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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	43A038	A. BUILDING _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	503 WEST PINE PHILIP, SD 57567

(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 000	INITIAL COMMENTS Surveyor: 16385 A recertification health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities, was conducted from 4/19/21 through 4/22/21. Philip Nursing Home was found in compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/10/2021

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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E 000	Initial Comments Surveyor: 16385 A recertification survey for compliance with 42 CFR Part 482, Subpart B, Subsection 483.73, Emergency Preparedness, requirements for Long Term Care Facilities, was conducted from 4/19/21 through 4/22/21. Philip Nursing Home was found in compliance.	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/10/2021

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	43A038	A. BUILDING 01 - MAIN BUILIDING 01 B. WING	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	503 WEST PINE PHILIP, SD 57567

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K 000	INITIAL COMMENTS Surveyor: 18087 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted from 4/20/21 through 4/21/21. Philip Nursing Home was found not in compliance with 42 CFR 483.70 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of deficiencies identified at K222 and K918 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the	K 222		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/10/2021

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	43A038	A. BUILDING 01 - MAIN BUILIDING 01 B. WING _____	04/21/2021

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K 222	Continued From page 1 Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by:	K 222		

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**04/21/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	**503 WEST PINE** **PHILIP, SD 57567**

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K 222	Continued From page 2 Surveyor: 18087 Based on observation and interview the provider failed to provide egress doors as required for two of three exit doors (south and north exits). Findings include: 1. Observation on 4/20/21 at 11:10 a.m. revealed the south exit door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was not the required signage mounted on the door indicating it was delayed egress and how to exit. 2. Observation on 4/20/21 at 11:15 a.m. revealed the north exit door was equipped with a magnetic lock that prevented egress. Testing of the door by applying force in the direction of the path of egress revealed that action would initiate an irreversible process to unlock the magnet and release the door. That indicated the magnetically locked door was functioning as a delayed egress locked door. There was not the required signage mounted on the door indicating it was delayed egress and how to exit. Interview at the time of the above observation with the director of support services confirmed that condition. He stated the windows in the doors had been replaced but signage had not been installed on the new windows. Failure to provide egress doors as required increases the risk of death or injury to all building occupants due to fire.	K 222	The Plant Operations Director or designee will install the required signage indicating that the south and north doors (mentioned) are equipped as delayed egress exits. The Plant Operations Director or designee will inspect all exits equipped as delayed egress to ensure the required signage is present. The Plant Operations Director or designee will inspect all delayed egress exits monthly for three months to ensure the required signage is in place. The Plant Operations Director or designee will report inspection results to the QAPI team monthly for three months for further recommendation.	5/28/2021

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	43A038	A. BUILDING **01 - MAIN BUILIDING 01** B. WING _____	**04/21/2021**

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K 222	Continued From page 3 The deficiency affected 100% of the building occupants. Ref: 2012 NFPA 101 Section 19.2.2.2.4(3), 7.2.1.6.2(3)(a)	K 222		
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing	K 918		

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K 918	Continued From page 4 the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 18087 Based on record review and interview, the provider failed to document generator battery conductivity monthly (no testing was being done in the past year). Findings include: 1. Record review on 4/21/21 at 1:45 p.m. revealed there was not any documentation of the battery conductivity in the monthly maintenance logs for the generator. Interview with the director of support services at the time of the record review confirmed that finding. He stated he was unaware of the monthly battery conductivity documentation requirement. The deficiency affected 100% of the building occupants.	K 918	The Plant Operations Director or designee will complete the battery conductivity test to ensure proper generator operation. The Plant Operations Director or designee will complete the battery conductivity test monthly as a prevenitive maintenance task and document the testing. The Plant Operations Director or designee will report the completion of this task and the results to the QAPI team monthly for three months for further recommendation.	5/28/2021

South Dakota Department of Health

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	10661	A. BUILDING: _____ B. WING _____	04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHILIP NURSING HOME	503 W PINE POST OFFICE BOX 790 PHILIP, SD 57567

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S 000	Compliance/Noncompliance Statement Surveyor: 18087 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 4/19/21 through 4/22/21. Philip Nursing Home was found not in compliance with the following requirement: S173.	S 000		
S 173	44:73:02:18(8-10) Occupant Protection The facility shall take at least the following precautions: (8) Any light fixture located over a resident bed, in any bathing or treatment area, in a clean supply storage room, in any laundry clean linen storage area, or in any medication set-up area shall be equipped with a lens cover or a shatterproof lamp; (9) Any clothes dryer shall have a galvanized metal vent pipe for exhaust; and (10) The storage and transfilling of oxygen cylinders or containers shall meet the requirements of the NFPA 99 Standard for Health Care Occupancies, 2012 Edition. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 18087 Based on observation and interview, the provider failed to maintain shatterproof lamps in overhead lighting in two of two tub rooms (front and side tub rooms). Findings include: 1. Observation at 11:15 a.m. on 4/20/21 revealed the overhead heat lamp in the front tub room had	S 173	The Plant Operations Director or designee will replace the lamp with one that has shatter proof protective coating in both mentioned resident tub areas. The Plant Operations Director or designee will inspect all lighting in the nursing home to ensure each light fixture has a protective lens or shatter proof coating intact. The Plant Operations Director or designee will repair or replace any light fixtures as necessary.	5/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/10/2021

South Dakota Department of Health

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	10661	A. BUILDING: _____ B. WING _____	04/22/2021

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S 173	Continued From page 1 the protective coating peeling off the surface of the lamp. Over fifty percent of the lamp's surface was not protected with a shatterproof covering. Interview with the director of support services at the time of the observation confirmed that condition. He stated he was unaware the lamp's protective coating had peeled away from the lamp surface. 2. Observation at 11:20 a.m. on 4/20/21 revealed the overhead heat lamp in the side tub room had the protective coating peeling off the surface of the lamp. Over fifty percent of the lamp's surface was not protected with a shatterproof covering. Interview with the director of support services at the time of the observation confirmed that condition. He stated he was unaware the lamp's protective coating had peeled away from the lamp surface. These conditions would affect occupants of these tube rooms due to broken glass.	S 173	The Plant Operations Director or designee will inspect lighting fixtures monthly for 3 months to ensure the protective lens/coating is in place. The Plant Operations Director or designee will report inspection results to the QAPI team monthly for 3 months for further recommendation.	
S 000	Compliance/Noncompliance Statement Surveyor: 16385 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 04/19/21 through 04/22/21. Philip Nursing Home was found in compliance.	S 000		