STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING 02 - BAPTIST HEALTH CARE CENTER B. WING	01/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	3400 NEBRASKA DRIVE BISMARCK, ND 58503

(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 2000 edition of NFPA 101, Life Safety Code, Chapter 18 New Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type II (111) construction with a partial basement. The facility was protected throughout by an automatic wet sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.	K 000	K054-The facility failed to ensure smoke detectors were installed were installed in accordance with NFPA72. The deficiency will be corrected by the company that installed the smoke detectors. The smoke detectors will be moved to the correct location in accordance with NFPA72. 2. All areas of the facility were checked by Director of Plant Operations and building project manager to ensure that all smoke detectors were installed in the correct area. 3. If at any time that construction is required that would involve installation of smoke detectors, the Director of Plant Operations or his designee would follow NFPA72 guidelines so as to ensure that smoke detectors are placed appropriately. 4. The Director of Plant Operations or his designee will monitor all installation of any new smoke detectors to ensure that NFPA72 guidelines are met. 5. Corrective action will be completed on or before February 21, 2014.	
K 054 SS=D	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: Smoke detectors should not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. NFPA 72 A-2-3.5.1 The facility failed to ensure smoke detectors were installed in accordance with NFPA72. Observation determined that the smoke detectors located in the sitting areas of the Western Skies and the Wild Rose Wings were mounted on the ceiling less than six inches from the HVAC diffuser and within three feet of a ceiling mounted fan.	K 054		
K 143	NFPA 101 LIFE SAFETY CODE STANDARD	K 143		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vincent Kemple	Administrator	1/21/2014

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355058	A. BUILDING 02 - BAPTIST HEALTH CARE CENTER B. WING _____	01/07/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAPTIST HEALTH CARE CENTER	3400 NEBRASKA DRIVE BISMARCK, ND 58503

(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 143 SS=D	Continued From page 1 Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: The facility failed to ensure the transferring of liquid oxygen locations met NFPA 99, Standard for Health Care Facilities. Interview of staff confirmed that transferring of oxygen does take place in the Oxygen Storage Rooms. Observation determined the doors to the Oxygen Storage Rooms on first and second floor did not have a fire rating tag. The fire rating of the doors could not be verified.	K 143	K143-The facility failed to ensure the transferring of liquid oxygen meets NFPA 99, Standard for Health Care Facilities. Observation determined the doors to the Oxygen Storage Rooms on the first and second floor did not have a fire rating tag. Doors have been ordered and are scheduled to be installed in mid February. 2. The facility only has the two liquid oxygen rooms, all other doors in the facility were monitored by Director of Plant Operations, and building project manager and conferred with supply personnel to ensure that all doors meet code requirements. 3. If at any time there would be need to order new doors the Director of Plant Operations would make sure that doors meet the NFPA requirements. 4. The Director of Plant Operations or his designee will monitor the installation of any new doors, ensure that the proper have a fire rating tag in place so that rating can be verified. 5. Corrective action will be completed on or before February 21, 2014	