptions were in that pad. *The facility had locked them up but had not accounted for them. *She agreed any nursing staff that had access to the medication room would be able to access the key, and remove a blank prescription without the facility's knowledge. *The above mentioned key had always been left hanging unsecured in the medication room.</p> <p>2a. Observation and interview on 7/19/16 at 9:00 a.m. with licensed practical nurse (LPN) F in the medication room regarding the medication refrigerator revealed two inches of frost around it.</p>	F 431	<p>F431 1) *Review policy and procedure for disposition and receipt of all controlled substances for all nursing staff and reviewed by DON. *Keys to be kept on charge nurse key ring at all times. *Prescription pads returned to MD and all physicians notified TLC can no longer store prescription pads for them</p> <p><i>*Mandatory nursing meeting on 8/15/16 educated staff to review P and P and keys to controlled substances on charge nurse at all times. NPN/SPDOH/EL</i></p> <p><i>*DON to take findings to QA x 90 days x2. NPN/SPDOH/EL</i></p>	8-17-16

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F 431	<p>Continued From page 23</p> <p>*It was the night staffs responsibility to clean and maintain that refrigerator.</p> <p>*The refrigerator temperatures had not gone out of the acceptable range of 36-46 degrees Fahrenheit (F), but the temperature had to be adjusted regularly to maintain temperatures within that zone.</p> <p>b. Observation and interview on 7/19/16 at 10:40 a.m. at the east nurses station with registered nurse (RN) G regarding the medication refrigerator located there revealed:</p> <p>*The refrigerator temperature upon opening was at 30 degrees F.</p> <p>*That refrigerator contained numerous insulin medications for the residents located in the east hall.</p> <p>*When asked what their policy was in regard to insulin medications that had been frozen RN G replied they were to destroy it per manufacturer's recommendations.</p> <p>*A large ring of frost was noted around the freezer portion of the refrigerator.</p> <p>*According to the log the last time the refrigerator had been cleaned and defrosted was 5/15/16.</p> <p>*That was the night shift's nursing responsibility to clean and maintain the medication refrigerators.</p> <p>3. Interview on 7/20/16 at 4:30 p.m. with the director of nursing regarding the above observations revealed:</p> <p>*She was unaware a physician had asked staff to store his prescription pads in the medication destruction box.</p> <p>*She agreed the key needed to be kept secured with limited access, and it would now be in the possession of the charge nurse at all times.</p> <p>*The medication refrigerators used to be cleaned monthly, but that had changed to an as needed</p>	F 431	<p>F431</p> <p>b</p> <p>*Revise policy to include defrosting of medication refrigerator monthly.</p> <p>*Nursing to sign off upon completion of cleaning/defrosting/temperature control.</p> <p>*DON to monitor monthly and findings reported to QA quarterly</p>	8-17-16
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F 431	Continued From page 24 cleaning as staff felt it was done too often. Review of the current undated Storage of Medications policy revealed drugs were to have been stored in a safe and secure manner. Review of the current undated Med Room Refrigerator Cleaning policy revealed: *Cleaning was to be done as needed and when visibly soiled. *Thawing of accumulated ice/frost was part of the cleaning process.	F 431		
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 (3) Maintains a record of incidents and corrective actions related to infections. (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	F 441		

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F 441	<p>Continued From page 25</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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: 35625 Based on observation, interview, documentation review, and policy review, the provider failed to ensure three of three stand lifts were cleaned when visibly soiled. Findings include:</p> <p>1. Observation on 7/19/16 at 8:25 a.m. and on 7/20/16 at 2:40 p.m. revealed there was a significant amount of tan-colored debris at the base of all three stand lifts.</p> <p>Interview on 7/20/16 at 4:45 p.m. with the director of nursing revealed: *The stand lifts were on a weekly schedule to be cleaned. *She did not offer information regarding as-needed cleaning when they were visibly soiled.</p> <p>Review of the monthly evening and weekend cleaning schedule for July 2016 revealed: *The lifts were cleaned every Wednesday on the night shift. *On 7/6/16 and 7/13/16 that was initialed as</p>	F 441	<p>F441</p> <p>*Review/Revise policy and procedure for cleaning of standlifts weekly and as needed</p> <p>*Review at mandatory staff meeting by 08-17-16</p> <p>*Cleaning to be done by night staff using a checklist with date and initials. <i>NPN/SDDOHT/EL</i></p> <p>*DON to monitor findings to infection control quarterly <i>IC nurse</i> <i>every 2 weeks</i> <i>NPN/SDDOHT/EL</i></p> <p><i>*Charge nurse to check daily. Sign off on a checklist and report to DON/IC nurse on cleanliness of standlifts.</i></p> <p><i>NPN/SDDOHT/EL</i></p>	<i>8-17-16</i>	

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F 441	Continued From page 26 completed. *There was no documentation provided that as-needed cleaning was provided. Policies concerning the cleaning of the stand lifts was requested from the director of nursing, however none were received by conclusion of the survey. Association for Professionals in Infection Control and Epidemiology, Inc., APIC Text of Infection Control and Epidemiology, 3rd Ed., Washington, DC, 2009, p.100, revealed: *The key to have cleaned and disinfected environmental surfaces was the use of friction to physically remove visible, dirt, organic material, and debris. *Routine cleaning was necessary to maintain a standard of cleanliness. *Procedures must have been effective, consistent, and thorough.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Surveyor: 35625 Based on observation, interview, and documentation review, the provider failed to ensure the facility had a thorough preventative maintenance program. Findings include: 1. Observation and interview with the	F 456		

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F 456	<p>Continued From page 27</p> <p>maintenance supervisor on 7/20/16 at 9:00 a.m. revealed:</p> <p>*He had been working for the facility since 3/1/16.</p> <p>*On exterior review of the front patio there was an area of uneven slabs of concrete.</p> <p>-It was not marked thus creating a trip and fall hazard to residents, staff, and visitors.</p> <p>*Acknowledged he was not aware of the above hazard, and that area was not reviewed on a consistent basis.</p> <p>Documentation review and interview on 7/20/16 at 9:15 a.m. with the maintenance supervisor revealed:</p> <p>*He followed a monthly checklist.</p> <p>*There were multiple duties not marked as completed on the checklist for May and June 2016.</p> <p>-May 2016 included eight duties that were not completed.</p> <p>-June 2016 included four duties that were not completed.</p> <p>-He did not offer information for the reason they were not completed.</p> <p>*The list did not include resident care items such as:</p> <p>-Side rails on the beds.</p> <p>-Stand lift and full body lifts.</p> <p>-Call lights.</p> <p>*The checklist did not include an exterior review of the building and area surrounding it.</p> <p>*He acknowledged there were additional items in the facility that needed to be monitored on a consistent basis.</p> <p>Policies concerning the preventative maintenance program were requested from the maintenance supervisor and director of nursing, however none were received by conclusion of the survey.</p>	F 456	<p>F456</p> <p>*Review policy and procedure of preventive maintenance checklist of rounds to include exterior of building.</p> <p>*Checklist for daily, monthly, quarterly and annual have been updated</p> <p>*Checklist to include date, items and initials of staff completing them.</p> <p>*Exterior review of patio uneven concrete slabs clearly labeled with yellow paint as to not be a trip hazard.</p> <p><i>*Findings to be quarterly by safety committee x 2. NPN/SDDO/H/E/L</i></p> <p><i>*checklist taken to safety committee for review by maintenance supervisor. NPN/SDDO/H/E/L</i></p> <p><i>*Administrator to monitor maintenance checklist monthly for the year NPN/SDDO/H/E/L</i></p>	8-17-16

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K 000	<p><i>*Addendums noted with an asterisk per 8/16/16 per telephone with facility administrator.</i></p> <p>Surveyor: 18087 <i>CH/SDDOHEL</i></p> <p>A recertification survey for compliance with the Life Safety Code (LSC) (2000 existing health care occupancy) was conducted on 7/19/16. Tekakwitha Living Center 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 and the Fire Safety Evaluation System (FSES) dated 7/25/16 upon correction of the deficiencies identified below.</p> <p>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 K025, K047, and K062 in conjunction with the provider's commitment to continued compliance with the fire safety standards.</p>	K 000		
K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain the thirty minute fire resistive rating of smoke barrier walls. One of two smoke barrier walls (at the north wing) had unsealed</p>	K 025	<p>K025</p> <p>*Both smoke barrier walls will be sealed correctly on the north wing openings above the ceiling in conjunction with discussion to become compliant with fires safety standards</p> <p><i>*CH/SDDOHEL</i></p>	
			<p><i>*The maintenance supervisor will report the completion of the repairs to O.A. The inspection of the smoke barrier walls will be put on a quarterly preventive maintenance schedule.</i></p> <p><i>CH/SDDOHEL</i></p>	<p><i>*8/17/16</i></p> <p><i>CH/SDDOHEL</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mary Beth Grase RCHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/2/16</i>
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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 033	Continued From page 2 into a main level vestibule. The vestibule was not separated by a one hour fire resistive construction. Further observation at 1:30 p.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.	[REDACTED]	*CHSDDOHEL	
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 1:30 p.m. on 7/19/16 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 "F" in the completion date column to indicate the provider's intent to correct the deficiencies identified in K000.	K 040		F

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K 047 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Surveyor: 18087</p> <p>A. Based on observation and interview, the provider failed to provide exit signs with continuous illumination. Three randomly observed exit signs had lamps burned out. Findings include:</p> <p>1. Observation beginning at 10:30 a.m. on 7/19/16 revealed the following exit signs had lamps burned out: *The exit sign over the door to the south dining room from the south wing had one of two lamps out. *The exit sign in front of Rainbow Day Care (the sign in the south dining room showing the egress path for the south wing) had one of two lamps out. *South dining room-above the east exit door-the exit sign had one of two lamps out. Interview with the maintenance supervisor at the time of the observations confirmed those conditions existed.</p> <p>The deficiency had the potential to affect 100% of the smoke compartment's occupants.</p> <p>B. Based on observation and interview, the provider failed to furnish lit exit signs to ensure the path of egress to exits were identified for the basement boiler room. Findings include:</p>	K 047	<p>K047 i)</p> <ul style="list-style-type: none"> *Review and revise policy and procedure for exit signs and maintenance of them *Maintenance to inspect the exit signs when completing rounds using checklist. *Maintenance to make repairs/replacement of items found while completing rounds *Maintenance to monitor and bring findings to safety committee monthly. *Replacement of bulbs to exit sign over the door to the south dining room from the south wing bulb replaced 08-11-16 * Exit sign in front of the Rainbow Day Care (sign in the south dining room showing the egress path for the south wing) was replaced 08-11-16 *South Dining room above the east exit door bulb replaced 08-11-16 <p>*The maintenance supervisor will report the completion of the repairs to QA. CH/SDDOT/EL</p>	<p>*CH/SDDOT/EL</p> 	

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

PRINTED: 08/03/2016
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 07/19/2016
NAME OF PROVIDER OR SUPPLIER TEKAKWITHA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
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K 047	Continued From page 4	K 047		
K 062 SS=D	<p>1. Observation at 11:00 a.m. on 7/19/16 revealed the basement boiler room had three fuel-fired boilers (Kewanee-Dresel) with 1550 million British Thermal Units (Mbtuh) input each. That provided a cumulative Mbtuh input over 3100 when two boilers were in-use. The boiler room was over 500 square feet in area. For those conditions, two marked exits were required. There were no exit signs with emergency lighting (either generator or battery backup lighting) to indicate the path of egress for the required (and remotely located) exits from the basement boiler room. Interview with the maintenance supervisor at the time of the observations confirmed those findings.</p> <p>The deficiency affected one of numerous requirements for marking the paths of egress. 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</p> <p>Based on record review and interview, the provider failed to ensure the automatic sprinkler system had required quarterly flow testing performed during the previous twelve months. Record review of the previous twelve months fire sprinkler system inspections revealed quarterly flow testing documentation was not available. Findings include:</p> <p>1. Review of the provider's automatic sprinkler system inspection reports at 2:30 p.m. on 7/19/16</p>	K 062	<p>K047 b *Adhesive exit sign tape placed in boiler room to ensure path of egress for exit in case of fire 08-11-16 *Revise policy to include maintenance of exit signs in boiler room *Add to checklist for maintenance to be completed on rounds and findings given to safety committee on monthly basis,</p>	8-11-16

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NAME OF PROVIDER OR SUPPLIER TEKAKWITHA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6 E CHESTNUT SISSETON, SD 57262	
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K 062	Continued From page 5 revealed quarterly flow testing documentation was not available. Interview with the maintenance supervisor at the time of the record review indicated he was unaware of the quarterly flow testing requirements. He stated he was a new employee at the facility in March 2016.	K 062	K062 1 *Review policy and procedure for automatic sprinkler system and testing of it. *Test to be completed yearly by Nova and maintenance to complete testing quarterly.	8-17-16
K 130 SS=C	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 1:00 p.m. on 7/19/16 of the south corridor from the south, 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	* Maintenance to monitor this process through checklist * Findings given to safety committee quarterly.	F

ORIGINAL

SD Department of Health Vital Records

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 10685	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2016
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S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 7/18/16 through 7/20/16. Tekakwitha Living Center was found in compliance.	S 000		
S 000	Compliance/Noncompliance Statement Surveyor: 33488 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:74, Nurse Aide, requirements for nurse aide training programs, was conducted from 7/18/16 through 7/20/16. Tekakwitha Living Center was found in compliance.	S 000		

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

Mary Beth Grose RNHA

TITLE

Administrative

(X6) DATE

8/12/16

STATE FORM

6899

JAN 11

In continuation sheet 1 of 1

