

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021	
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	Initial Comments			E 000			
K 000	A recertification survey conducted on 11/02/2021 found Minot Health and Rehab, LLC in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness. 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. Note: At the time of this survey no residents occupied the lower level of the facility.			K 000			
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9.18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Testing of required emergency lighting systems			K 291	1.The Maintenance Director or designee		11/12/21

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

TITLE

(X6) DATE

Electronically Signed

11/12/2021

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.

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 291	Continued From page 1 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. Review of records indicated the facility failed to conduct a 30-second monthly test of the emergency battery back-up lights during the month of October 2021. 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 291	tested all emergency battery back-up lights for thirty seconds. 2.The Maintenance Director or designee will ensure the required test of the emergency battery back-up lights is completed monthly per the facility's preventative maintenance program. The 3.Maintenance Director or designee and the Executive Director will be responsible to ensure future compliance. 4.Date of Completion: 12/17/21.		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities	K 324		11/12/21	

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 324	Continued From page 2 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. Automatic wet chemical fire-extinguishing systems shall be installed in accordance with the terms of their listing, the manufacturer's instructions, and NFPA 17A, Standard for Wet Chemical Extinguishing Systems. 19.3.2.5.1, 9.2.3, NFPA 96 10.2.6(4). 1) The facility failed to install cooking equipment	K 324	1.The manual activation for the fire extinguishing system serving the kitchen exhaust hood was lowered to a height of (48) inches or less. 2.The Maintenance Director or designee inspected the wet chemical extinguishing system in the kitchen. 3.The Maintenance Director or designee will ensure the required inspection of the wet chemical extinguishing system in the kitchen is completed and the tag is signed		

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021	
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 324	Continued From page 3 in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. A readily accessible means for manual activation shall be located between 1067 mm and 1219 mm (42 in. and 48 in.) above the floor, be accessible in the event of a fire, be located in a path of egress, and clearly identify the hazard protected. 19.3.2.5.1, 9.2.3, NFPA 96 10.5.1. Observation determined the manual actuation device for the fire-extinguishing system serving the Kitchen exhaust hood was mounted at a height of more than forty-eight (48) inches above the floor. The manual pull was 57 inches above the floor. 2) The facility failed to test and maintain the wet chemical extinguishing system in the Kitchen in accordance with NFPA 17A, Standard for Wet Chemical Extinguishing Systems. On a monthly basis, inspection shall be conducted in accordance with the manufacturer's listed installation and maintenance manual or the owner's manual. At a minimum, this quick check or inspection shall include verification of the following: (1) The extinguishing system is in its proper location. (2) The manual actuators are unobstructed. (3) The tamper indicators and seals are intact. (4) The maintenance tag or certificate is in place. (5) No obvious physical damage or condition exists that might prevent operation.			K 324	on a monthly basis. This task is part of the facility's monthly preventative maintenance program. 4.The Maintenance Director or designee and the Executive Director will be responsible to ensure future compliance. 5.Date of Completion: 12/17/21.		

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 324	Continued From page 4 (6) The pressure gauge, if provided, shall be inspected physically or electronically to ensure it is in the operable range. (7) The nozzle blowoff caps, where provided, are intact and undamaged. (8) Neither the protected equipment nor the hazard has not been replaced, modified, or relocated. If any deficiencies are found, appropriate corrective action shall be taken immediately. Where the corrective action involves maintenance, it shall be conducted by a trained service technician. Personnel making inspections shall keep records for those extinguishing systems that were found to require corrective actions. At least monthly, the date the inspection is performed and the initials of the person performing the inspection shall be recorded. The records shall be retained for the period between the semiannual maintenance inspections. NFPA 17A 7.2.1 through 7.2.6 Review of documentation and interview with staff determined the monthly inspections of the wet chemical extinguishing system in the Kitchen had not been completed during October 2021. Failure to install, inspect and maintain the wet chemical extinguishing system in accordance with NFPA 96 and NFPA 17A increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) wet chemical extinguishing system in the facility.	K 324			
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101	K 345			12/17/21

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 345	Continued From page 5 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 System defects and malfunctions shall be corrected. NFPA 72 14.2.1.2.2 The facility failed to ensure the fire alarm system was maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm Code. Observation and staff interview determined the fire alarm panel was indicating a trouble condition for the fire alarm control panel motherboard that had failed on 10/28/2021 and had not been repaired or replaced at the time of the survey. The Administrator indicated an outside company had a replacement motherboard ordered and would install it as soon as it arrives. The facility was conducting an approved fire watch. Failure to maintain the fire alarm system in accordance with NFPA 72 increases the risk of death or injury due to fire.	K 345	1.The center has contracted Johnson Controls to repair the fire alarm system. New parts have been identified and the order has been placed. 2.Johnson Controls will test all new equipment during installation. The center is currently conducting an approved fire watch. 3.Date of Completion: 12/17/21.		

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021	
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 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
K 345	Continued From page 6			K 345			
K 355 SS=E	The deficiency affected the complete fire alarm system, which serves the entire building. 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: Fire extinguishers shall be manually inspected when initially placed in service and thereafter either manually or by means of an electronic monitoring device/system at a minimum of 30-day intervals. 19.3.5.12, 9.7.4.1, NFPA 10 7.2.1.1, 7.2.1.2 The facility failed to inspect and maintain portable fire extinguishers in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Record review and observation determined: 1) No documentation was available to indicate an inspection of the portable fire extinguisher on the east wall of the Maintenance Office had been completed during October 2021. 2) No documentation was available to indicate an inspection of the portable fire extinguisher by the Laundry Room had been completed during October 2021. 3) No documentation was available to indicate an inspection of the portable fire extinguisher in the			K 355	1.The Maintenance Director or designee inspected the portable fire extinguishers located at the east wall of the maintenance office, the laundry room, the corridor by the therapy room, and the corridor by the DON office. 2.An audit was performed on the facility and no other issues were found. The Maintenance Director or designee will inspect all portable fire extinguishers on a monthly basis. This task is part of the facility's preventative maintenance program. 3.The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. 4.Date of Completion: 12/17/21.		12/17/21

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 355	Continued From page 7 corridor by the Therapy Room had been completed during October 2021. 4) No documentation was available to indicate an inspection of the portable fire extinguisher in the corridor by the DON Office had been completed during October 2021. Failure to ensure portable fire extinguishers comply with NFPA 10 increases the risk of death or injury due to fire. The deficiency affected four (4) of numerous portable fire extinguishers in the facility.	K 355			
K 916 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: A remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows:	K 916	1.Main Electric has been contracted to install an annunciator panel for the emergency generator at the second-floor nurse station. New parts have been ordered and will be installed upon delivery. 2.Date of Completion: 12/17/21.	12/17/21	

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 916	Continued From page 8 1) Individual visual signals shall indicate the following: a) When the emergency or auxiliary power source is operating to supply power to load b) When the battery charger is malfunctioning 2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: a) Low lubricating oil pressure b) Low water temperature c) Excessive water temperature d) Low fuel when the main fuel storage tank contains less than a 4-hour operating supply e) Overcrank (failed to start) f) Overspeed NFPA 99 6.4.1.1.17 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Standard for Health Care Facilities. Observation determined there was no remote annunciator located at a work site readily observable by personnel. A remote annunciator was located at the Lower Level Nurses Station which was not occupied at the time of this survey. Failure to ensure the emergency generator was in compliance with NFPA 99 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 916			
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		12/17/21	

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 918	Continued From page 9 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 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 ensure the emergency generator was in compliance with NFPA 99 and	K 918	1.The Maintenance Director or designee has completed the monthly(load) testing		

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

PRINTED: 04/29/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355031	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 11/02/2021
NAME OF PROVIDER OR SUPPLIER MINOT HEALTH AND REHAB, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 918	Continued From page 10 NFPA 110. Review of generator test records and interview with staff: 1) Did not indicate the weekly inspection of the emergency generator was conducted for all weeks since 10/06/2021. 2) Did not indicate the monthly test of the emergency generator was conducted during October 2021. Failure to inspect, test and maintain the emergency generator 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 918	and inspection of the emergency generator. 2.The Maintenance Director or designee has completed the weekly testing and inspection of the emergency generator. The weekly and monthly testing and inspection of the generator is part of the facility's preventative maintenance program. 3. The Maintenance Director or designee and the Executive Director will monitor to ensure future compliance. 4.Date of Completion: 12/17/21.		