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

PRINTED: 09/04/2014
FORM APPROVED
OMB NO. 0938-0391

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	08/27/2014

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 program. 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, K027, K029, K046, K054, K056 & K0144.	
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 corridor walls that	K 017	The wall opening was used for the portable AC units received by the Emergency State Casche to help maintain the regulatory 71 to 81 degrees Fahrenheit required for the facility. The units had been deactivated on 8/25/14 and loaded up in preparation for the trailer to be picked up. The opening had not yet been covered when this survey occurred. The opening will be covered with sheet rock and dry wall material and repainted. No other opening of this type were opened in the facility so no other areas are affected. Completed Date: 10/11/14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/15/14

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.

emailed 9-16-14

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K 017	Continued From page 1 were constructed to resist the passage of smoke. Observation determined there was a 13" x 13" opening in the west wing corridor wall between Resident Room #14 and the west exit door. Failure to provide corridor walls that resist the passage of smoke increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous corridor walls in the facility.	K 017		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: The facility failed to ensure doors located in smoke barrier walls resisted the passage of smoke. Observation determined the smoke barrier doors located in the Physical Therapy Room would not close into the door frame. These doors are located in the smoke barrier.	K 027	The fire doors are inspected as well as other doors in the facility which has been reported on the door audit done attached. This is done due to constant adjusting needed on the doors due to building shifting that occurs seasonally. The Therapy Room Fire Barrier Door will be adjusted to close into the door frame. The Fire door in Therapy will be added to the Quarterly Fire Barrier Audit as well which is also attached as part of the corrective action to ensure all the fire barrier doors in the facility are checked at least that often and not missed. Completed Date: 10/11/14	

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K 027	Continued From page 2 Failure to maintain smoke barrier doors increases the risk of death or injury due to fire. The deficiency affected two (2) of nine (9) smoke compartments in the facility.	K 027		
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 other spaces with smoke resisting partitions and self-closing door assemblies. Observation determined: 1) The west leaf of the Central Supply Room corridor doors did not have a self-closing device. 2) The Kitchen Storage Room door did not have a self-closing device. Failure to separate hazardous areas from other spaces increases the risk of death or injury due to fire.	K 029	**#1 West Leaf of Central Supply Door from Back Hall Corridor to partitioned off Central Supply Room.** The West leaf of the double door is kept closed with a pull type spring bar device that will release only if the chain is pulled and held down. There is no closing device on the west leaf due to proximity conflicts with the Kitchen Dry Good Area Door. To rectify the issue, a self- closing device will be installed on the Office Door because a partition between the office and central supply rooms would obstruct access to light fixture and heating/ cooling unit maintenance which is why it was removed. The closing device will be placed on the Environmental Services Office door and monitored ensure the door closes and latches into the door frame. This door will be added to the monthly audit tool so that it will be looked at to ensure the device is working properly and the door latches into the door frame. Completion Date:	10/11/14

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K 029	Continued From page 3 The deficiency affected two (2) of nine (9) hazardous areas in the facility.	K 029	door will not be opened and will always stay closed. To ensure the door remains closed and device is in place, the door will be added to the Quarterly Fire Barrier Audit Sheet. Completion Date:	10/11/14
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: A functional test must be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test must be conducted for 1 1/2-hour duration. Written records of testing must be kept by the owner for inspection by the authority having jurisdiction. Review of records indicated the facility failed to conduct monthly thirty (30) second tests on emergency battery pack lights in November 2013, March 2014, and February 2014. Failure to provide emergency lighting as required increases the risk of death or injury due to fire. The deficiency affected all emergency battery back-up lights throughout the building.	K 046	This room is considered a hazardous area due to the gas water heaters contained within. Though the content of this room have not changed in the last 4 years, a self-closing door device is now required on the door and will be installed. To ensure the self-closing device closes the door completely to the latched position it will be added to the Hazardous Areas Audit sheet which provides an Audit of all Hazardous Areas in the facility is done per quarter year. See the attached Hazardous Area Audit Form. Completion Date:	10/11/14
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054	Emergency Lighting will be removed from the other Audit Forms and given an Audit Sheet of its own. The Audit sheet will indicate that the Emergency Lights will be audited monthly and annually as well as any issues that are found with them. The Emergency Lighting Audit Form is attached. The Maintenance Supervisor will then review the Audit Sheet Quarterly to ensure the task is being done and documentation is in place. Completion Date:	10/11/14

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K 054	Continued From page 4 This STANDARD is not met as evidenced by: The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with the manufacturer's specifications. Record review indicated the smoke detectors in the corridor outside of East Wing Resident Room #16 and in the corridor outside the Laundry Room failed when tested on 02/27/2014 and had not been replaced. Failure to maintain smoke detectors as required increases the risk of death or injury due to fire. The deficiency affected two (2) of numerous smoke detectors in the facility.	K 054	Documentation from testing contractor indicated that these fixtures did react outside of the specified time but Maintenance had not replaced them yet. Smoke detector failing to react within the specified time will be replaced. The Environmental Services Supervisor will review the testing and sensitivity report and track that repairs are done more timely to ensure reported issues are rectified timely. It will also be explored regarding if the testing and sensitivity contractor can replace items as they are found which will also rectify this issue from happening again. Completion Date: 10/11/14	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Automatic fire sprinkler systems must be	K 056	The contractor that installed the updated boiler heating system will be contacted to replace/ re-install the missing sprinkler head. Date Completed: 10/11/14 More guidance was requested by the State regarding these two items but has not been received by the time this POC needed to be done. For both cited issues #2 & #3; outdoor, seasonally appropriate sprinkler heads will be installed in both spaces cited. Date Completed: 10/11/14	

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K 056	Continued From page 5 installed in accordance with NFPA 13. The facility failed to install the automatic sprinkler system in accordance with NFPA 13 to provide adequate coverage for all portions of the building. Observation determined: 1) The southwest corner of the Boiler Room lacked adequate sprinkler coverage. 2) The combustible overhang greater than 4 feet outside of the northeast exterior door from the Kitchen did not have sprinkler coverage. 3) The combustible overhang greater than 4 feet outside of the north exterior doors from the Boiler Room did not have sprinkler coverage. 4) The West Wing Shower Room contained a mixture of quick response and ordinary-temperature-rated sprinklers. 5) The Central Supply Room contained a mixture of quick response and ordinary-temperature-rated sprinklers. Failure to install the automatic sprinkler system in accordance with NFPA 13 increases the risk of injury and death due to fire. The deficiency affected five (5) of numerous areas in the facility.	K 056	For both cited issues #4 & #5, the sprinkler heads will be replaced so that the same type of sprinkler heads (quick response or ordinary-temperature-rated sprinkler heads) will monitor and protect an individual room or space. An observance regarding that all sprinkler heads in an individual room or space are the same type of sprinkler head will be added to the Sprinkler Head Audit Form. See attached form. Date Completed: 10/11/14	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. 1) All Level 1 and Level 2 installations of an emergency generator shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. For Level 1 and Level 2 systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. NFPA 110, Standard for Emergency and Standby Power Systems. Observation determined there was no remote stop switch for the generator located outside of the generator room. 2) Record review determined the specific gravity of the emergency generator battery was not checked at seven (7) day intervals as required. Failure to inspect and maintain the emergency	K 144	A remote emergency stop switch has been ordered and WHCC is waiting for the electrician to install the device during the time of the Life Safety Survey. The switch will be installed and an outdoor appropriate case and signage will be put up also. The Switch will then be added to the Monthly Generator Audit Sheet to be tested to ensure operation of switch. Date Completed: 10/11/14 To correct this issue, the Battery Specific Gravity Test will be taken off the Monthly Generator Checklist and put on the Weekly Generator Checklist. See the Generator Checklist (Monthly) and the Generator Checklist (Weekly) audit sheets attached. The audit sheet will be reviewed by the supervisor on a monthly basis to ensure that the task and documentation is in place for the first 2 months then annually of there are no issues with the documentation. Date Completed: 10/11/14	

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K 144	Continued From page 7 generators in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 144		