STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 two-story building of Type II (000) construction with a basement. The building had a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. An occupancy separation wall constructed to have a two-hour fire resistance rating separated a clinic building to the east from the hospital. The nursing facility occupied the second floor of the hospital. Note: A Fire Safety Evaluation System (FSES) was conducted as a result of the 09/11/2019 Life Safety Code survey. The FSES was specifically used as an alternative safety method for Tag K 271 (Discharge from Exits). The facility passes the FSES when all other deficiencies have been corrected.	K 000		
K 100 SS=D	General Requirements - Other CFR(s): NFPA 101 General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General Requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard	K 100		10/26/19

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

Electronically Signed | 09/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 100	Continued From page 1 citation, should be included on Form CMS-2567. This REQUIREMENT is not met as evidenced by: Multiple occupancies shall be in accordance with 6.1.14. 19.1.3.1. Multiple occupancies shall comply with the requirements of 6.1.14.1 and one of the following: (1) Mixed occupancies - 6.1.14.3 (2) Separated occupancies - 6.1.14.4 6.1.14.1.1. Mixed Occupancy. A multiple occupancy where the occupancies are intermingled. 6.1.14.2.2. The building shall comply with the most restrictive requirements of the occupancies involved, unless separate safeguards are approved. 6.1.14.3.2. Approved single-station smoke alarms, other than existing smoke alarms meeting the requirements of 26.3.4.5.3, shall be installed in accordance with 9.6.2.10 in every sleeping room. 26.3.4.5.1. The facility failed to provide smoke detection in a sleeping room used by staff. Observation determined a Doctor's Sleeping Room on the first floor was not equipped with a smoke detector. Failure to provide smoke detection in a staff sleeping room increases the risk for injury or death due to fire.	K 100	K100 1. The Intent of CHI St. Alexius Health Garrison is to comply with the ND Conditions of Participation. We called Johnson Controls Simplex Grinnell on 7-16-19 at 1:35 pm to schedule a smoke detector install in our DR□s Lounge 2. We will add to our quarterly Hazard Surveillance/Life Safety Tour (check for smoke detectors in sleeping rooms) 3. We will add to our quarterly Hazard Surveillance/Life Safety Tour (check for smoke detectors in sleeping rooms) 4. We will add to our quarterly Hazard Surveillance/Life Safety Tour (check for smoke detectors in sleeping rooms) 5. The corrective action will be completed no later than October 26, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 100	Continued From page 2 This deficiency affected one (1) of one (1) staff sleeping room in the facility.	K 100		
K 271 SS=B	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 19.2.7, 7.7.1 To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. CMS S&C-05-38 The facility failed to provide all occupants with safe access to a public way. Observation determined the west exterior exit discharge traversed the lawn to get to a public way. Failure to maintain the means of egress as required increases the risk of death or injury due to fire. The deficiency affected one (1) of three (3) paths	K 271	A Fire Safety Evaluation System (FSES) was conducted as a result of the 09/11/2019 Life Safety Code survey. The FSES was specifically used as an alternative safety method for Tag K 271 (Discharge from Exits). The facility passes the FSES when all other deficiencies have been corrected.	10/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 271	Continued From page 3 of egress from the facility.	K 271		
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 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.	K 321	K321 1. 1. The Intent of CHI St. Alexius Health Garrison is to comply with the ND	10/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 321	Continued From page 4 Observation determined the corridor door to the Laundry Room in the basement failed to self-close and latch into the door frame. Failure to ensure hazardous areas were separated from other spaces by self-closing, latching doors increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous hazardous areas in the facility.	K 321	Conditions of Participation. The door was adjusted to self-close, hinges were tightened and jam was adjusted 2. We will add this to our Hazard Surveillance/Life Safety tour (doors to hazardous areas must have closers, fully self-close and latch) 3. We will add this to our Hazard Surveillance/Life Safety tour (doors to hazardous areas must have closers, fully self-close and latch) 4. We will add this to our Hazard Surveillance/Life Safety tour (doors to hazardous areas must have closers, fully self-close and latch) 5. Fixed 9-12-19 by Huston	
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	K 324		10/26/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 5 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. 8) Neither the protected equipment nor the hazard has not been replaced, modified, or relocated. 7.2.2	K 324	K324 1. 1.The Intent of CHI St. Alexius Health Garrison is to comply with the ND Conditions of Participation. We will add kitchen hood inspection to our monthly computerized Fire Extinguishing checklist 2. This is a one-time fix since we only have (1) kitchen and hood 3. The kitchen exhaust hood fire suppression monitor will be in our monthly computerized preventive maintenance plan 4. The kitchen exhaust hood fire suppression monitor will be in our monthly computerized preventive maintenance plan 5. The inspection checklist was implemented on 9-16-19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355115	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/11/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARRISON MEM HOSP NSG FAC	**407 3RD AVE SE** **GARRISON, ND 58540**

(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 6 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		