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
	355031	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	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 000	INITIAL COMMENTS This survey used the 2000 edition of NFPA101, 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 requirements. The facility was located in a two-story building of Type II (000) construction with a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems.	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: The facility failed to ensure smoke barriers were maintained to provide at least a half-hour fire resistance rating. Observation determined two (2) of four (4) smoke barriers had less than a half-hour fire resistance rating. Spaces around cables through the wall above the first floor east corridor smoke doors	K 025	K 025 1. Unsealed penetrations have been sealed with UL Fire Resistant materials to meet the UL Fire/ Smoke design Standards. 2. All Smoke Barriers will be re-inspected for loose or damaged sealant and will be resealed with appropriate fire rated materials. 3. Building smoke barriers will be inspected monthly for three months and quarterly thereafter for loose or open penetrations and sealed appropriately. 4. Maintenance department will provide QA Committee Smoke Barrier audits and reports of findings, monthly for 3 months and quarterly thereafter. Audit form attached 5. 3/12/2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 3-24-14

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.

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K 025	Continued From page 1 and spaces around cables through the wall above the second floor south corridor smoke doors were not sealed with fire rated materials. The unsealed spaces were sealed with fire caulk prior to the exit conference. REPEAT DEFICENCY	K 025	K054	
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 This STANDARD is not met as evidenced by: Visual inspection frequencies and specific testing and maintenance frequencies for smoke detection systems are dictated by the prescriptive requirements of NFPA 72, National Fire Alarm Code (Chapter 10-Inspection, Testing and Maintenance Tables 10.3.1, 10.4.2.2 and 10.4.3). This code identifies specific inspection, testing and maintenance frequencies and methods. 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. The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with NFPA 72. Review of the fire alarm test results indicated that	K 054	1. Sensitivity Testing Contractor was contacted and arrangements made for testing Duct Detector #10. 2. Maintenance will prepare a listing of all devices in the building requiring sensitivity tests and coordinate a complete testing of the building. Prior to leaving the facility, the Contractor will be required to review the listing and tests completed for incomplete or missing test data. 3. Maintenance will provide to QA Committee Duct Detector #10 sensitivity test when corrected and the compared device listing with the contractor when complete. 4. Maintenance will report to QA committee annual sensitivity results until system no longer requires testing for 5 years. 5. 3/28/2014	

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	355031	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2014**

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K 054	Continued From page 2 duct detector #10 had not been tested during the March 2013 sensitivity testing.	K 054		
K 062 SS=D	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: The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. 1) Observation determined two (2) sprinklers in the Maintenance Room were obstructed by metal deflectors. The metal deflectors were removed prior to the exit conference. 2) Heat from a fire stratifies to the ceiling and travels along the ceiling to activate the sprinkler. When ceilings are removed, it delays the activation of the automatic fire sprinkler system. Observation determined approximately four (4) suspended ceiling tiles in the Laundry Corridor were lifted out of place.	K 062	**K062** 1. A. Sprinklers in Maintenance room with deflectors were modified to remove deflectors. B. Ceiling Tiles in Laundry Corridor area have been corrected to prevent lifting 2. Maintenance will monitor other sprinkler locations in building and remove deflectors in like situations. 3. Maintenance will work with sprinkler contractor on quarterly visit to insure no other locations are found and left uncorrected. 4. Maintenance / Contractor report will be provided to QA Committee on non-compliant findings. 5. 3/19/2014	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		

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K 072	Continued From page 3 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: The facility failed to maintain exit corridors free of all obstructions or impediments to full instant use. Observation determined patient lifts were stored in five (5) of eight (8) exit corridors during the survey. REPEAT DEFICIENCY	K 072	**K072** 1. All Lifts and devices excluding Isolation carts not in use were removed from aisle way locations with obstructed egress. 2. Nursing staff on both floors were re-educated to not utilize hallways as storage areas for lifts and other devices. Maintenance assisted Nursing in finding alternate storage areas for lifts and devices 3. Monitoring of use of lifts and devices and proper storage will be done by Nursing on both floors. 4. Hallways will be audited daily times 2 weeks, weekly times four weeks, and monthly thereafter by Nursing Floor Managers (DCD's), for lifts and devices not in use being stored in hallways. Audit form attached 5. 03/28/2014	