

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

PRINTED: 04/13/2015  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  435127	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALLEN WING  B. WING _____	(X3) DATE SURVEY COMPLETED  04/06/2015
NAME OF PROVIDER OR SUPPLIER  DOW RUMMEL VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 1321 W DOW RUMMEL ST SIOUX FALLS, SD 57104	
(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
K 000	INITIAL COMMENTS  000  Stories: 1 Construction: Type V(111) Constructed: 1988 K0180: Fully Sprinkled  Certified Beds: 50 Capacity: 50 Census: 48	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain common wall fire barriers between non-conforming buildings.  Findings include:  On 4/6/15 unsealed penetrations were found in the two hour fire barrier between the health care occupancy and the adjacent non health care occupancy at the following locations. The space between the penetrating item and the fire barrier is required to be filled with a material that is capable of maintaining the fire resistance rating	K 011	K011: The West and North Exits will be fixed to contain seal with fire proof caulk by 5-13-15.  All fire walls/barriers will be checked quarterly by Environmental Services Director (ESD) to assure life safety standards are met. Fire barriers involved in adding or removing wires or pipes from fire barriers will be repaired after project completion.	5-13-15

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

*Rebecca Barush*

TITLE

*Administrator*

(X6) DATE

*4/22/15*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 011	Continued From page 1 of the barrier or protected by an approved device that is designed for the specific purpose. West exit-2inch unsealed orange conduit North exit- 2 x 2 inch square opening The Director of Environmental Services was present when the deficiency was identified.  Failure to maintain fire barriers as required increases the risk of death or injury due to fire.  The deficiency affected 2 of 3 common wall barriers.  Ref: 2000 NFPA 101 Section 19.1.2.1(2), 8.2.3.2.4.2	K 011	ESD or designee will keep quarterly monitoring records and report these findings to the Continuous Quality Improvement (CQI) committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.	
K 022 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to mark the means of egress as required.  Findings include:  On 4/6/15 doors at the following location that	K 022	K022:  All identified doors lacking proper egress including exterior door near #709 and the door through independent living will be labeled with a NO EXIT sign. The arrows will also be removed from exit signs where needed to make exits more clear.	5-13-15

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K 022	Continued From page 2 could be mistaken for an exit were not marked with a " NO EXIT " sign as required. · Egress through independent living that led to enclosed courtyard. · Exterior door near room 709 that led to courtyard.  On 4/6/15 exit signs at the following location did not have the required directional indicator as required. · Exit sign above courtyard door in means of egress through independent living area that was referring to exit to the right.  The Director of Environmental Services was present when the deficiency was identified.  Failure to mark the means of egress as required increases the risk of death or injury due to fire.  The deficiency affected one of five exits.  Ref: 2000 NFPA 101 Section 19.2.10.1, 7.10.2, 7.10.8.1	K 022	The Environmental Services Director (ESD) or designee will conduct quarterly inspections of the area to assure means of egress are properly identified.  ESD or designee will keep quarterly monitoring records and report these findings to the Continuous Quality Improvement (CQI) committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the means of egress as required.	K 038	K038: The storage room by #709 and the medical records office doors will be fixed to be operable from the egress side by 5-13-15.	5-13-15	

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K 038	Continued From page 3  Findings include:  On 4/6/15 doors in the means of egress at the following location were not arranged to be opened readily from the egress side as required.  Storage room near room 709- hasp lock on outside of room door, not operable from egress side. Medical Records office- slide bolt on outside of room door, not operable from egress side.  The Director of Environmental Services was present when the deficiency was identified.  Failure to maintain the means of egress as required increases the risk of death or injury due to fire.  The deficiency affected two of numerous rooms in the building.  Ref: 2000 NFPA 101 Section 19.2.2.2.1, 7.2.1.5.1 NFPA 101 LIFE SAFETY CODE STANDARD	K 038	Any doors that have door locks or restrictions that do not meet life safety code will be either removed or fixed to meet code by 5-13-15.  ESD or designee will conduct quarterly inspections of the doors. ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.		
K 046 SS=D	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide emergency lighting as required.  Findings include:  On 4/6/15 there were no records of the required	K 046	K046  The battery powered light in the generator cab will be functioning no later than 5-13-15.	5-13-15	

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K 046	Continued From page 4 annual 90 minute or the required monthly 30 second test of battery powered emergency lights had been conducted in the past 12 months. In addition the required light in the generator room did not function as required when the test button was pressed. The Director of Environmental Services was present when the deficiency was identified.  Failure to test and maintain emergency lighting as required increases the risk of death or injury due to fire.  The deficiency affected one location.  Ref: 2000 NFPA 101 Section 19.2.9.1, 4.6.12.1, 7.9.3	K 046	The ESD or designee will conduct testing patterns to include 30 seconds once a month and 90 minutes once a year. ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters, and determine the need for further review.	
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide a fire plan as required.  Findings include:  On 4/6/15 the fire plan did provide for evacuation of smoke compartment as required. The Director of Environmental Services was present when the deficiency was identified.  Failure to provide a fire plan as required increases the risk of death or injury due to fire.	K 048	Facility fire plan was updated with the following statements under the Evacuation part of the Fire Emergency Information and Guidelines: Evacuate all residents and personnel from the hallway that the fire is contained in. Evacuation should be to a point beyond the fire doors making sure all doors are closed.	5-13-15

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K 048	Continued From page 5	K 048	All staff will be trained on the change no later than 5-13-15. ESD will bring new plan and training reports to the next CQI meeting for further discussion.	
K 052 SS=C	<p>The deficiency affected one of eight required components of a fire plan.</p> <p>Ref: 2000 NFPA 101 Section 19.7.1.1, 19.7.2.2 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test the fire alarm system as required.</p> <p>Findings include:</p> <p>On 4/6/15 there was no documentation that the required annual testing audible and visible notification devices of the fire alarm system had been performed in the past year as required. The Director of Environmental Services was present when the deficiency was identified.</p> <p>Failure to test the fire alarm system as required increases the risk of death or injury due to fire.</p>	K 052	<p>K052</p> <p>Starting 4/22/15, we will ask for specific documentation from our fire testing contractor. Information to include (but not limited to): specific device testing including pull stations, strobes and horns, determined quarterly or annual test, and what type of test is being done. Facility will also keep documentation of tests.</p> <p>ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters.</p>	5-13-15

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K 052	Continued From page 6 The deficiency affected all notification devices.  Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 Table 7-3.2 item 19	K 052	The CQI committee will make recommendations for continued monitoring after 4 quarters.	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD  All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test smoke detectors as required.  Findings include:  On 4/6/15 the Director of Environmental Services confirmed that the annual smoke detector testing was done with a magnet that did not assure smoke entry as required for the annual detector functional test. The Director of Environmental Services was present when the deficiency was identified.  Failure to test smoke detectors as required increases the risk of death or injury due to fire.  The deficiency affected all smoke detectors.  Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 Section 7-3.2 Table 7-3.2 15h, Table 7-2.2, 13., g., 1.	K 054	K054 Starting 4/22/15, we will ask for specific documentation from our fire testing contractor. Information to include (but not limited to): specific device testing including pull stations, strobes and horns, determined quarterly or annual test, and what type of test is being done. Facility will keep documentation of annual smoke test done.  ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters.	5-13-15
K 074 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains.	K 074		

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K 074	<p>Continued From page 7</p> <p>and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide curtains meeting NFPA 701 requirements.</p> <p>Findings include:</p> <p>On 4/6/15 curtains were identified in the following locations that were not tagged as meeting flame resistance requirements. Housekeeping staff indicated that they did not treat facility provided curtains that did not meet NFPA 701 requirements.</p> <p>Rooms 708, 709, 712, 713, 714</p> <p>The Director of Environmental Services was</p>	K 074	<p>K074 All window coverings not having a fire rating will be sprayed with a fire retardant spray by 5-13-15. In accordance with manufacturers recommendations, when the window coverings are washed they will be retreated before being put back into resident population. Documentation of application will be kept by the Director of Housekeeping.</p> <p>ESD or designee will keep quarterly monitoring records and report these findings to the Continuous Quality Improvement (CQI) committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.</p>	5-13-15

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K 074	Continued From page 8 present when the deficiency was identified.	K 074		
K 104 SS=D	<p>Failure to provide curtain meeting NFPA 701 requirements increases the risk of death or injury due to fire.</p> <p>The deficiency affected five of numerous rooms in the building.</p> <p>Ref: 2000 NFPA 101 Section 19.7.5.1, 10.3.1 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect duct penetrations in smoke barriers.</p> <p>Findings include:</p> <p>On 4/6/15 the smoke barrier locations listed below were unsealed where the penetration would not resist the passage of smoke. Penetrations in smoke barriers by conduits are required to be filled with material that will resist the passage of smoke or be protected by an approved device that is designed for the specific purpose. East wing- wire and pipe penetrations unsealed.</p> <p>The Director of Environmental Services was</p>	K 104	<p>K104 The East Wing wire and pipe penetrations will be fixed to contain seal with fire proof caulk by 5-13-15.</p> <p>All fire walls/barriers will be checked quarterly by Environmental Services Director (ESD) to assure life safety standards are met. Fire barriers involved in adding or removing wires or pipes from fire barriers will be repaired after project completion.</p>	5-13-15

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K 104	Continued From page 9 present when the deficiency was identified.  Failure to protect smoke barrier penetrations as required increases the risk of death or injury due to fire.  The deficiency affected one of four smoke barriers.  Ref: 2000 NFPA 101 Section Ref: 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 NFPA 101 LIFE SAFETY CODE STANDARD	K 104	ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.		
K 144 SS=C	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to exercise generators providing power for emergency lighting as required.  Findings include:  On 4/6/15 there were no records that the generator was exercised to 30% of nameplate rating monthly or that an annual supplemental load exercise was conducted as required when diesel generators are not loaded to 30% of nameplate rating during the required monthly	K 144	K144 The generator will be tested monthly for no less than 30 minutes. Documentation will be kept including hours on generator before and after test, percent of Name Plate Rating used under load. If the percent of capacity does not reach 30% of Name Plate once a year, a yearly test will be run to assure the generator is running at maximum operation levels.		5-13-15

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K 144	<p>Continued From page 10 exercises. The Director of Environmental Services was present when the deficiency was identified.</p> <p>Failure to exercise emergency generators as required increases the risk of death or injury due to fire.</p> <p>The deficiency affected all required exercising in the past year.</p> <p>Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.2.3; 1999 NFPA 110 Section 6-4.2.2</p>	K 144	<p>ESD or designee will keep quarterly monitoring records and report these findings to the CQI committee for 4 quarters. The CQI committee will make recommendations for continued monitoring after 4 quarters.</p>		