

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                     |                                                                            |                                                                 |                                                        |
|-----------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01 | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
|                                                     |                                                                            | B. WING                                                         |                                                        |

|                                                                   |                                                                                     |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b> |
|-------------------------------------------------------------------|-------------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X5)<br>COMPLETION<br>DATE |
|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| K 000                    | INITIAL COMMENTS<br><br>This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these requirements.<br><br>The facility was located in a one-story building of Type II (000) construction protected throughout by a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.                                                                                                                                                                                                                                                                                                       | K 000               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                            |
| K 012<br>SS=F            | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>The facility failed to ensure the appropriate building construction type.<br><br>On 11/05/2014, observation and staff interview determined the facility was conducting a renovation of Resident Rooms 2A and 2B that will be used as a single resident room. This included removal of walls and replacing a bearing wall with wood studs in the building classified Type II (000).<br><br>Failure to maintain the existing construction type as required increases the risk of death or injury due to fire.<br><br>The deficiency affected one (1) of six (6) smoke compartments in the facility. | K 012               | <p><i>→ 1 of 3 pages</i></p> <p><b>Plan of Correction K012</b></p> <ol style="list-style-type: none"> <li>1. Wood studs in new wall in double rooms 2A and 2B will be replaced by steel studs. Initial plans were submitted to the Department on November 11, 2014. The Department responded on November 19, 2014 requiring a floor plan of the double room. A floor plan will be submitted to the Department. No work will be done on the double room until plans are approved by the Department, except replacing the wood studs with steel studs.</li> </ol> | 12/20/14                   |

|                                                                                                                                                             |                               |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> | TITLE<br><b>Administrator</b> | (X6) DATE<br><b>December 1, 2014</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|--------------------------------------|

A deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the institution's 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: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b> - MAIN BUILDING <b>01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  | (X5)<br>COMPLETION<br>DATE                             |
| K 000                                                             | INITIAL COMMENTS<br><br>This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these requirements.<br><br>The facility was located in a one-story building of Type II (000) construction protected throughout by a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.                                                                                                                                                                                                                                                                                                       | K 000                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  |                                                        |
| K 012<br>SS=F                                                     | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>The facility failed to ensure the appropriate building construction type.<br><br>On 11/05/2014, observation and staff interview determined the facility was conducting a renovation of Resident Rooms 2A and 2B that will be used as a single resident room. This included removal of walls and replacing a bearing wall with wood studs in the building classified Type II (000).<br><br>Failure to maintain the existing construction type as required increases the risk of death or injury due to fire.<br><br>The deficiency affected one (1) of six (6) smoke compartments in the facility. | K 012                                                                      | <p><i>2 of 3 pages</i></p> <p>2. Facility will identify other portions of the facility having the potential to be affected by any new construction, remodeling and installations planned for the facility.</p> <p>The only other current project is the remodeling of residents' closets. No work has begun on this project. Plans were submitted to the Department on November 11, 2014 for this remodeling project. The Department responded on November 19, 2014 requiring additional information on the closet rod support. This information will be provided to the Department. No work on the closet remodeling project will begin until plans are approved by the Department.</p> |  | 11/11/14<br>and<br>Ongoing                             |

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

TITLE

(X6) DATE

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: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      |                                                        |
|-----------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                      | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b>     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                      |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                              | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X5)<br>COMPLETION<br>DATE                                           |                                                        |
| K 000                                                                 | INITIAL COMMENTS<br><br>This survey used the 2000 edition of NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these requirements.<br><br>The facility was located in a one-story building of Type II (000) construction protected throughout by a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.                                                                                                                                                                                                                                                                                                       | K 000                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                      |                                                        |
| K 012<br>SS=F                                                         | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>The facility failed to ensure the appropriate building construction type.<br><br>On 11/05/2014, observation and staff interview determined the facility was conducting a renovation of Resident Rooms 2A and 2B that will be used as a single resident room. This included removal of walls and replacing a bearing wall with wood studs in the building classified Type II (000).<br><br>Failure to maintain the existing construction type as required increases the risk of death or injury due to fire.<br><br>The deficiency affected one (1) of six (6) smoke compartments in the facility. | K 012                                                                      | 3. Policy will be implemented that no construction, remodeling or installation can occur before plans have been submitted to the Department and approved by the Department. Management Team will be trained on this policy.<br><br>4. Facility will monitor its corrective actions by consistently following its policy of submitting plans to the Department before beginning any remodeling, construction or installation project. Administrator would be the person submitting the plans to the Department and Administrator will follow the policy noted above. | 11/11/14<br><br><br><br><br><br><br><br><br><br>11/11/14 and Ongoing |                                                        |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | TITLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                      | (X6) DATE                                              |

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: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |  |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |  | (X5)<br>COMPLETION<br>DATE                             |
| K 029<br>SS=E                                                     | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by:<br/>The facility failed to ensure doors to hazardous areas in fully sprinklered existing health care occupancies were equipped with self-closing/automatic latching hardware.</p> <p>Observation determined:<br/>1) The corridor door to the South Wing Storage Room which housed the soiled linen and garbage collection was not equipped with a self-closing device.</p> <p>2) The corridor door to the West Wing Storage Room which housed the soiled linen and garbage collection was not equipped with a self-closing device.</p> <p>Failure to ensure doors to hazardous areas self-close and latch to the door frame increases the risk of death or injury due to fire.</p> <p>This deficiency affected two (2) of eleven (7) hazardous areas in the facility.</p> | <b>K 029</b>                                                               | <p><b><u>Plan of Correction K029</u></b></p> <ol style="list-style-type: none"> <li>1. Self-closing/automatic hardware installed on the South Wing Storage Room door (soiled linen and garbage cart) and on the West Wing Storage Room door (soiled linen and garbage cart).</li> <li>2. Check throughout facility to ensure all doors of combustible storage rooms are equipped with self-closing devices on doors.</li> <li>3. Added to Maintenance's monthly inspection list a category for combustible storage rooms to ensure they all have working, self-closing devices on doors.</li> </ol> |  | <p>11/25/14</p> <p>11/25/14</p> <p>11/25/14</p>        |

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X5)<br>COMPLETION<br>DATE                                                                   |                                                        |
| K 052<br>SS=F                                                     | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>This STANDARD is not met as evidenced by:<br/>The facility failed to test the fire alarm system as required.</p> <p>Review of fire alarm system test records indicated the semiannual load voltage tests of the sealed lead acid batteries were not performed as required.</p> <p>Failure to test and maintain the fire alarm system in accordance with NFPA 72, National Fire Alarm Code, increases the risk of death or injury due to fire.</p> <p>This deficiency affected one (1) of two (2) required load voltage tests of the batteries in the last year.</p> <p>Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 table 7-3.2 item 6.d.3.</p> | K 052                                                                      | <p><b><u>Plan of Correction K052</u></b></p> <ol style="list-style-type: none"> <li>1. Load voltage tests of the fire alarm system's sealed lead acid batteries have been performed by Simplex.</li> <li>2. No other portion of the facility or other system has the potential to be affected by this deficient practice.</li> <li>3. Added to Maintenance's testing calendar for 6 month testing of the fire alarm system's sealed lead acid batteries.</li> </ol> <p>Purchased battery tester from Simplex for Maintenance to perform the semiannual tests. Simplex performs the annual load voltage testing of the fire alarm system's sealed lead batteries.</p> | 11/24/14<br><br><br><br><br><br><br><br><br><br>11/24/14<br><br><br><br><br><br><br>11/24/14 |                                                        |
| K 062<br>SS=F                                                     | <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | K 062                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                        |

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  |                                                        |
|-------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                             |  | (X5)<br>COMPLETION<br>DATE                             |
| K 062                                                             | <p>Continued From page 3</p> <p>continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by:<br/>The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems.</p> <p>All backflow devices installed in fire protection water supply shall be tested annually at the designed flow rate of the fire protection system, including hose stream demands, if appropriate. Exception: Where connections of a size sufficient to conduct a full flow test are not available, tests shall be conducted at the maximum flow rate possible.</p> <p>On 11/05/2014, no record of the required annual back flow preventer test was available.</p> <p>The deficiency affected one of numerous required tests of the automatic sprinkler system.</p> <p>Failure to test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due to fire.</p> <p>The automatic sprinkler system serves the entire building.</p> <p>Reference: 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-6.2</p> | K 062                                                                      | <p><b><u>Plan of Correction Ko62</u></b></p> <ol style="list-style-type: none"> <li>1. Backflow devices in fire protection water supply will be tested at the designed flow rate of the fire protection system by Allied (sprinkler company).</li> <li>2. No other portion of the facility or other system has the potential to be affected by this deficient practice</li> <li>3. Added to Maintenance's and Allied's testing calendars for Allied's annual testing of backflow devices in fire protection water supply.</li> </ol> |  | <p>12/15/14</p> <p>11/24/14</p>                        |

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

PRINTED: 11/19/2014  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                        |
|-------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355051</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01</b> - MAIN BUILDING <b>01</b><br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                             |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>11/05/2014</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>HATTON PRAIRIE VILLAGE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>950 DAKOTA AVE<br/>HATTON, ND 58240</b>                                                                                                                                                                                                                                                                                                                                                                                                                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                       |  | (X5)<br>COMPLETION<br>DATE                             |
| K 144<br>SS=F                                                     | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by:<br/>Maintenance of emergency generator batteries must include checking and recording the value of the specific gravity. NFPA 110, Section A-6-3.6</p> <p>Record review and interview of maintenance staff determined the batteries in the emergency generator were not tested for specific gravity.</p> <p>Failure to ensure the emergency generator is in compliance with NFPA 110, Standard for Emergency and Standby Power Systems, increases the risk of death or injury due to fire.</p> <p>The deficiency affected one (1) of one (1) emergency generator which provides all emergency power for the building.</p> | K 144                                                                      | <p><u><b>Plan of Correction K144</b></u></p> <ol style="list-style-type: none"> <li>Emergency generator batteries were checked for the value of the specific gravity.</li> <li>No other portion of the facility or other system has the potential to be affected by this deficient practice.</li> <li>Added to Maintenance's weekly testing calendar to test the generator batteries for the value of the specific gravity.</li> </ol> <p>Purchased a 4 ball battery tester to perform these weekly tests.</p> |  | <p>11/18/14</p> <p>11/18/14</p> <p>11/18/14</p>        |