STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING **02 - KNIFE RIVER CARE CENTER** B. WING _____	**07/30/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KNIFE RIVER CARE CENTER	**118 22ND ST NE BEULAH, ND 58523**

(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 This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (111) construction with a partial basement. The building was equipped with an automatic wet and dry sprinkler system with quick response sprinklers designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.	K 000		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Means of egress shall have signs in accordance with Section 7.10. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT	K 293	The facility has placed a "No Exit" sign on the Shady Lane exterior door to indicate this door is not part of the exit system on August 2, 2019. All building doors which are not part of the exit system have the potential to be affected by the same practice.	8/30/19

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

Electronically Signed | 08/09/2019

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 293	Continued From page 1 The NO EXIT sign shall have the word NO in letters 2 in. high, with a stroke width of 3/8 in., and the word EXIT in letters 1 in. high, with the word EXIT below the word NO, unless such sign is an approved existing sign. 19.2.10.1, 7.10.8.3.1, 7.10.8.3.2 The facility failed to mark the means of egress as required. Observation determined the exterior door from the Shady Lane Dining Room, not used as part of the exit system, that could be mistaken for an exit was not marked with a "No Exit" sign as required. Failure to provide exit signage as required increases the risk of death or injury due to fire. The deficiency affected exiting from one (1) of seven (7) smoke compartments.	K 293	Education will be provided to facility staff at an all staff meeting on August 14th, 2019 regarding the need to have doors properly marked which are not part of the exit system. Observation and monitoring to ensure "No Exit" signage is displayed on doors that are not part of the exit system will occur with the monthly safety checks for 4 months, beginning the week of August 18th, 2019, and thereafter as deemed necessary by the QA committee . Date of Compliance: August 30, 2019	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under	K 324		8/30/19

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K 324	Continued From page 2 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: The facility failed to test and maintain the wet chemical extinguishing system in the Kitchen in accordance with NFPA 17A, Standard for Wet Chemical Extinguishing Systems. On a monthly basis, inspection shall be conducted in accordance with the manufacturer's listed installation and maintenance manual or the owner's manual. 7.2.1 At a minimum, this quick check or inspection shall include verification of the following: 1) The extinguishing system is in its proper location. 2) The manual actuators are unobstructed. 3) The tamper indicators and seals are intact. 4) The maintenance tag or certificate is in place. 5) No obvious physical damage or condition exists that might prevent operation. 6) The pressure gauge, if provided, shall be inspected physically or electronically to ensure it is in the operable range. 7) The nozzle blowoff caps, where provided, are intact and undamaged.	K 324	An inspection and verification of the chemical extinguishing system in the kitchen was completed on August 2, 2019 with the following components being examined and verified: 1. The system is in the proper location 2. The manual actuators are unobstructed 3. The tamper indicators and seals are intact 4. The maintenance tag or certificate is in place 5. No obvious physical damage or condition exists that might prevent operation 6. The pressure gauge, if provided, shall be inspected physically or electronically to ensure it is in the operable range 7. The nozzle blow off caps, where provided, are intact and undamaged 8. Neither the protected equipment nor the hazard has not been replaced, modified, or relocated No other chemical extinguishing systems exist in the facility to be affected by the same practice. A facility policy will be developed to	

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K 324	Continued From page 3 8) Neither the protected equipment nor the hazard has not been replaced, modified, or relocated. 7.2.2 Review of documentation and interview with staff determined the monthly inspections of the wet chemical extinguishing system in the Kitchen had not been completed in the past year. An outside company did conduct semi-annual inspections of the system. Failure to conduct monthly inspections of the wet chemical extinguishing system increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) wet chemical extinguishing system in the facility.	K 324	ensure monthly inspections of the chemical extinguishing system occurs, inclusive of the previous mentioned 8 components. Documented monthly inspections will occur indefinitely per facility policy and regulatory requirements. Date of compliance: August 30, 2019	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided	K 363		8/30/19

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K 363	Continued From page 4 with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Dutch doors shall be permitted where they conform to 19.3.6.3 and meet all of the following criteria: 1) Both the upper and lower leaf are equipped with a latching device. 2) The meeting edges of the upper and lower leaves are equipped with an astragal, a rabbet, or a bevel. 3) Where protecting openings in enclosures around hazardous areas, the doors comply with NFPA 80, Standard for Fire Doors and Other Opening Protections. 19.3.6.3.13 The facility failed to provide corridor doors as required.	K 363	The two dutch doors in the Whispering Winds neighborhood will be fitted with the proper devices to meet the standard, identified in NFPA 80, standard 19.3.6.3.13. No other dutch doors exist in the facility to be affected by the same practice. A monthly inspection will be implemented for a period of 4 months beginning the week of August 30, 2019, to ensure the two dutch doors in Whispering Winds are functioning properly with the newly installed devices, and thereafter as deemed necessary by the QA committee.	

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K 363	Continued From page 5 Observation determined the corridor doors to the Kitchenettes in the Whispering Winds and the Harvest Lane Neighborhoods were dutch doors and did not have an astragal, a rabbet, or a bevel at the meeting edge of the doors. Each Kitchenette had two (2) doors leading to the corridor. Failure to ensure dutch doors meet the criteria of NFPA 101, Life Safety Code, increases the risk of injury or death due to fire. This deficiency affected four (4) of numerous corridor doors in the facility.	K 363	Date of Compliance: August 30, 2019	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: The facility failed to ensure smoke barriers were at least one-half hour fire resistant and smoke resistant.	K 372	The smoke barrier in the Whispering Winds neighborhood which had an unsealed electrical conduit penetration was sealed to maintain the one-half hour	8/30/19

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K 372	Continued From page 6 Observation determined the Whispering Winds Neighborhood smoke barrier had an unsealed electrical conduit penetration through the wall above the ceiling near the Nurses Manager Office. Failure to maintain smoke barriers as required increases the risk of death or injury due to fire. The deficiency affected two (2) of seven (7) smoke compartments in the building.	K 372	fire resistant and smoke resistant standard on August 5, 2019. All smoke barriers have the potential to be affected by the same practice. Inspection of all the facility smoke barriers occurred to ensure fire and smoke resistant barriers were intact throughout the facility the week of August 18th, 2019. Upon any wiring, cabling or other construction project completion, an inspection will occur to ensure the fire and smoke resistant barriers remain intact. Date of Compliance: August 30, 2019	