

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

PRINTED: 06/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022
--	--

(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	<p>INITIAL COMMENTS</p> <p>Stories: 1 Construction: Type V(111) Constructed: 1970 K0180: Fully Sprinkled</p> <p>Certified Beds: 71 Capacity: 71 Census: 57</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide not less than two exits from every floor as required</p> <p>Findings include:</p> <p>On 5/31/16, the following floors did not have two exits as required.</p> <ul style="list-style-type: none"> Basement containing laundry, boiler room and storage rooms. <p>The Environmental Services Director was present when the deficiency was identified.</p> <p>Failure to provide not less than two exits form every floor increases the risk of death or injury due to fire.</p>	K 000	<p>K000</p> <p>The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of state and federal law. Without waiving the foregoing statement, the facility states that with respect to:</p>	
K 032 SS=D		K 032	<p>K032</p> <p>To the facilities knowledge, this deficiency is satisfied under FSES and does not constitute a POC.</p>	F

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE ADMINISTRATOR (X6) DATE 6/17/2016

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.

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

PRINTED: 06/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2016
NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022	
(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 046	Continued From page 2	K 046		
K 056 SS=E	<p>The deficiency affected two of numerous requirements for the emergency lighting system. NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect the facility with an automatic sprinkler system as required.</p> <p>Findings include:</p> <p>On 5/31/16, sprinklers at the following locations were obstructed by suspended or floor mounted obstructions.</p> <ul style="list-style-type: none"> • Closets in resident rooms 159-168, shelf wall obstruction at 18 inches lateral was 3 inches below deflector • Closet in room 112, 114, 121, 157, shelf wall obstruction to ceiling <p>Ref: 2000 NFPA 101 Section 31.3.5.1, 9.7.1.1; 1999 NFPA 13 5-6.5.2.3</p> <p>On 5/31/16, exterior roofs of combustible construction exceeding four (4) feet in width were not protected with automatic fire sprinklers as</p>	K 056	<p>Sprinklers located in closets of resident rooms 159-168, 112, 114, 121, and 157 will be made free from obstructions.</p> <p>An automatic fire sprinkler will be installed at the exterior smoking area.</p>	12/31/16

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

PRINTED: 06/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2016
NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022	
(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 056	Continued From page 3 required at the following locations: • Exterior smoking area, 8ft x 13 ft The Environmental Services Director was present when the deficiency was identified. Failure to protect the facility with automatic fire sprinklers as required increases the risk of death or injury due to fire. The deficiency affected two of four smoke compartments.	K 056		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10.18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide fire extinguishers as required. Findings include: On 5/31/16, fire extinguishers at the following location were not inspected at approximately 30 day intervals as required. • Near nurses station- last check Feb 2016 The Environmental Services Director was present when the deficiency was identified. Failure to provide fire extinguishers as required increases the risk of death or injury due to fire. The deficiency affected one of numerous fire	K 064	K064 Fire extinguisher located near nurse's station was inspected on 5/30/16 and will be inspected at approximately 30 day intervals. Administrator or designee will perform audit on fire extinguishers to ensure routine inspections are being completed monthly for three months.	7/15/16

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

PRINTED: 08/08/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435129	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/31/2016
--	--	--	--

NAME OF PROVIDER OR SUPPLIER DELLS NURSING AND REHAB CENTER INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 THRESHER DR DELL RAPIDS, SD 57022
--	--

(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 064	Continued From page 4 extinguishers in the building. Ref: 2000 NFPA 101 Section 19.3.5.6, 9.7.4.1, 1998 NFPA 10 Section 4-3.2, 4-3.4.3	K 064		
-------	---	-------	--	--