

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435072	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - SEVEN SISTERS B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2016
NAME OF PROVIDER OR SUPPLIER SEVEN SISTERS LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 HWY 71 SOUTH HOT SPRINGS, SD 57747	
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K 000	INITIAL COMMENTS Stories: 1 Construction: Type II (000) Constructed: 2014 K0180: Fully Sprinkled	K 000		
K 026 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one 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 in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide 1 hour fire resistance rated smoke barriers as required. Findings include: On 5/10/16, the smoke barrier locations listed below were unsealed where the penetration would not resist the passage of smoke. Penetrations in smoke barriers 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. • Dining Room- missing sheet rock on dining room side of barrier near outside wall at conduit penetrations. • Dining Room- unsealed communications cable penetration near middle of wall above	K 026	The pipe penetrations in the dining room for conduits and communication wiring shall be sealed with sheetrock and fire caulking. A policy has been developed for outside contractors and the monitoring will be done by the Environmental Services Director. The Environmental Services Supervisor will be inserviced regarding the new policy and the monthly walk through will be updated to include completion of outside contractors work. Fire barrier concerns will continue to also be monitored monthly. The monthly walk through will be reported to the QAPI Committee monthly x 3 with further follow up as recommended by the committee.	06-12-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE Administrator (X6) DATE 5/23/2016

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.

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PRINTED: 05/13/2016
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OMB NO. 0938-0391

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K 025	Continued From page 1 ceiling tile of dining room. The Environmental Director was present when the deficiency was identified. Failure to maintain smoke barriers as required increases the risk of death or injury due to fire. The deficiency affected one of one smoke barriers.	K 025		
K 029 SS=D	Ref: 2000 NFPA 101 Section 18.3.7.3, 8.3.6.1 NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4).	K 029	The ceiling in the hot water room off the chapel will have an additional 5/8" of sheetrock and penetrations sealed and caulked	
	Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect hazardous areas as required. Findings include: On 5/10/16 the following hazardous area was not protected with a 1 hour fire resistance rated barrier and door opening was not protected with 45 minute door as required. Hot water heater room off of chapel contained two natural gas fire hot water heater. Plan set and inspection could not confirm that the ceiling of the room was 1 hour fire resistance rated (FRR) construction as required. Plan set showed un rated room with electric hot water		to ensure a one hour fire rated barrier. A new door with a ¾ hour rating has been ordered and will be installed. The Environmental Services Supervisor will be inserviced on the requirements of this room and the room requirements will be put on the monthly walk through to ensure a proper barrier is maintained. The Environmental Services Director will report the monthly walk through to the QAPI Committee monthly x 3 with further follow up as recommended by the committee.	06-12-16

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K 029	Continued From page 2 heater. Door to room did not have evidence of ¾ hour FRR as required. The Environmental Director was present when the deficiency was identified. Failure to increases the risk of death or injury due to fire. The deficiency affected one of two smoke compartments.	K 029		
K 038 SS=D	Ref: 2000 NFPA 101 Section 18.3.2.1, 8.4.1.3 NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1, 18.2.1, 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. Findings include: On 5/10/16 the following doors were equipped with locks or latches that required special knowledge and effort to operate from the egress side. Doors are required to be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side. These locking latching arrangement do not meet this requirement. Exit discharge gate from dining room door marked with an exit sign- equipped with latching device on the outside of the gate with padlock hanging off of the latch. Ref: 2000 NFPA 101 Section 18.2.1, 7.7.4,	K 038	The gate outside the exit in the dining room that had an outside lock was replaced with an inside latch with no locking device. The hardware on the staff bathroom has been changed and the deadbolt removed. The Environmental Services Supervisor and general staff will be inserviced regarding that the gate shall remain unlocked and that no doors have deadbolts. The gate will be put on the monthly walk through to ensure the egress is operable and the monthly walk through will monitor that the facility has no deadbolts on any doors.	

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K 038	Continued From page 3 19.2.2.2.1, 7.2.1.5.1 On 5/10/16, the following doors were equipped with two locking/ latching devices where two releasing operations were required to operate the door. Doors in the means of egress are required to be operable with not more than one releasing operation. South staff bathroom- dead bolt and lever latch Ref: 2000 NFPA 101 Section 18.2.1, 7.2.1.5.4 The Environmental Director was present when the deficiency was identified.	K 038	The Environmental Services Director will report the monthly walk through to the QAPI Committee monthly x 3 with further follow up as recommended by the committee.	06-12-16	
K 052 SS=F	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 means of egress in the building. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test the fire alarm system as required.	K 052	The fire alarm system will be tested for audible and visible notification devices on 05-19-16. The Environmental Services Director has coordinated with the fire alarm contractor to ensure annual testing of the system and its completion in the month of May. The Environmental Services Supervisor will be inserviced regarding the annual testing dates and this will be put on a checklist.		

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K 052	Continued From page 4 Findings include: On 5/10/16 there was no documentation that the required annual testing of audible and visible notification devices of the fire alarm system had been performed in the past year as required. The Environmental Director was present when the deficiency was identified. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency the entire building. Ref: 2000 NFPA 101 Section 18.3.4.1, 9.6.1.4; 1999 NFPA 72 Table 7-3.2 Item 19	K 052	The Environmental Services Director will report to the QAPI Committee in June each year regarding the completion of the annual May testing.	06-12-16
K 054 SS=F	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 5/10/16, there was no record that the required annual functional testing of smoke detectors had been performed as required. The Environmental Director was present when the deficiency was identified. Failure to test smoke detectors increases the risk of death or injury due to fire.	K 054	The smoke detectors will be tested on 5-19-16 to ensure they are functioning properly. The Environmental Services Director has coordinated with the fire alarm contractor to ensure annual testing of the smoke detectors in May. The Environmental Services Supervisor will be inserviced regarding the annual testing dates and this will be put on a checklist. The Environmental Services Director will report to the QAPI Committee in June each year regarding the completion of the annual May testing.	06-16-16

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K 054	Continued From page 5 The deficiency affected the entire building.	K 054		
K 056 SS=D	Ref: 2000 NFPA 101 Section 18.3.4.1, 9.6.1.4; 1999 NFPA 72 Section 7-3.2 Table 7-3.2 15h, Table 7-2.2, 13., g., 1. NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. 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. 18.3.5, 18.3.5.1. 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. Findings include: On 5/10/16, the Hydraulic Design Information sign was not at the alarm valve as required. The Environmental Director was present when the deficiency was identified. Failure to provide an automatic sprinkler system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous required components of the automatic sprinkler	K 056	The hydraulic design information sign has been ordered and will be installed on the alarm valve in the sprinkler riser room. The Environmental Services Supervisor will be inserviced regarding the posted signage and it will be put on the monthly preventative maintenance checklist.	
			The Environmental Services Director will report to the QAPI Committee monthly x 3 with further follow up as recommended by the committee.	06-12-16

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K 056	Continued From page 5 system.	K 056		
K 076 SS=D	Ref: 2000 NFPA 101 Section 18.3.5.1, 9.7; 1999 NFPA 13 Section 24.5 NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	K 076	On 5-12-16 the combustibile materials were removed from the oxygen storage room. The electrical wall fixtures will be raised to at least 5 feet above the floor. The Environmental Services Supervisor and Seven Sisters Living Center staff were inserviced on May 10 and 11 regarding the change in the storage area and the requirement of the electrical wall fixtures.	
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect medical gas storage as required. Findings include: On 5/10/16, combustibile materials were found to be stored adjacent to and within 5 feet of oxygen cylinders in a storage area protected with automatic fire sprinklers at the following locations. The minimum 5 feet of separation between combustibles and oxygen storage was not maintained as required in this area protected with automatic fire sprinklers. • South wing storage room- 46 E tanks with wire rack shelf containing toilet paper, facial tissue, toiletries. On 5/10/16, ordinary electrical wall fixtures were not installed at 5 ft. above the floor as required.		These will be put on a monthly preventative maintenance checklist and the Environmental Services Director will report to the QAPI Committee monthly x 3 with further follow up as recommended by the committee.	06-12-16

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K 076	Continued From page 7 North wing- electrical outlet and switch at 45 inches above floor Ref: 2000 NFPA 101 Section 18.3.2.4; 1999 NFPA 99 Section 16-3.8.1, 8-3.1.11.2(f), 4-3.1.1.2(a)11d The Environmental Director was present when the deficiency was identified. Failure to protect medical gas storage as required increases the risk of death or injury due to fire. The deficiency affected one of two smoke compartments. Ref: 2000 NFPA 101 Section 18.3.2.4; 1999 NFPA 99 Section 16-3.8.1, 8-3.1.11.2(c)2	K 076		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110, 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to exercise the emergency electrical generator as required. Findings include: On 5/10/16, the Environmental Director confirmed that a diesel generator provided power for emergency lighting. There were no records that showed that the monthly exercise of the diesel generator loaded the generator to 30	K 144	The generator will be load bank tested on 6-1-16. The Environmental Services Director has coordinated with the generator testing company to annually load bank test the generator. The Environmental Services Supervisor will be inserviced regarding the annual testing dates and this will be put on a checklist. The Environmental Services Director will report to the QAPI Committee in June each year regarding the completion of the annual June testing.	06-12-16

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K 144	Continued From page 8 percent of nameplate rating or that minimum exhaust temperature provided by the manufacturer were achieved as required. The facility did not perform an annual supplemental load exercise as required when diesel generators are not loaded to 30% of nameplate rating or manufacturers recommended temperature during the required monthly exercises. The Environmental Director was present when the deficiency was identified. Failure to exercise the emergency generator as required increases the risk of death or injury due to fire. The deficiency affected one of thirteen required exercises. Ref: 2000 NFPA 101 Section 18.2.9.1, 7.9.2.3; 1999 NFPA 110 Section 6-4.2, 6-4.2.2	K 144			