STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING **02** B. WING _____	**07/23/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	**600 S MAIN ST** **MINOT, ND 58701**

(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
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		9/9/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/02/2019

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E 039	Continued From page 1 [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: The facility failed to conduct exercises to test the emergency plan annually. Review of documentation and interview with staff determined the facility did not conduct a full-scale exercise or a tabletop exercise in the past year. Failure to conduct annual exercises to test the emergency preparedness plan increases the risk of injury or death due to fire. This deficiency affected the entire facility.	E 039	1)The full-scale facility and the table top exercise will be completed before the compliance date of Sept.9th. 2)The maintenance director will review a check list to go over these things. 3)The full-scale facility and the table top exercise will be incorporated into the annual preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance director/designee and will be reported to the compliance by the quality assurance committee annually to meet compliance.	

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E 039	Continued From page 2	E 039	5)September 9th.	
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 two-story building of Type II (000) construction. The building had no basement. The building was protected by a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening	K 211	1)All fire rated door assemblies will be inspected and fixed through-out the facility by September 9th. 2)The maintenance director will review a check list for each fire rated door assembly to see that each one is in compliance.	9/9/19

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K 211	Continued From page 3 Protectives, except as otherwise specified in this code. 8.3.3.1. Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.2 The facility failed to inspect and test all fire rated door assemblies throughout the facility. Review of documentation and interview with staff determined not all fire rated door assemblies had been inspected in the past year. Failure to inspect and test fire rated door assemblies increases the risk of injury or death due to fire. The deficiency affected numerous fire rated door assemblies throughout the facility.	K 211	3)The maintenance director will incorporate annual testing into the preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance director/designee and will be reported to the quality assurance committee quarterly for the next 6 months and reviewed for compliance by the quality assurance committee annually to meet compliance. 5)September 9th.	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff	K 222		9/9/19

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K 222	Continued From page 4 at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on	K 222		

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K 222	Continued From page 5 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This REQUIREMENT is not met as evidenced by: Where a door assembly is required to be equipped with panic or fire exit hardware, such hardware shall meet all of the following criteria: 1) It shall consist of a cross bar or push pad, the actuating portion of which extends across not less than one-half of the width of the door leaf. 2) It shall be mounted as follows: a) New installations shall be not less than 34 in., and not more than 48 in., above the floor. b) Existing installations shall be not less than 30 in., and not more than 48 in., above the floor. 3) It shall be constructed so that a horizontal force not to exceed 15 lbf actuates the cross bar or push pad and latches. 7.2.1.7.1. The facility failed to provide exit hardware as required. Observation determined the exit hardware on the stairway doors on the first and second floors at the north and northeast stairways did not extend at least half the width of the door leaf. Failure to provide exit hardware as required increases the risk of injury or death due to fire. This deficiency affected four (4) of numerous doors in the means of egress.	K 222	1)The door assemblies in the facility will be fixed to meet proper construction standards by September 9th. 2)The maintenance director will review a check list for each door assembly to see that each one is in compliance. 3)The maintenance director will incorporate quarterly testing into the preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance director/designee and will be reported to the quality assurance committee quarterly for the next 6 months and reviewed for compliance by the quality assurance committee annually to meet compliance. 5)September 9th.	

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K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Health care occupations shall be provided with a fire alarm system in accordance with 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, Standard Electrical Code, and NFPA 72, Standard Fire Alarm and Signaling Code. 9.6.1.3. All door hold-open release and integral door release and closure devices used for release service shall be monitored for integrity in accordance with Section 21.2. NFPA 72, 21.8.3.	K 341	1)The devices that are holding the 3 doors to the magnetic hold-open devices which were modified will be replaced and fixed with appropriate magnetic hold-open device by Sept.9th. 2)All doors in the facility with means of egress will be checked to see that each one is in compliance. 3)The maintenance director will incorporate quarterly testing into the preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance	9/9/19

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K 341	Continued From page 7 Observation determined numerous doors in the means of egress were held in the open position by a magnetic hold-open device operated by the fire alarm system. The devices attaching the door to the magnetic hold-open devices had been modified with rope and electrical conduit. Failure to ensure the integrity of all components of the fire alarm system increases the risk of injury or death due to fire. This deficiency affected numerous doors linked to the fire alarm system in the facility. The fire alarm system serves the entire facility.	K 341	director/designee and will be reported to the quality assurance committee quarterly for the next 6 months and reviewed for compliance by the quality assurance committee annually to meet compliance. 5) September 9th.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by: Sensitivity testing of smoke detectors is to be completed for all smoke detectors during the first year in service, and the alternate year following. After the second required calibration test, if the detector has remained within its listed and marked sensitivity range, the length of time between calibration tests may be extended, not to exceed five years. 19.3.4.5, 9.6.2.10.1.1, NFPA 72 14.4.5.3 The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm	K 347	1)Sensitivity testing for all the smoke detectors in the facility will be completed by September 9th. 2)A contractor will be hired to do the sensitivity testing every two years. 3)The maintenance director will incorporate this into his preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance	9/9/19

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K 347	Continued From page 8 and Signaling Code. Review of the fire alarm test results indicated the smoke detection system did not have sensitivity testing at frequencies in compliance with the minimum requirements of NFPA 72. No record was available to indicate when the last sensitivity test of the smoke detectors was completed. Failure to test the smoke detection system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected all smoke detectors in the facility.	K 347	director/designee yearly and will be reported to the quality assurance committee annually and reviewed for compliance by the quality assurance committee annually to meet compliance. 5)September 9th.	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351		8/2/19

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K 351	Continued From page 9 This REQUIREMENT is not met as evidenced by: Buildings containing nursing homes shall be provided throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. 19.3.5.1 Sprinkler piping or hangers shall not be used to support non-system components. NFPA 13, 9.1.1.7 The facility failed to install the automatic sprinkler system in accordance with NFPA 13. Observation determined a copper water line in the second floor Boiler Room was attached to and supported from the automatic sprinkler system pipe. Failure to install the automatic sprinkler system in accordance with NFPA 13 increases the risk of injury or death due to fire. This deficiency affected the automatic sprinkler system in one (1) of numerous rooms in the facility. The automatic sprinkler system serves the entire facility.	K 351	1)The copper water line has been detached from the automatic sprinkler system. 2)An audit was performed by the maintenance director and there are no other water lines connected to the automatic sprinkler system. 3)Since the audit was completed this will not occur in the facility. 4)The maintenance director will report this to the quality assurance committee during the next meeting to let them know about the action that has been taken to be in compliance. 5)August 2nd.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily	K 353		9/9/19

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K 353	Continued From page 10 available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. 19.7.6, 4.6.12, NFPA 25 4.1.4.1 The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25. Observation determined numerous sprinklers throughout the facility were covered in dust and lint. Failure to inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due to fire.	K 353	1)All of the sprinklers in the facility will be cleaned to get rid of the dust and lint by September 9th. 2)The maintenance director will make a check list to make sure the sprinklers are cleaned. 3)The maintenance director will incorporate this into his preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance director/designee quarterly for the next 6 months and reviewed for compliance by the quality assurance committee quarterly. 5)September 9th.	

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K 353	Continued From page 11 The deficiency affected the complete automatic sprinkler system, which serves the entire facility.	K 353		
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Portable fire extinguishers shall be provided in all health care occupancies. Extinguishers shall be selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 19.3.5.12, 9.7.4.1 Fire extinguishers having a gross weight not exceeding 40 lb. (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor. Fire extinguishers having a gross weight greater than 40 lb. (18.14 kg) (except wheeled types) shall be installed so that the top of the fire extinguisher is not more than 3 1/2 ft (1.07 m) above the floor. In no case shall the clearance between the bottom of the hand portable fire extinguisher and the floor be less than 4 in. (102 mm). NFPA 10 6.1.3.8.1, 6.1.3.8.2, 6.1.3.8.3 The facility failed to install fire extinguishers in accordance with NFPA 10. Observation determined portable fire extinguishers throughout the facility were installed with the top of the extinguisher more	K 355	1)The existing fire extinguishers in the facility will be replaced with fire extinguishers where the top of the extinguisher is not more than 5 feet above the floor per new regulations by September 9th. 2)The maintenance director will make a check list to make sure all the appropriate fire extinguisher are put in the appropriate place in the facility. 3)The maintenance director will incorporate this into his preventive maintenance log. 4)The monitoring of the corrective action will be performed by the maintenance director/designee annually and reviewed for compliance by the quality assurance committee annually. 5)September 9th.	9/9/19

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K 355	Continued From page 12 than 5 ft. above the floor. Failure to install fire extinguishers in accordance with NFPA 10 increases the risk of injury or death due to fire. The deficiency affected numerous fire extinguishers in the facility.	K 355		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and	K 918		9/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355031	A. BUILDING **02** B. WING _____	**07/23/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MINOT HEALTH AND REHAB, LLC	**600 S MAIN ST** **MINOT, ND 58701**

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K 918	Continued From page 13 circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to test the emergency power generator in accordance with NFPA 110, Standard for Emergency Power and Standby Systems. Record review and interview with staff determined the diesel emergency power generator was not exercised under load for 4 continuous hours in the past 36 months. Failure to test the emergency power generator in accordance with NFPA 110 increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) emergency power generator in the facility. The emergency power generator serves the entire facility.	K 918	1)The facility generator will have had it's 4 hour load test completed by September 9th. 2)No occupants in the facility will be affected. 3)The maintenance director will put this on his annual preventive maintenance schedule. 4)The monitoring of the corrective action will be performed by the maintenance director/designee annually and reviewed for compliance by the quality assurance committee annually. 5)September 9th.	