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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 2000 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies in compliance with 42CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type II (000) construction that was protected by a wet automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000	K011 1. Hardware at door was adjusted so that self-close and latch functions work properly. 2. Doors at other separations will be inspected and adjusted if necessary. 3. A "Building Inspection Checklist" will be developed. It will include a review of self-closing and latching doors. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: The facility failed to ensure complete two-hour fire rated wall assemblies between the nursing facility and the adjoining nonconforming Assisted Living building. Observation determined the 90-minute fire rated door in the occupancy separation wall failed self-close and latch into its frame.	K 011		
K 014 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as	K 014	K014 1. A fire-retardant spray will be applied to the wainscot in east and west corridors. 2. A walk-through of the facility will be conducted to identify other areas where interior finishes may not have a flame spread rating of Class A or Class B. 3. A "Fire Safety Manual" will be set up for the Care Center. The "Manual" will contain a section devoted to flame spread ratings. Certificates and samples of materials will be included.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bruce Bergeson | TITLE: CEO Admin | (X6) DATE: 10/10/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	**108 E NYHUS AVE** **MCVILLE, ND 58254**

(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 014	Continued From page 1 fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: The facility failed to ensure the interior finish for corridors had a flame spread rating of Class A or Class B. Observation determined wood wainscot was applied to the east and west corridor walls. No documentation of the flame spread rating of the wainscot was available.	K 014	4. The "Building Inspection Checklist" will include a question regarding the installation of any new interior finishes. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
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	K018 1. A smoke detector will be installed at the Locker Room. 2. A walk-through of the building will be completed, to identify other areas where the corridors are unprotected. 3. A "Building Inspection Checklist" will be developed. The Checklist will include a review of corridor separations. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 018	Continued From page 2 This STANDARD is not met as evidenced by: The facility failed to ensure doors were provided to protect corridor openings. Observation determined the Locker Room lacked a door to separate the room from the corridor. The area had no smoke detector.	K 018	K029 1. Self-closing and latching hardware has been installed at the door to the Environmental Storage Room. 2. Doors at other hazardous areas will be inspected and any self-closing and latching hardware that is not working properly will be repaired or replaced. 3. A "Building Inspection Checklist" will be developed. It will include a review of self-closing and latching doors. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
K 029 SS=D	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	K 029		
	This STANDARD is not met as evidenced by: The facility failed to ensure hazardous areas were enclosed with self-closing doors equipped with automatic latching hardware. Observation determined the east door leaf of the pair of doors to the Environmental Storage Room was equipped with a manual latching device. Doors to hazardous areas must be self-closing and automatic latching.		K050 1. Quarterly fire drills will be conducted on each shift. Between 9PM and 6 AM a coded announcement will be used instead of an audible alarm. At those times the audible alarm will still be tested. Maintenance personnel are required to complete these drills.	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 050 SS=F	Continued From page 3 Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: The facility failed to conduct quarterly fire drills on each shift. Records reviewed indicated no documentation of fire drills conducted in 2013.	K 050	2. All areas of the building have the potential to be impacted by this practice. 3. Maintenance personnel will report drills to monthly Department Manager meetings. 4. Reports of drills will also be forwarded to the QA Committee monthly for the first month and then quarterly for the remainder of one year.	11/09/13
K 062 SS=F	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: 1) Testing frequencies for automatic sprinkler systems range from quarterly to annually. Inspection frequencies can be as often as weekly to as long as annually. The frequencies for testing, inspection and maintenance of automatic sprinkler systems are dictated by the requirements as outlined by Table 5-1 of NFPA	K 062	K062 1. A quarterly flow alarm has been conducted. All storage areas have been inspected and materials have been moved if they are within 18" of the sprinkler head. 2. All areas of the building have the potential to be impacted by this practice. 3. A "Building Inspection Checklist" will be developed. The Checklist will include a review of sprinkler testing and an inspection of storage areas. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 062	Continued From page 4 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. NFPA 25 requires the facility to complete, maintain and make available to the authority having jurisdiction copies of records which indicate the procedure performed, by whom, the results and the date. These records are to be retained for the life of the system. The automatic sprinkler system is required to have specified maintenance. The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25. Records review determined quarterly flow alarm tests of the sprinkler system were not conducted in the past twelve months. A flow alarm test was not completed during the 4th quarter of 2012. 2) Obstructions located less than or equal to 18 inches below a sprinkler deflector prevent the sprinkler discharge pattern from fully developing. NFPA 13-5-5.5.2.1. The facility failed to maintain adequate distance between storage and the sprinkler deflectors. Observation determined storage in numerous resident room closets was located less than 18 inches below the sprinkler deflector.	K 062	months and then quarterly for the remainder of one year. K130 1. A preventive maintenance program will be set up for the transfer switches. The transfer switches were examined with thermal imaging. Results will be forwarded to the Department. All combustible material has been removed from the Boiler Room. 2. All areas of the building have the potential to be impacted by this practice. 3. A "Building Inspection Checklist" will be developed. The Checklist will include a review of the preventative maintenance on the transfer switches. It will also include inspection for combustible storage in the boiler room. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786	K 130		11/09/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/25/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	**108 E NYHUS AVE** **MCVILLE, ND 58254**

(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 130	Continued From page 5 This STANDARD is not met as evidenced by: 1) Transfer switches must be subjected to a maintenance program including connections, inspection or testing for evidence of overheating and excessive contact erosion, removal of dust and dirt, and replacement of contacts when required. NFPA 110, Standard for Emergency and Standby Power Systems The facility failed to provide documentation of a preventive maintenance program for the emergency generator electrical transfer switch. 2) The facility failed to ensure the Boiler Room was not used for the storage of combustible materials. Observation determined the entire rooms housing the four (4) boilers had a large volume of combustible storage within one (1) foot of the boilers.	K 130	K135 1. Flammable and combustible have been removed from the Boiler Room. 2. All areas of the building have the po tential to be impacted by this practice. 3. A "Building Inspection Checklist" will be developed. The Checklist will include inspection for combustible and flammable liquids stored in the boiler room. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.	K 135		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 135	Continued From page 6 This STANDARD is not met as evidenced by: Flammable and combustible liquids must be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code. Storage cabinets for flammable and combustible liquids must be constructed in accordance with Section 4-3 of NFPA 30. Storage cabinets must be marked in conspicuous lettering: FLAMMABLE - KEEP FIRE AWAY. Precautions must be taken to prevent the ignition of flammable vapors. Sources of ignition include, but are not limited to open flames, smoking, cutting or welding, hot surfaces, frictional heat, static electricity, electrical or mechanical sparks and spontaneous heating, including heat-producing chemicals. Storage cabinets for flammable and combustible liquids are to be constructed in accordance with NFPA 30, 4.3. The facility failed to ensure the proper storage of flammable and combustible liquids. Observation determined flammable and combustible liquids were stored in the Boiler Room. A container labeled extremely flammable was stored in the Boiler Room outside the cabinet on a shelf.	K 135	K144 1. The emergency generator has been run under load for thirty minutes. It will continue to be run under load, for thirty minutes, on a monthly basis. 2. All areas of the building have the potential to be impacted by this practice. 3. A "Building Inspection Checklist" will be developed. The Checklist will include a review of the "Generator Testing Log." Maintenance personnel will make monthly notes on the Log discussing generator performance and items of concern. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NELSON COUNTY HEALTH SYSTEM CARE CENTER	108 E NYHUS AVE MCVILLE, ND 58254

(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 144	Continued From page 7 This STANDARD is not met as evidenced by: The facility failed to exercise the emergency generator on a monthly basis. According to signage on the generator transfer switch, the emergency generator was operated under load for twenty (20) minutes and run on a cool down basis for ten (10) minutes. Review of generator test records could not verify the emergency generator was being exercised under load for 30 minutes monthly from August 2012 through September 2013.	K 144	K147 1. Power strips and extension cords are used on a temporary basis, only. These items will be removed and permanent wiring will be installed, if possible. The facility will not allow the use of these temporary wiring devices on a regular of permanent basis. 2. All areas of the building have the potential to be impacted by this practice. 3. A "Building Inspection Checklist" will be developed. The Checklist will include inspection for power strips and extension cords. 4. The "Checklist" will be completed monthly by Maintenance personnel. Results will be reported to the QA Committee for the first three months and then quarterly for the remainder of one year.	11/09/13
K 147 SS=F	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 electrical wiring and electrical equipment met NFPA 70 requirements. Observation determined multiple power strips and extension cords located throughout the facility were used in place of permanent wiring.	K 147		