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 _____	**01/10/2017**

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
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=D	NFPA 101 Means of Egress - General 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 STANDARD is not met as evidenced by: The facility failed to ensure exit access was readily accessible at all times. During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 inches into the required width of an aisle, corridor, passageway, or landing, when fully open. 7.2.1.4.3.1 Observation determined the following doors	K 211	K-211 During the tour 2 electrical panel doors which opened into the egress hallway did not leave 1/2 of the required width of passage and need to project no more than 7 inches when fully open. 1. The action to correct the open door passage was to remove the self-closing device and remove a section of railing which impeded the opening of the doors to within 7 inches of the wall when fully opened.	2/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/19/2017

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K 211	Continued From page 1 opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened. 1) The corridor door to the Electrical Closet on the 1st floor. 2) The corridor door to the Electrical Closet on the 2nd floor. Failure to ensure exit access was readily available at all times increases the risk of death or injury due to fire. This deficiency affected two (2) of numerous corridor doors in the means of egress throughout the facility.	K 211	2. A safety committee tour will be used to identify any other doors which open into the egress corridor and insure that they are compliant with NFPA Means of Egress with current of proposed future renovation. 3. Regular safety tours will monitor that no impediments causing obstruction to means of egress will be added to the existing structure and NFPA Means of Egress code will be included in the facility risk assessment. 4. The results of regular safety tours will be reviewed for compliance within the Quality Assurance Committee meetings. Completion Date February 1	
K 291 SS=F	NFPA 101 Emergency Lighting 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 STANDARD is not met as evidenced by: A functional test must be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test must be conducted for 1 1/2-hour duration. Written records of testing must be kept by the owner for inspection by the authority having jurisdiction. 7.9.3 The facility failed to ensure emergency lighting of at least 1 1/2-hour duration.	K 291	K-291 Emergency Lighting Testing and Record Keeping. The facility did not log 30 second testing in each 30 day period or 90 minute testing annually for the emergency battery pack lights throughout the facility. 1. A Emergency Lighting test log has been developed to provide for regular 30 second testing within every 30 day period ongoing and 90 minute testing annually to	2/10/17

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K 291	Continued From page 2 Review of records indicated the facility failed to conduct monthly 30-second and annual 1 1/2-hour tests on the emergency battery pack lights throughout the facility. 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	comply with NFPA code. 2. The safety committee will tour on a regular basis to identify any other portions of the facility that requires emergency lighting and assure testing is done and recorded in compliance with NFPA code. 3. The facility will incorporate the requirements of inspection into the facility risk assessment as a systemic change to ensure that the deficient practice will not recur. 4. The safety committee reports the results of the regular safety inspection to the Quality Assurance Committee and any recommendations adopted will be incorporated into the facility risk assessment. 5. February 10	
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection 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. This STANDARD is not met as evidenced by: Existing life safety features obvious to the public, if not required by the Code, shall be either	K 300	K-300 Existing life safety features obvious to the public, if not required by	2/10/17

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K 300	Continued From page 3 maintained or removed. Any device, equipment, system, condition, arrangement, level of protection, fire-resistive 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 this Code or as directed by the authority having jurisdiction. 4.6.12.3, 4.6.12.4 The facility failed to ensure fifty five (55) of fifty five (55) battery powered smoke detectors located in Resident Rooms were tested weekly in accordance with the manufacturer's guidelines. Written documentation must be maintained. Failure to test the battery-powered smoke alarms weekly in accordance with guidelines from the manufacturer increases the risk of death or injury due to fire. This deficiency affected fifty five (55) of fifty nine (59) Resident Rooms in the facility.	K 300	code, shall be either maintained or removed. If retained the device must be tested and recorded weekly per LSC 2012 Health Existing. 1. The facility has created a smoke detector log record for weekly testing of the 55 resident room smoke detectors which are not required by code, but are obvious to the public, as identified by the manufacturer's guidelines until a decision is made to remove or continue to maintain weekly testing and documentation. 2. The safety committee will conduct regular safety tours to identify other portions of the facility having the potential to be affected and assure that testing is completed within manufacturer's guidelines and meets LSC 2012 Health Existing Code. 3. The facility will review existing systems for compliance of testing and record keeping and evaluate necessity of detection and monitoring within LSC 2012 Health Existing. Any potential modification to detection equipment will be in compliance with 2012 code and maintained with documentation per Manufacturer's guidelines for devices not required by NFPA code. 4. The safety committee will tour at regular intervals with inspections of testing records to assure documentation requirements are being met and report the results to the Quality Assurance	

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K 300	Continued From page 4	K 300	Committee. 5. February 10	
K 321 SS=E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating	K 321	K-321 Hazardous Areas-Enclosure The facility failed to ensure hazardous areas	2/10/17

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K 321	Continued From page 5 or shall be provided with an automatic extinguishing system. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. 19.3.2.1 The facility failed to ensure hazardous areas in fully sprinklered existing health care occupancies were separated from other spaces by smoke-resisting partitions. Observation determined: 1) The ceiling in the Soiled Laundry Room had an unsealed 6" x 12" opening. 2) The ceiling in the Central Storage Room had an unsealed 12" x 12" opening. 3) The corridor door to Room 236 did not have self-closing hardware. The Room was greater than 50 square feet and used to store combustible materials. Failure to ensure hazardous areas are separated from other spaces by smoke-resisting partitions and self-closing doors increases the risk of death or injury due to fire. The deficiency affected three (3) of numerous hazardous areas in the facility.	K 321	in fully sprinklered existing health care occupancies were separated from other spaces by smoke resisting partitions. a. 6"X12" ceiling exploratory maintenance space in soiled utility b. a 12"X12" ceiling breach in Central Storage, and c. Corridor room 236 needed self-closure device due to storage of combustible materials in an area greater than 50 square feet. 1. The ceiling in both Soiled Laundry and Central Storage will be sealed and separated by smoke-resisting partitions and a self-closing device will be installed to room 236 for combustible storage requirements for a room greater than 50 square feet. 2. The safety committee will conduct regular inspections of hazardous areas and combustible storage area to assure spaces are separated without breaches by smoke-resisting partitions and all combustible storage is equipped with self-closing devices. 3. The regular safety tours for maintaining smoke-resisting partition criteria and self-closing storage doors to hazardous areas will be incorporated into the facility risk assessment plan for inspections as a systemic change. 4. The completion of corrections indicated and incorporation into the Facility Risk Assessment ongoing activity will be communicated and evaluated by	

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K 321	Continued From page 6	K 321	the Quality Assurance Committee at regular intervals to ensure the deficient practice will not recur. 5. February 10	
K 347 SS=E	NFPA 101 Smoke Detection 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 STANDARD is not met as evidenced by: Smoke detectors must not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. 19.3.4.5.1, 9.6.2.10.1.1, NFPA 72 17.7.4.1. The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm Code. Observation determined three (3) smoke detectors in the Therapy Area were installed within 3 ft. of an air supply diffuser or return air opening. Failure to install the smoke detection system as required increases the risk of death or injury due to fire. This deficiency affected three (3) of numerous smoke detectors in the facility. The smoke detection system serves the entire facility.	K 347	K-347 Smoke detectors must not be located in a direct airflow nor closer than 3ft. from an air supply diffuser or return air opening. The Therapy Area constructed in 2008 contained 3 hard wire smoke detectors that were installed within 3 ft. of an air supply diffuser or return air opening. 1. A contractor quoted the movement of the 3 hard wire smoke detectors for relocation compliant with room size and outside the 3 ft. air supply diffuser or return air supply opening. The bid has been accepted and scheduled. 2. The safety committee conducts regular inspections of all areas of the facility and will include visual inspection of smoke detection devices inclusive of the 3 ft. restriction of an air supply diffuser or return air opening. 3. The smoke detection system will be incorporated into the Facility Risk	2/10/17

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K 347	Continued From page 7	K 347	Assessment along with regular safety tours by the safety committee. 4. The monitoring of the corrective action will be reported to the Quality Assurance Committee and ongoing Risk Assessment Program. 5. February 10	
K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing 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 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 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.	K 353	K-353 Sprinkler System NFPA 25 Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Observation determined the Housekeeping Closet on the 2nd floor	2/10/17

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K 353	Continued From page 8 Observation determined the Housekeeping Closet on the 2nd floor had a 6" x 12" opening in the ceiling that could delay the activation of the sprinkler system. 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. This deficiency affected one (1) of six (6) smoke compartments.	K 353	had a 6"X 12" opening in the ceiling that could delay activation of the sprinkler system. 1. The 6"X 12" exploratory opening will be repaired to assure the smoke-resisting partition will not have potential to delay the activation of the sprinkler system. 2. The safety committee will conduct regular facility inspections to identify and assure separation by smoke-resisting partition is not compromised due to maintenance inspection without completion of repair. 3. The systemic change will be to incorporate smoke-resisting partition inspection into the Fire Protection System portion of the Facility Risk Assessment Program. 4. The Safety Committee will make regular reports to the Quality Assurance Committee on the corrections implemented and the progress of incorporation into the Risk Assessment Program for approval and evaluation. 5. February 10	
K 361 SS=D	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1.	K 361		2/10/17

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K 361	Continued From page 9 18.3.6.1, 19.3.6.1 This STANDARD is not met as evidenced by: Corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5. 19.3.6.1, 19.3.6.1(1) Smoke compartments protected throughout by an approved supervised automatic sprinkler system shall be permitted to have spaces that are unlimited in size and open to the corridor, provided that all of the following criteria are met: a) The spaces are not used for patient sleeping rooms, treatment rooms, or hazardous areas. b) The corridors onto which the spaces open in the same smoke compartment are protected by an electrically supervised automatic smoke detection system or the smoke compartment in which the space is located is protected throughout by quick-response sprinklers. c) The open space is protected by an electrically supervised automatic smoke detection system or the entire space is arranged and located to allow direct supervision by the facility staff from a nurses station or similar space. d) The space does not obstruct access to required exits. The facility failed to separate other areas from corridors in accordance with 19.3.6.1. Observation determined the Library without a door separating the room from the corridor did not have automatic smoke detection and was not located to allow direct supervision by the facility staff from a nurses' station or similar space. Failure to separate corridors from other areas in accordance with 19.3.6.1 increases the risk of	K 361	K-361 Areas open to Corridor Spaces. The Library located in the front lobby was without a door, did not have automatic smoke detection and was not located to allow direct supervision. 1. The corrective action for the Library space will be to install a non-rated door to secure the unmonitored compartment that lacks approved supervised automated sprinkler systems to prevent access during periods where direct supervision is not provided. 2. The Safety Committee does regular facility inspections to identify areas of concern and report findings to Administration. Emphasis will be placed on adoption of LSC 2012 Health Existing code. 3. The space specific to this correction was a former resident phone/ privacy area that has be adapted to Library book storage. The library storage will be relocated to a location that is accessible with approved supervised automatic sprinkler systems. 4. The facility will report completion of the approved correction to the Quality Assurance Committee for final resolution and continue to inspect with regular safety tours as scheduled. 5. February 10	

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K 361	Continued From page 10 death or injury due to fire. This deficiency affected one (1) of numerous exit corridors in the facility.	K 361		
K 712 SS=E	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: 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: 1) No fire drills were conducted on the AM Shift during the third quarter of 2016. 2) No fire drills were conducted on the Night Shift during the fourth quarter of 2016. Failure to conduct fire drills as required increases	K 712	K-712 NFPA Fire Drills to be conducted and recorded quarterly on each shift to familiarize facility personnel with action required. 1. A fire drill grid for quarterly and annual compliance has been revised to assure each shift is conducted quarterly in addition the electronic reminders for impending time lines. 2. The regular inspection by safety committee personnel of required documentation will include inspection of records to assure compliance.	2/10/17

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K 712	Continued From page 11 the risk of death or injury due to fire. The deficiency affected two (2) of twelve (12) drills in the past year.	K 712	3. Monitoring and reporting by the safety committee will assure that the responsibility of completion and recording is not the sole responsibility of the Environmental Service Director. 4. Regular reporting of compliance will be included in the safety report to Quality Assurance for compliance and efficacy of response. 5. February 10	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: The facility failed to provide a documented risk assessment of building systems. NFPA 99, 4.2 Review of documentation and interview of staff determined the facility failed to conduct and document a risk assessment of building systems. Failure to conduct a risk assessment of building systems increases the risk of injury or death due to fire.	K 901	K-901 Building Systems Facility Risk Assessment 1. The facility has begun to conduct the Category 1 through 4 requirements on Building Systems "Facility Risk Assessment". Due to many of the corrections identified with the adoption of (LSC 2012 Health Existing)adoption for inspection, Life Safety Survey results will be incorporated into the Program.	2/10/17

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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
K 901	Continued From page 12 This deficiency affected building systems throughout the entire facility.	K 901	2. The "Facility Risk Assessment" is a building comprehensive assessment which will involve evaluating systems throughout the facility as a whole and their potential risk to the resident population. 3. The systemic change is to complete and adopt the "Facility Risk Assessment" as a working tool to evaluate building systems operations and their potential for risk. The ongoing adaptation will apply to existing systems as well as proposed adaptations. 4. The "Facility Risk Assessment" will be reviewed by the Quality Assurance Committee to adopt the completed program into effect and monitor any risk remediation. 5. February 10	
K 915 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Categories *Critical care rooms (Category 1) in which electrical system failure is likely to cause major injury or death of patients, including all rooms where electric life support equipment is required, are served by a Type 1 EES. *General care rooms (Category 2) in which electrical system failure is likely to cause minor injury to patients (Category 2) are served by a Type 1 or Type 2 EES. *Basic care rooms (Category 3) in which	K 915		2/10/17

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 _____	**01/10/2017**

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K 915	Continued From page 13 electrical system failure is not likely to cause injury to patients and rooms other than patient care rooms are not required to be served by an EES. Type 3 EES life safety branch has an alternate source of power that will be effective for 1-1/2 hours. 3.3.138, 6.3.2.2.10, 6.6.2.2.2, 6.6.3.1.1 (NFPA 99), TIA 12-3 This STANDARD is not met as evidenced by: Emergency generators and standby power systems shall be installed, tested, and maintained in accordance with NFPA 110. EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. NFPA 99, 6.4.4.1.1.4, NFPA 110, 8.4.1 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Health Care Facilities Code and NFPA 110, Standard for Emergency and Standby Power Systems. Review of generator test records could not verify that weekly inspections were conducted in the past year. Failure to ensure the emergency generator was in compliance 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 915	K-915 Electrical Systems Emergency Generator Weekly Inspection 1. The requirement of weekly inspections of the Generator for inspection requirement to electrical systems for testing and maintaining EPSSs including appurtenant components has been implemented to weekly documented inspection criteria in compliance with LSC 2012 Health Existing code. 2. The facility Safety Committee conducts regular inspections of the facility to identify ongoing compliance of LSC systems. Review of documentation to assure compliance encompasses all areas of the facility. 3. Electrical Systems and Generator Inspection protocol will be added as a component on the "Facility Risk Assessment" as a systemic change to Building Systems monitoring and reporting. 4. The correction of deficient practices and completion of the incorporation into the "Facility Risk Assessment Program"	

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 _____	**01/10/2017**

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K 915	Continued From page 14	K 915	will be reviewed and adopted through the Quality Assurance Committee which meets at regular intervals to evaluate facility programs. 5. February 10	