

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

PRINTED: 01/29/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355042		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/13/2018	
NAME OF PROVIDER OR SUPPLIER WESTERN HORIZONS CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1104 HWY 12 HETTINGER, ND 58639			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction with 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			
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. 4.6.12.3 Any device, equipment, system, condition, arrangement, level of protection, fire-resistive			K 200	1. Emergency lighting will be connected to the emergency generator. 2. All residents have the potential to be impacted by the current practice. 3. Testing of the emergency lighting will be tested monthly and logged.		12/28/18

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

TITLE

(X6) DATE

Electronically Signed

11/26/2018

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.

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K 200	Continued From page 1 construction, or any other feature requiring periodic testing, inspection, or operation to ensure its maintenance shall be tested, inspected, or operated as specified elsewhere in the Code or as directed by the authority having jurisdiction. 4.6.12.4 Emergency illumination shall be provided for not less than 1½ hours in the event of failure of normal lighting. 7.9.2.1 Testing of required emergency lighting systems shall be permitted to be conducted as follows: 1) Functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds. 2) The test interval shall be permitted to be extended beyond 30 days with the approval of the authority having jurisdiction. 3) Functional testing shall be conducted annually for a minimum of 1½ hours if the emergency lighting system is battery powered. 4) The emergency lighting equipment shall be fully operational for the duration of the tests. 5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. 7.9.3.1.1 The facility failed to ensure the emergency lighting was in proper operating condition to provide 1½ hours of emergency illumination in the event of failure of normal lighting. Records review determined monthly and annual testing of the emergency battery-powered	K 200	4. Environmental Services Director or designee will audit that the emergency lighting is tested monthly and logged. These monthly audits will be reported by the Environmental Services Director at the monthly QAPI meetings for review and consideration.		

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K 200	Continued From page 2 emergency lighting system was not documented.			K 200			
K 345 SS=F	Failure to test and maintain the emergency lights in accordance with NFPA 101 increases the risk of death or injury due to fire. The deficiency affected all emergency battery back-up lights throughout the building. Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 19.3.4.1 A fire alarm system required for life safety shall be installed, tested and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm and Signaling Code. 9.6.1.3 The facility failed to test the fire alarm system as required. Review of documentation determined device test results (alarm initiating, supervisory alarm			K 345	1. Fire alarm system will be tested and maintained according to NFPA 72 2. All residents have the potential to be impacted by the current practice. 3. Fire alarm system testing will be audited once a quarter by the Environmental Services Director. 4. Environmental Services Director or designee will report the monthly audits of the fire alarm system at the monthly QAPI meetings for review and consideration.		11/30/18

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K 345	Continued From page 3 initiating, and notification) did not provide an itemized list with the device type, address, location, and test result as required.	K 345			
K 363 SS=D	Failure to install, test and maintain the fire alarm system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected one (1) of one (1) fire alarm system. The fire alarm system serves the entire facility. Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are	K 363			11/30/18

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K 363	Continued From page 4 permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. 19.3.6.3.5 The facility failed to ensure corridor doors latched into their frames and resisted the passage of smoke. Observation determined the corridor door to the Clean Linen Room in the Northwest Wing failed to latch into the door frame. Failure to ensure corridor doors latch properly increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous corridor doors in the facility.	K 363			
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712	1. Clean linen door was adjusted so that it latches into the door frame. All other corridor doors were audited to ensure that they latch into the door frames. 2. All residents have the potential to be impacted by the current practice. 3. Environmental Services Director or designee will audit corridor doors quarterly for one year to ensure doors latch into door frames. 4. These quarterly audits will be reported by the Environmental Services Director at the monthly QAPI meetings for review and consideration.		12/28/18

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K 712	Continued From page 5 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Fire drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions. 19.7.1.6 The facility failed to conduct fire drills as required. Fire drill records review determined no fire drills were conducted on the Second Shift during the second quarter of 2018 or the Third Shift during the fourth quarter of 2017. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected two (2) of twelve (12) drills in the past year.	K 712	1. A fire drill schedule will be created so as to ensure a fire drill will be conducted quarterly on each shift. 2. All residents have the potential to be impacted by the current practice. 3. Environmental Services Director or designee will audit fire drill reports monthly for one year to ensure that a fire drill is conducted quarterly on each shift. 4. These monthly audits will be reported by the Environmental Services Director at the monthly QAPI meetings for review and consideration.		