STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355042	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTERN HORIZONS CARE CENTER	1104 HWY 12 HETTINGER, ND 58639

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K 000	INITIAL COMMENTS 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 standards. The facility was located in a one-story building of Type V (000) construction with no basement. The building was protected throughout with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000	The facility has prepared and submitted this plan of correction because of the requirements under state and federal law that mandate submission of a plan of correction to participate in the title 42 programs. The submission of the plan of correction should in no way be considered or construed as an agreement with the allegations of non-compliance shall constitute this facility's credible allegation of compliance. This applies to the following tags: K017, K018, K025, K029, K045, K051, K062, & K147	
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: The facility failed to provide corridors that were	K 017	Maintenance will check all the walls along the North and South Corridors from the East End to the West End for smoke barrier breaches. Any breaches will be sealed with recommended silicone caulk to prevent smoke passing to or from corridors. To ensure smoke barriers are in place and continue to be a smoke barrier going forth, maintenance will do quarterly inspections on corridor walls. "Quarterly Wall Ceiling Audit" Form is enclosed. Completion goal date will be	8/23/12

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	8/1/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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K 017	Continued From page 1 separated from use areas by walls that were smoke resisting. Corridor walls may terminate at a suspended ceiling which can limit the transfer of smoke. If the suspended ceiling cannot provide a nominal degree of smoke resistance, the corridor walls must extend to the roof deck. Observation determined the north side of the north corridor wall had unsealed spaces in the wall by the bathroom west of the smoke barrier that were not sealed. The corridor ceiling tiles were broken, water damaged, warped or did not fit into the grid system to provide a nominal degree of smoke resistance.	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The cited doors are monitored and adjusted as the seasons change. These doors will be looked at more closely for adjustments to try to decrease the seasonal adjustments they require as well as maintenance will remove the excess paint from the door edge and the door frame. These steps should ensure the door closes more reliably. Maintenance will walk thru the facility and check for doors that will not latch to closed position also. Staff education will be done so staff recognize this as an issue and submit maintenance slips to correct issues they come across. A Monthly QA will be done and documented on the "Interior Door Monthly" Form enclosed. Completion goal date will be	8/23/12

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K 018	Continued From page 2 This STANDARD is not met as evidenced by: The facility failed to ensure corridor doors were provided with a means suitable for keeping the door closed. Observation determined: 1) The south door to the Activity Room did not self-close and latch into the frame. 2) The north door to the Activity Room did not self-close and latch into the frame.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: The facility failed to ensure smoke barriers were maintained to provide at least a half-hour fire resistance rating. Observation determined the integrity of one (1) of two (2) smoke barriers had less than a half-hour fire resistance rating. Openings were not sealed	K 025	It was cited that a 3" pip through the Firewall was not sealed properly due to the fire rated caulk material present had cracked and fell out.. Maintenance has resealed the 3" pipe with fire rated caulk material again. To try to prevent this fire wall breach in the future, maintenance will inspect firewall for breaches and fire caulking material integrity quarterly. Any breaches to the firewall will be sealed with fire rated material. The quarterly building inspections will be documented on the "Fire Barrier Audit" Form. Completion goal date will be	8/23/12

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K 025	Continued From page 3 with fire rated materials around a three inch pipe penetration above the south smoke doors in smoke barrier #2.	K 025		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: The facility failed to separate hazardous areas from all other spaces with smoke resisting walls and non-rated doors that were equipped with self-closing devices and positive latching hardware. Observation determined: 1) The door to the Soiled Linen Room did not was not self-close to the latched position. 2) The north wall between the corridor and the Laundry had unsealed spaces around two (2) pipe penetrations.	K 029	#1) The cited door in the hazardous area had a door closing device that did not allow adjustment to increase tension so the door closes properly. The closing device will be replaced and tension set on the new device so the door will close to the latching position. Doors to hazardous areas will be checked quarterly and documentation of the checks will be on the QA audit "Hazardous Area Doors" Form which has been included. Completion goal date will be #2)It was cited that 2 pipes breaching a wall to the North Corridor between East and West ends from the Clean Laundry/ Linens Room did not provide smoke containment. As stated in K017, any breaches will be sealed with recommended silicone caulk to prevent smoke passing to or from corridors. To ensure smoke barriers are in place and continue to be a smoke barrier going forth, maintenance will do quarterly inspections on corridor walls. "Quarterly Wall Ceiling Audit" Form is enclosed. Completion goal date will be	8/23/12 8/23/12
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit	K 045	Outside Light fixture at the West Exit Emergency Discharge and Egress did	

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K 045	Continued From page 4 discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: The facility failed to ensure the illumination of means of egress. Observation determined the light fixture at the west exit discharge had one bulb that was not illuminated.	K 045	not light up. Light fixture has been replaced due to light taking 2-3 minutes to turn on after photo-sensor was covered. A pattern was established after repeated testing. Due to the unreliability of the fixture, the fixture was replaced. To help ensure the required outside lighting will be operational going forth, a daily QA form has been established to ensure daily checks are done. The form includes outside light & photocells are working, fire door exits are free of debris, and sidewalks are passible. Documentation of these tasks will take place on "Exterior Daily Audit" Form. Completion goal date is	8/23/12
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	The automatic dialer device will be kept in a locked cabinet to ensure limited accessibility so only authorized staff will have access to the device. Malfunctioning of the device does affect the whole building if there is a fire event but there is no other device like this in the facility so this is the only one to monitor. The facility will subscribe to a service that will monitor the system to ensure the dialer and fire panel is working. The service will alert us if there is an issue with the system or if they lose communication with the system. Documentation of the subscribed	

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K 051	Continued From page 5 This STANDARD is not met as evidenced by: The facility failed to ensure the fire alarm system with approved components, devices or equipment was installed and maintained according to NFPA 72. Observation determined the automatic digital dialer component of the fire alarm system used to summon the fire department indicated "turned off". There was no audible or visual indication on the fire alarm panel that would alert staff that the automatic digital dialer was turned off.	K 051	service will be provided when service is in place. Until the service is in place a daily QA audit will be done by maintenance to ensure the dialer is active which will be documented on the "Daily Dialer Audit" form. Completion goal date is	8/23/12
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are 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 This STANDARD is not met as evidenced by: 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. Observation determined:	K 062	#1)Room 1 East closet sprinkler head has been replaced due to the cited paint on top of the deflector. This was done immediately on 7/10/12. Maintenance will do a quarterly audit on all sprinkler heads in the facility to look for paint and other noticeable obstructions to the operation of the sprinkler heads. The audit will be documented on the "Quarterly Sprinkler Head Audit" Form enclosed. Completion goal date is #2)Maintenance consulted with Western Fire and Safety as to which sprinkler rating is needed for this area and has replaced all 4 heads so they all match with	8/1/12

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K 062	Continued From page 6 1) One (1) sprinkler in the closet in Resident Room #1 had paint on the sprinkler deflector and may not operate at the designed temperature. 2) Three (3) of four (4) sprinklers in the Boiler Room were blue color-coded which is an indication of high temperature rating and classification. This type of sprinkler is only permitted in locations where the maximum ceiling temperature exceeds 225 degrees F. 3) The southeast sprinkler in the Boiler Room had mechanical damage to the deflector and was no longer deemed in a reliable operating condition.	K 062	the same protection rating: 200 Degrees F. Maintenance will consult with Western Fire and Safety about the all the sprinkler heads used in the facility to ensure they are appropriately rated for the location of their use. There will be a key added "Quarterly Sprinkler Head Audit" Form so maintenance will know what sprinkler heads should be seen in the different areas of the facility. Completion goal date is #3)Sprinkler head cited has been replaced as of 7/17/12 as part of the 4 sprinkler heads replaced in the Boiler Room cited is K062, #2.	8/23/12
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: The facility failed to ensure the electrical wiring was maintained in accordance with NFPA 70. Observation determined: 1) The electrical cord for the aquarium was plugged into a receptacle that did not have ground-fault circuit interrupter (GFCI) protection. 2) Electrical power strips were used as a substitute for adequate electrical outlets. a) Two (2) power strips were in use in place of permanent wiring to provide electricity to a lamp, telephone and radio in Resident Room #9.	K 147	#1)Electrical outlet cited has been replaced with a GFCI protection outlet on 7/24/12. Maintenance will inspect the facility for GFCI protection outlet needs. GFCI audit will be documented on the "Weekly GFCI Receptacle Test" form. Completion goal date is #2a)Resident Room #9 as well as all resident rooms will be inspected for power strip usage. Rm #9 power strip was removed 7/10/12. This guidance is given as part of the admission paperwork and reviewed with resident and families at that point. Maintenance and staff have been educated on this subject and do keep an eye out for power strips being brought into the facility.	8/23/12

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K 147	Continued From page 7 b) Several battery chargers for resident lifts were plugged into a power strip in the West End Soiled Utility Room. c) Several battery chargers for hand-held radio communicators were plugged into power strips in the Medication Room.	K 147	Staff will be re-educated to keep an eye out for power strip usage in the resident rooms and to report them if found to Maintenance Department. A QA audit will also be put in place for Maintenance and Housekeeping to check all rooms on a weekly basis to ensure outlets use is appropriate. Documentation of the audit will be done on the "Weekly Power Strip Audit" form. Completion goal date is #2b)It was cited that several low amp/ low voltage battery chargers for resident lifts were plugged into a power strip in the West End Soiled Utility Room. Since the survey, other outlets have been located to plug these chargers into. Completion goal date is #2c)It was cited that several low amp battery/ low voltage battery chargers for hand held radios for nursing staff to communicate were plugged into power strips in the Medication Room. Since the survey, other outlets have been located to plug these chargers into. Completion goal date is	8/23/12 7/30/12 7/30/12