STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355053	A. BUILDING **02** B. WING _____	**08/30/2021**

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

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E 000	Initial Comments A recertification survey conducted on 08/30/2021 found Knife River Care Center in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.	E 000		
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 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	K 321		10/14/21

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

Electronically Signed | 09/09/2021

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K 321	Continued From page 1 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) 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: The facility failed to ensure hazardous areas were separated from other areas with self-closing doors. Observation determined the corridor door to the Lower-Level Therapy Suite lacked self-closing hardware. The Therapy Suite was more than 50 square feet and was used to store combustible materials. Failure to separate hazardous areas from other spaces increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous hazardous areas in the facility.	K 321	K321, SS=D How the corrective action will be accomplished. 1. The facility will adjust the downstairs therapy area to be sure all combustible storage material that is considered hazardous be behind a self-closing door that provides a smoke barrier as the facility utilizes the approved automatic fire extinguishing system option in accordance with 8.4. How the facility will identify other portions of the facility having the potential to be affected by the same deficient practice. 2. The facility has identified areas to move hazardous material to assure proper safety measures are being taken so hazardous, combustible material is in an approved area that is smoke resistant:	

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K 321	Continued From page 2	K 321	a. Current materials will first be moved to the IT storage area in the basement. This area has smoke/fire resistant ceiling tiles, smoke rated door, and a self-closing mechanism on the top of the door. b. Second, we will be utilizing the treatment rooms in the downstairs therapy area. These treatment rooms are equipped with smoke/fire resistant ceiling tiles, smoke resistant doors, and a self-closing door. c. Third, we will utilize another storage area that has smoke barriers, smoke/fire rated door, and a self-closing door. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 3. Education provided to maintenance personnel and all staff at facility on having hazardous combustible material/supplies in an area that is behind a self-closing door and smoke resistant partitions. Safe areas to have hazardous material with a self-closing door and smoke resistant were identified in the above bullet points (A, B, & C) and all staff were educated. How the facility will monitor its corrective action(s) to ensure the deficient practice is being corrected and will not recur. 4. The facility will monitor the downstairs therapy area through observation and monitoring to assure all combustible storage items are behind a self-closing door. These checks will be made part of the monthly safety checks for 4 months, beginning the week of September 13th, and thereafter as deemed necessary by the safety committee, maintenance	

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K 321	Continued From page 3	K 321	supervisor, and/or administrator. Date(s) when the corrective action(s) will be completed. These date(s) must be acceptable to the department. Corrections must be completed within forty-five days of the survey completion date or October 14, 2021 unless an alternative schedule of correction is accepted by the department. 5. Date of Compliance: 10/14/2021	
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 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	K 324		10/14/21

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K 324	Continued From page 4 This REQUIREMENT is not met as evidenced by: The facility failed to install cooking equipment in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. A readily accessible means for manual activation shall be located between 1067 mm and 1219 mm (42 in. and 48 in.) above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. 19.3.2.5.1, 9.2.3, NFPA 96 10.5.1. Observation determined the manual actuation device for the fire-extinguishing system serving the Kitchen exhaust hood was mounted at a height of more than forty-eight (48) inches above the floor. The manual pull was 53 inches above the floor. Failure to inspect, maintain, and install the wet chemical extinguishing system in accordance with NFPA 96 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	K324, SS=D How the corrective action will be accomplished. 1. The facility contacted Nardini Fire Equipment Company on 9/1/2021. In this call we informed Nardini Fire Equipment Company of the situation with the pull station in our Kitchen. Nardini will be utilizing NFPA 96, Standard Ventilation Control and Fire Protection of Commercial Cooking Operations to be sure the pull station is in compliance. Nardini Fire Equipment Company will be coming to the facility to reposition the pull station in our kitchen to assure that it is 42 to 48 from the ground. How the facility will identify other portions of the facility having the potential to be affected by the same deficient practice. 2. The identified issue through the inspection is unique to the kitchen. Nardini Fire Equipment Company will be coming to move the pull station. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 3. Maintenance staff education on NFPA 96, Standard Ventilation Control and Fire Protection of Commercial Operations, in regards to the pull station being 42 to 48 from the floor. How the facility will monitor its corrective action(s) to ensure the deficient practice is being corrected and will not recur. 4. The facility will inspect Nardini Fire	

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K 324	Continued From page 5	K 324	Equipment Company installation of the new pull station in the kitchen to be sure it is in compliance with NFPA 96 and 42 to 48 from the floor. Inspection will be completed by the maintenance supervisor with Nardini Fire Equipment Company□s presence. Date(s) when the corrective action(s) will be completed. These date(s) must be acceptable to the department. Corrections must be completed within forty-five days of the survey completion date or October 14, 2021 unless an alternative schedule of correction is accepted by the department. 5. Date of Compliance: 10/14/2021.	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of	K 918		10/14/21

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K 918	Continued From page 6 stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to ensure the emergency generator was in compliance with NFPA 99, Health Care Facilities Code and NFPA 110, Standard for Emergency and Standby Power Systems. Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. Diesel-powered EPS installations that do not meet the requirements shall be exercised	K 918	K918, SS=D How the corrective action will be accomplished. 1. Maintenance personnel has been educated and trained on documentation of monthly PM checks of the generator. Education provided was via paper and physical presence by the generator to show maintenance personnel where the percentage was located, how to properly record and calculate the 30% load for the generator, and what to do in the event the generator is not at 30% load capacity. How the facility will identify other portions of the facility having the potential to be affected by the same deficient practice. 2. On Tuesday, 8/31/2021 the generator was used as part of the weekly check of operations. The generator ran at 32% capacity, above the 30% threshold. What measures will be put into place or	

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K 918	Continued From page 7 monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99 6.4.4.1.1.4, NFPA 110 8.4.1, 8.4.2, 8.4.2.3 Review of generator test records did not indicate the minimum exhaust temperature provided by the manufacturer was achieved and that the monthly exercise of the 500 kW diesel generator loaded the generator to at least 30% (150 kW) of the nameplate rating. The facility did not perform annual supplemental load exercises as required when diesel generators are not loaded to 30% of nameplate rating or manufacturer's recommended temperature during all required monthly exercises. Failure to inspect, test and maintain the emergency generator in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 918	systemic changes made to ensure that the deficient practice will not recur. 3. Education on weekly PM checks of the generator will be conducted with our maintenance staff. Maintenance supervisor will educate all maintenance staff on the 30% generator load. Generator policy was reviewed and updated. Maintenance personnel were trained and educated on the policy. How the facility will monitor its corrective action(s) to ensure the deficient practice is being corrected and will not recur. 4. Continued observation and monitoring to verify correct documentation that the generator is running at 30% capacity will be conducted weekly by the maintenance staff and verified monthly by the maintenance supervisor. Date(s) when the corrective action(s) will be completed. These date(s) must be acceptable to the department. Corrections must be completed within forty-five days of the survey completion date or October 14, 2021 unless an alternative schedule of correction is accepted by the department. 5. Date of Compliance: 10/14/2021	