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
	435038	A. BUILDING _____ B. WING _____	01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

(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 1/25/22 through 1/27/22. Tekakwitha Living Center was found not in compliance with the following requirements: F575, F625, F812, and F880.	F 000		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Surveyor: 06365	F 575	SSD posted phone numbers for SD DOH at areas mentioned in survey on 1-30-2022. An assesment of the facility was completed to ensure other areas needing postings are covered. Education on contact informatio was provided to residents and staff on 2-23-2022. Audits will be completed monthly for 3 months by SSD or designee to ensure postings provide phone numbers to pertinent state agencies and advocacy groups. SSD or Designee will report findings at Monthly QAPI meetings for review.	2-25-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Holler	Administrator	2-17-2022

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 575	Continued From page 1 Based on observation, interview, and document review, the provider failed to post contact information for filing a complaint with the state survey agency. Findings include: Interview on 1/26/22 at 10:00 a.m. with 11 residents (2, 7, 8, 10, 12, 18, 21, 33, 34, 36, and 37) in attendance for a group interview revealed they were not aware of their right to complain to the state if they had concerns about the care they received. Observation on 1/26/22 at 10:35 a.m., following the group interview, revealed posters providing contact information for the state ombudsman were posted on bulletin boards on the wall outside of the north dining room doorway and on the wall next to the east wing nurses' station. There were no signs posted with contact information for filing a complaint with the South Dakota Department of Health (SD DOH). Review of the admission packet revealed a one page insert in a South Dakota Department of Human Services brochure that included a SD DOH phone number, but it was not the current contact number for the SD DOH complaint coordinator. Interview on 1/27/22 at 10:48 a.m. with social services designee D revealed she did not know the complaint phone number on the insert was outdated and did not realize the contact information for SD DOH was not included on the ombudsman poster.	F 575		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625	Bed Hold Policy updated by ... on 1-30-2022 to ensure information is provided to a resident or thier representitive within state specifics. DON or designee will ensure that resident 7 ande 13 have a bed hold option if still out of the facility. Both resident 7 and 13 are back in the facility. All other residents that are aon a bed hold or out of the facility on leave will be reserved to ensure a bed hold was offered Administrator or designee will audit for other policies lacking specifics. Continued on next page	2-25-2022

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F 625	Continued From page 2 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview, record review, and document review, the provider failed to provide bed-hold notices at the time of transfer for two of two sampled residents (7 and 13). Findings include: 1. Review of the electronic medical record (EMR) for resident 7 revealed: *A health status progress note (PN) dated 10/9/21	F 625	Administrator or designee will audit for other policies lacking specifics. Saff will be educated on the updated policy. Audits will be conducted by DON or designee once a week x4m then monthly for 2 months Findings will be brought to monthly QAPI by DON for review	

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F 625	Continued From page 3 at 1:09 a.m. to "send resident to ER [emergency room] for evaluation via ambulance." *A PN dated 10/9/21 at 1:37 a.m. indicating the daughter-in-law was notified of the resident's transfer to the ER. *Neither of the above PNs reported anything about providing notice of the bed-hold policy. *A hospital transfer form dated 10/13/21 noted she returned to the facility on that date. 2. Review of the EMR for resident 13 revealed: *A PN dated 12/22/21 at 2:06 p.m., the resident left the facility to go home until 12/24 or 12/25. *A PN dated 12/25/21 at 10:56 a.m., the resident returned to the facility. *A PN dated 1/1/22 at 10:36 a.m. the resident went home "until Monday with wife." *A PN dated 1/3/22 at 1:00 p.m., the resident had returned to the facility. *None of those notes indicated notification of the bed-hold policy. Interview on 1/27/22 at 9:37 a.m. with registered nurse E revealed the business office takes care of providing bed-hold notices. Interview on 1/27/22 at 10:57 a.m. with social service designee (SSD) D revealed: *The business office does not provide the bed-hold notices. *She thought the nurses sent the bed-hold notice with hospital transfer paperwork. *She visited with resident 13 about the bed-hold policy before he went out for therapeutic leave but she did not document those conversations. *She would look for a copy of the policy and procedure for the bed hold notification process. Review of the "Bed Hold Policy Notification" form	F 625		

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F 625	Continued From page 4 provided by SSD D revealed: *The bed-hold policy is defined for hospital and therapeutic leaves for Medicaid and other payment sources. *The general rules include removing "personal belongings from the facility within 24 hours" if the resident decides to not hold the bed. *A place for the resident and/or legal representative to check "I DO" or "I DO NOT" choose to hold the bed and a place to sign and date the form. *The form did not specify the process for obtaining signatures on the bed hold form.	F 625		2-25-2022
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Surveyor: 16385	F 812	On 1-30-2022 Maintenance Supervisor deep cleaned the kitchen ice machine and replaced the greate on 2-10-2022. North Ice machine was deep cleaned 1-30-2022 and rust removed 2-11-2022. Staff were educated on reporting cleaning/repair requests on 2-23-2022. Ice machine cleaning policy will be revised as needed. Maintenance or a designee will preform a one time audit on on other drink machines to ensure compliance. Maintenance or a designee will audit ice machine for clenliness once per month for 3 months. Maintenance director will present audit findings at the monthly QAPI meeting for review.	

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F 812	Continued From page 5 Based on observation and interview, the provider failed to ensure two of two Manitowac water/ice machines (hallway by the kitchen and north dining room) were maintained in a clean, operable condition. Findings include: 1. Observation on 1/25/22 at 8:15 a.m. of the Manitowac water/ice machine in the hallway by the kitchen revealed mineral (lime) and rust build-up on the tray grate and tray of the machine. A tan rust liquid was on the the entire tray lip and dripping into the drainage tray. Observation on 1/26/22 at 8:30 a.m. of the Manitowac water/ice machine in the north dining room revealed a large amount of brown/tan rust build-up on the lower shelf of the stainless steel table below the ice machine. Interview on 1/27/22 at 9:15 a.m. with the maintenance supervisor C confirmed the above observations. Further interview revealed both machines were on the preventative maintenance schedule to be cleaned once per week. Neither of the water/ice machines had been cleaned this week due to other priorities.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880	1. For the identification of Lack of: *Posted information on type of personal protective equipment (PPE) worn by staff to care for residents on isolation precautions. *Posted information for individuals visiting residents on isolation precautions: The administrator, DON, and interdisciplinary team in collaboration with the medical director to review, revise, create as necessary the policies and procedures for the above identified areas. All facility staff who provide or are responsible for the above cares and services will be educated/re-educated by 3-1-2022 by DON or designee. 2. All residents, staff, and visitors have the potential to be affected by lack of: Posted PPE instructional signage and visitation guidance when residents are on isolation precautions. *Policy education/re-education about roles and responsibilities for the above identified assigned care and services tasks will be provided by 2-20-2022 by DON or designee. 3. Root cause analysis conducted answered the 5 Whys: The procaution information needs to be kown to anyone who may try to enter the room. Even visitors or other residents needs to know that that space has procautions.	2-25-2022

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F 880	Continued From page 6 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct	F 880	Administrator, DON, medical director, and any others identified as necessary will ensure ALL facility staff responsible for the assigned task(s) have received education/training with demonstrated competency and documentation. Administrator and DON contacted the South Dakota Quality Improvement Organization (QIN) on 2-14-2022. QIN gave resources to Admin and DON. Monitoring: 4. Administrator, DON, and/or designee will conduct auditing and monitoring 2 to 3 times weekly over all shifts to ensure identified and assigned tasks are being done as educated and trained. Monitoring for determined approaches to ensure effective implementation and ongoing sustainment. *Staff compliance in the above identified area. *Any other areas identified through the Root Cause Analysis. After 4 weeks of monitoring demonstrating expectations are being met, monitoring may reduce to twice monthly for one month. Monthly monitoring will continue at a minimum for 2 months. Monitoring results will be reported by administrator, DON, and/or a designee to the monthly QAPI committee and continued until the facility demonstrates sustained compliance as determined by committee.	

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F 880	Continued From page 7 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Observation and interview on 1/25/22 at 11:21 a.m. with resident 13 in his room revealed: *He was seated in a wheelchair with his feet touching the floor. *His left foot wore a shoe. *His right foot was wrapped halfway up his calf. The leg and foot appeared swollen, and there was redness visible above the top of the wrap. *He responded to the surveyor's inquiry about the leg by saying he was "told I had to stay in my room. I'm quarantined." *He said there were open areas on his leg underneath the wrap but they were improving. *He also reported he had recently "flicked" a scab off one of the open areas when it was hanging loose. Observation after the interview revealed there was no sign regarding isolation precautions posted on resident 13's door.	F 880		

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F 880	Continued From page 8 Observation on 1/26/22 at 10:30 a.m. revealed resident 12 was seated in a wheelchair in resident 13's room next to resident 13's left side. Surveyor: 45383 Based on observation, interview, and policy review, the provider failed to post information regarding the type of personal protective equipment (PPE) to be worn before entering the rooms of two of two sampled residents (13 and 30) on isolation precautions. Findings include: 1. Observation on 1/25/22 at 8:34 a.m. of resident 30's doorway revealed: *A sign instructing please check at nurses' station. *A clear plastic shower curtain placed in doorway of resident's room. Interview on 1/25/22 at 8:59 a.m. with licensed practical nurse F regarding the sign posted for resident 30 revealed: *He had recently been diagnosed with methicillin-resistant staphylococcus aureus (MRSA) in his sputum. *She did not realize there was no signage posted for PPE use. 2. Interview on 1/27/22 at 9:51 a.m. with registered nurse E regarding treatment for resident 13's right leg revealed: *He had been diagnosed with MRSA on his right leg. *His wounds on his right leg had been weeping. *He received the antibiotic Bactrim orally for the wound infection. *His right leg was wrapped to keep him from scraping the wounds. *He had been on contact precautions.	F 880		

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F 880	Continued From page 9 *He had been reminded to stay in his room. *He had another resident visiting him in his room. *Residents should not be in his room. *"We don't like to put up precaution signs because it could be demeaning, but could put up a sign to check with the nurse before entering." Interview on 1/27/22 at 10:30 a.m. with director of nursing B revealed: *She thought that type of precaution was a Health Insurance Portability and Accountability Act (HIPPA) violation. *A sign should have been posted outside of the resident's door to instruct staff and visitors proper PPE to wear. Review of the provider's undated transmission based precautions policy revealed: *For resident's on contact precautions staff would wear gloves and isolation gown before contact with the resident. *For resident's on droplet precautions staff would wear facemask within six feet of a resident. *The policy did not state to display signage for instruction of PPE to be worn with precautions.	F 880		

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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 1/25/22 through 1/27/22. Tekakwitha Living Center was found not in compliance with the following requirements: E004 and E013.	E 000		
E 004 SS=E	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must	E 004	EP plan will be reviewed and revised at least annualy by Administrator, DON, and saftey committee. Attention will be given to areas specified. Education will be completed by managers to ensure staff know of the updated policies. Audits will be completed monthly for three months by Administrator or designee to ensure compliance. Findings will be communicated at Monthly QAPI by Administrator or designee for Review	2-25-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rachel Holler | Administrator | 2-17-2022

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E 004	Continued From page 1 develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview and document review, the provider failed to maintain, review, and update at least annually a comprehensive emergency preparedness (EP) program. Findings include: 1. Review of the current copy of the provider's EP "Disaster Plan" manual revealed: *Policies revised: "01/2019." *Policies reviewed: [no date listed]. Further review of the EP manual revealed the table of contents did reference the following documents: -A room list of residents that was dated June 2021 and did not reflect the current resident census. -Procedures for "Emergency Preparedness for COVID-19." -A policy and procedure for "Automated	E 004		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

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E 004	Continued From page 2 Emergency Calling System." -Floor maps showing locations of sprinkler zones, shut-offs for sprinkler zones, exit doors for the main floor and basement storage. -A policy and procedure for "Emergency Preparedness Medication Administration Plan. -A letter from a dialysis provider regarding disruption of services during a blizzard. -An "Emergency Water Agreement" with a local entity. -A facility- and community-based hazards assessment provided by director of nursing (DON) B upon request. -A facility assessment of the resident population, facility services, and succession plans for continuity of operations provided by administrator A with the entrance conference documents. Interview on 1/27/22 at 11:30 a.m. with administrator A revealed she had just received a resource manual regarding disaster and emergency planning that she planned to use for modifying the facility EP manual.	E 004		
E 013 SS=E	Development of EP Policies and Procedures CFR(s): 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of	E 013	EP plan will be reviewed and revised at least annualy byAdministrator, DON,and saftey committee. Attentione will be given to arreas specified. Education will be completed by managers to ensure staff know of the updated policies Audits will be completed monthly for 3 months by Administrator or designee to ensure compliance Findings will be communicated at Monthly QAPI by administrator or designee for review.	2-25-2022

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E 013	Continued From page 3 this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk	E 013		

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E 013	Continued From page 4 assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Surveyor: 06365 Based on interview and document review, the provider failed to sufficiently detail procedures regarding: *Evacuation, sheltering in place, and subsistence needs for staff and residents during an emergency event. *Communication and arrangements with entities to ensure continuity when facility operations were affected by an emergency event. The above noncompliance has the potential to affect all residents residing in the facility at the time of an emergency event. Findings include: 1. Review of the most current copy of the provider's emergency preparedness "Disaster Plan" manual revealed: *Evacuation procedures were described in the fire policy and procedures and in the "Disaster Policy & Procedure" without adequate details of: -Alternate placement with arranged evacuation locations and how many residents could be accommodated at the arranged locations, instead of the statement, "This can be arranged by contacting the American Red Cross by calling 9-1-1- and requesting a shelter through the County Department of Emergency Government."	E 013		

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E 013	Continued From page 5 -Arranged transportation contact information and how many residents could have been transported with each trip to the arranged evacuation locations. -The location of the "meeting spot outside of the facility" and how many residents and staff that spot would have been accommodated before needing to transport to an evacuation location. -The specific medical record documentation to transport with the residents included in the evacuation kit and method of sharing that documentation with other providers to ensure continuity of care. -The "food and dietary supplies" dietary personnel should have gathered for evacuation, and where those supplies were stored. -A system that would have been used to track the location of staff and residents if relocated within the facility and/or evacuated to another location. *Evacuation procedures were referred to in the procedures for bomb threat and explosion but did not direct the reader to where the evacuation procedures were detailed. *Shelter-in-place procedures did not describe how to accommodate residents and staff while they remained in the facility and the provision of subsistence needs, including: -How much food, water, and medical/pharmaceutical supplies would have been needed for an estimated number of residents and staff in the facility for an estimated number of sheltering days, and how long the 180 gallons of water arranged with a local entity would last. -Alternates sources of energy to maintain comfortable temperatures, emergency lighting, and fire detections and alarm systems. -A back-up plan for disposal of sewage and waste if those operations were affected by the	E 013		

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E 013	Continued From page 6 emergency event. *Communication procedures were not included on the manual's table of contents to direct the reader to: -The policy and procedure for the "Automated Emergency Calling System." -The names and contact information for all staff, entities providing services under arrangement, resident's physicians, emergency officials at the local, tribal, county, state, and federal levels, and the State Ombudsman. *The fire drill procedure stated, "Call Fire Systems at -----[no phone number was listed]." Interview on 1/27/22 at 11:30 a.m. with administrator A revealed she had just received a resource manual regarding disaster and emergency planning that she planned to use for modifying the facility EP manual.	E 013		

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K 000	INITIAL COMMENTS Surveyor: 27198 A recertification survey for compliance with the Life Safety Code (LSC) (2012 existing health care occupancy) was conducted on 1/25/22. Tekakwitha Living Center was found not in compliance with 42 CFR 483.90 (a) requirements for Long Term Care Facilities. The building will meet the requirements of the 2012 LSC for existing health care occupancies and the Fire Safety Evaluation System (FSES) dated 1/25/22. Please mark an F in the completion date column for K233 and K251 deficiencies identified as meeting the FSES. The building will meet the requirements of the 2012 LSC for existing health care occupancies upon correction of the deficiencies identified at K321, K522, K781 and K920 in conjunction with the provider's commitment to continued compliance with the fire safety standards.	K 000		
K 233 SS=C	Clear Width of Exit and Exit Access Doors CFR(s): NFPA 101 Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 This REQUIREMENT is not met as evidenced by:	K 233	F	2-25-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Rachel Holler | Administrator | 2-17-2022

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 233	Continued From page 1 Surveyor: 27198 Based on observation and record review, the provider failed to maintain clear door widths of at least thirty-two inches for one randomly observed set of exit access doors (double-door number 7). Findings include: 1. Observation on 1/25/22 at 11:50 a.m. revealed the leaves for double-door number 7 between the stairwell and the corridor were only thirty inches wide. They did not provide a clear opening width of thirty-two 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 233		
K 251 SS=C	Dead-End Corridors and Common Path of Travel CFR(s): NFPA 101 Dead-End Corridors and Common Path of Travel 2012 EXISTING Dead-end corridors shall not exceed 30 feet. Existing dead-end corridors greater than 30 feet shall be permitted to be continued to be used if it is impractical and unfeasible to alter them. 19.2.5.2 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, measurement, and interview, the provider failed to maintain exit and exit access, so any dead-end corridor (south corridor by kitchen) did not exceed thirty feet. Findings include:	K 251	F	2-25-2022

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K 251	Continued From page 2 1. Observation and measurement on 1/25/22 at 1:18 p.m. 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 years ago 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 251		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet)	K 321	Door stops mentioned were removed 1-25-2022. Maintenance supervisor checked the facility for other door stops 1-26-2022. Education will be provided at monthly All Staff meeting. An audit will be preformed by Maintenance supervisor monthly for 3 months to ensure compliance. Maintenance supervisor or designee will present audit findings at monthly QAPI for review.	2-25-2022

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K 321	Continued From page 3 c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview, the provider failed to maintain one hazardous area (boiler room/maintenance office) as required. Findings include: 1. Observation on 1/25/22 at 11:58 a.m. revealed the door to the boiler room/maintenance office was a fire rated door provided with an automatic closer. That door was propped open with a plastic door wedge. That door wedge impaired the required self-closing feature. Interview with the director of maintenance at the time of the observation confirmed that finding. The deficiency affected one of numerous requirements for hazardous storage rooms.	K 321		
K 522 SS=D	HVAC - Any Heating Device CFR(s): NFPA 101 HVAC - Any Heating Device Any heating device, other than a central heating plant, is designed and installed so combustible materials cannot be ignited by device, and has a safety feature to stop fuel and shut down equipment if there is excessive temperature or ignition failure. If fuel fired, the device also:	K 522	Maintenance supervisor fixed fresh air return to laundry room 2-2-2022. Maintenace supervisor checked other areas of gas combustion to ensure fresh air return. Review and revise preventitive maintenance program as needed. Audits will be conducted in the laundry area monthly for 3 months by maintenance supervisor to ensure compliance. Findings of audits will be communicated at monthly QAPI by maintance supervisor or designee for review.	2-25-2022

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K 522	Continued From page 4 * is chimney or vent connected. * takes air for combustion from outside. * provides for a combustion system separate from occupied area atmosphere. 19.5.2.2 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on testing and interview, the provider failed to maintain combustion (fresh) air in one randomly observed area (laundry). Findings include: 1. Observation of the four commercial natural gas-fired dryers in the laundry room on 1/25/21 at 1:10 p.m. revealed the following: a. There was dedicated combustion (fresh) air ductwork provided for the operation of the natural gas-fired commercial clothes dryers. b. The ductwork provided for combustion air had been blocked off by a piece of wood. c. The corridor door to the laundry room may not be used as a source of combustion air for the dryers. Interview with the maintenance director at the time of the observations confirmed those findings. The deficiency affected one of several requirements for fuel fired devices.	K 522		
K 781 SS=D	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed	K 781	Heating device removed 1-25-2022. Maintenance checked the facility to ensure no other heating devices were in use on 1-26-2022 Education will be provided at monthly All Staff meeting. Audits will be preformed monthly around the facility by maintenance supervisor or designee to ensure no other heating devices, becides central heating, are in the facility. Maintenance supervisor or designee will bring audit results to monthly QAPI for review.	2-25-2022

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K 781	Continued From page 5 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to prohibit space heaters from unapproved locations (behind dryers in laundry) as required. Findings include: 1. Observation on 1/25/21 at 1:05 p.m. revealed a space heater in use in the area behind the dryers in the laundry room. Interview with the maintenance director at the time of the observation and testing confirmed that finding. He stated he had placed that space heater there to keep the water supply there from freezing when it had gotten very cold. He further stated now that he had installed heat tape and insulation on that pipe, he believed that the pipe would not freeze again. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 781		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920	An electritian was brought in 2-2-2022 to rewire the heater mentioned on 1-26-2022, maintenance supervisor observed other machinary to ensure permeant wiring An audit will be conducted by amintenance supervisor or designee on effected area monthly for 3 months to ensure compliance. Maintenance director will report audit findings at monthly QAPI meetings for review.	2-25-2022

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K 920	Continued From page 6 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Surveyor: 27198 Based on observation and interview the provider failed to ensure extension cords were not used as a substitute for fixed wiring in one randomly observed location (water heater/boiler room). Findings include: 1. Observation on 1/25/21 at 11:38 p.m. revealed the westernmost water heater in the water heater/boiler room had recently been installed. That water heater was wired with an extension cord instead of permeant wiring. Interview with the director of maintenance at that same time confirmed that finding. He stated he was unaware that condition existed. He further stated the plumber who had installed that water heater was responsible for the wiring of it. The deficiency had the potential to affect 100% of the occupants of the smoke compartment.	K 920		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TEKAKWITHA LIVING CENTER	6 E CHESTNUT SISSETON, SD 57262

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Compliance/Noncompliance Statement Surveyor: 27198 A licensure survey for compliance with the Administrative Rules of South Dakota, Article 44:73, Nursing Facilities, was conducted from 1/25/22 through 1/27/22. Tekakwitha Living Center was found not in compliance with the following requirement: S157.	S 000		
S 157	44:73:02:13 Ventilation Electrically powered exhaust ventilation shall be provided in all soiled areas, wet areas, toilet rooms, and storage rooms. Clean storage rooms may also be ventilated by supplying and returning air from the building's air-handling system. This Administrative Rule of South Dakota is not met as evidenced by: Surveyor: 27198 Based on observation, testing, and interview, the provider failed to maintain exhaust ventilation in two randomly observed rooms (200 wing soiled utility room and north nurse station soiled utility room). Findings include: 1. Observation on 1/25/22 at 3:02 p.m. revealed the exhaust ventilation for the soiled utility room adjacent to room 214 was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the director of maintenance at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. He added he had checked all the exhaust fans for the building within the last month and they were working at that time.	S 157	Maintenance Supervisor returned airflow to the ventilation system 1-28-2022 Maintenance observed all vents in soiled areas, wet ares, toilet rooms, and store rooms to ensure proper ventilation. Review and revise preventitive maintenance as needed. Mantenance supervisor or designee will complete audits monthly for 3 months to ensure compliance Maintenance supervisor will report audit findings at monthly QAPI meetings for review	2-25-2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rachel Holler — TITLE: Administrator — (X6) DATE: 2-17-2022

South Dakota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	10685	A. BUILDING: _____ B. WING _____	01/27/2022

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S 157	Continued From page 1 2. Observation on 1/25/22 at 3:46 p.m. revealed the exhaust ventilation for the soiled utility room adjacent to north nurse station was not functioning. Testing of the grille with tissue paper at the time of the observation confirmed that finding. Interview with the director of maintenance at that same time confirmed that finding. He revealed he was unaware as to why the exhaust ventilation was not working at that location. Those rooms are required to have exhaust ventilation directed to the exterior of the building.	S 157		
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 1/25/22 through 1/27/22. Tekakwitha Living Center was found in compliance.	S 000		