

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

PRINTED: 04/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2019	
NAME OF PROVIDER OR SUPPLIER DUNSEITH COM NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 15 1ST ST NE DUNSEITH, ND 58329			
(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 (000) construction with a partial basement. The building was protected by a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The fire rated doors at the lower level of each stair enclosure provided the fire separation between the basement and the main floor for the stair openings.			K 000			
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			12/26/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/03/2020

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: 04/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2019	
NAME OF PROVIDER OR SUPPLIER DUNSEITH COM NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 15 1ST ST NE DUNSEITH, ND 58329			
(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 324	Continued From page 1 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	1. The Maintenance Supervisor will conduct and document monthly inspections of cooking hood fire suppression system. Any problems will be repaired if needed. 2. The entire facility has the potential to be affected by this deficient practice. 3. Monthly inspections of cooking hood fire suppression system will be added to the Maintenance Supervisor's monthly Safety Rounds Inspections Form and Addressed at DCHN Safety Meetings. 4. The results of inspections will be given to the DCHN Administrator and reviewed at DCHN Quality Assurance Meetings for 4 months and inspections will continue monthly after monitoring is completed 5. Completion Date: 12/26/2019		

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

PRINTED: 04/14/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/23/2019
NAME OF PROVIDER OR SUPPLIER DUNSEITH COM NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 15 1ST ST NE DUNSEITH, ND 58329		
(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 324	Continued From page 2 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			