

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017	
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR				STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563			
(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			K 000			
K 131 SS=D	Stories: 1 Construction: Type V(000) Constructed: 1969, addition 2009 K0180: Fully Sprinkled Certified Beds: 68 Capacity: 68 Census: 65 NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: * They are not intended to serve four or more inpatients. * They are separated from areas of health care occupancies by construction having a minimum 2-hour fire resistance rating in accordance with Chapter 8. * The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 18.1.3.3, 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the common wall fire barrier with non-health care occupancy. Findings include: On 5/15/17, the fire doors at the following			K 131	1. Door latch on fire door leading into the Assisted Living facility was immediately fixed on 5/15/17. 2. All other fire doors were checked for proper latching on 5/15/17. All others worked properly. 3. All fire doors will be checked for proper latching on a weekly basis by maintenance department. Please refer to Attachment A. 4. The Interdisciplinary Quality Assurance Team will review the monitor on a Quarterly basis.		5/15/17

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

TITLE

(X6) DATE

Administrator

7/5/17

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: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 131	Continued From page 1 location leading to the non-health care occupancy did not close and latch when released from the open position. Fire doors are required to latch on closure. - Near hair salon, door to assisted living, corrected during survey. The Director of Maintenance was present when the deficiency was identified. Failure to maintain common wall fire barrier as required increases the risk of death or injury due to fire. The deficiency affected one of five smoke compartments. Ref: 2012 NFPA 101 Section 19.1.3.3, 6.1.14.4.1, 8.3.3.1, 2010 NFPA 80 Section 6.1.4.3.1	K 131			
K 222 SS=D	NFPA 101 Egress Doors 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 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	K 222	1. Contracted Electrician was immediately contacted on 5/15/17 to assess the problem and find a solution. 2. Contracted Electrician came and assessed all egress doors to make sure proper wiring was in place and working efficiently. 3. The maintenance department staff will do weekly checks of all egress doors. Please refer to Attachment B. 4. The Interdisciplinary Quality Assurance Team will review the monitor on a Quarterly basis.	6/12/17	

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 222	Continued From page 2 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 door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved,	K 222			

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 222	Continued From page 3 supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the provider failed to provide egress doors as required. Findings include: On 5/15/17, delayed egress locks mounted on doors in the means of egress at the following locations did not function as required: - Exit door at end of Oak wing, delayed egress door does not alarm or open The Director of Maintenance was present when the deficiency was identified. Failure to provide egress doors as required increases the risk of death or injury due to fire. The deficiency affected one of numerous egress doors in the building. Ref: 2012 NFPA 101 Section 19.2.2.2.1, 7.2.1.6.1.1(3)	K 222			
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities 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	K 324	1. The vent from the kitchen stove leading out to the roof was examined to see if it needed professional cleaning. It showed it was in need and so a contracted cleaning company was contacted to schedule a time to clean. 2. This is the only stove in the facility so only vent that needs to be checked and cleaned. 3. The maintenance department staff will check the vent every Spring and Fall and if it shows signs to be cleaned		6/8/17

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 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 STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to protect cooking facilities as required. Findings include: On 5/15/17, records did not verify that the hood ventilation system ductwork had been inspected for cleaning or cleaned as required. Kitchen hood systems as used in this facility are required to be inspected semiannually to determine if they are contaminated with deposits from grease-laden vapors. If contaminated, the entire exhaust system is required to be cleaned to bare metal. The Director of Maintenance was present when the deficiency was identified. Failure to protect cooking facilities as required increases the risk of death or injury due to fire. The deficiency affected one of five smoke	K 324	contracted company will be called in. Please refer to attachment C. 4. The Interdisciplinary Quality Assurance Team will review the monitor Quarterly.		

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 5 compartments.	K 324			
K 345 SS=D	Ref: 2012 NFPA 101 Section 19.3.2.5.1, 9.2.3; 2011 NFPA 96 Sections 11.4, 11.6 NFPA 101 Fire Alarm System - Testing and Maintenance 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. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to test the fire alarm system as required. Findings include: On 5/15/17, there was no documentation that the required annual testing of audible and visible notification devices of the fire alarm system had been performed in the past year as required. 35 horn strobes and 8 strobes were totaled as system components. Device test results (alarm initiating, supervisory alarm initiating, and notification) are required to be itemized list with the following information, device type, address, location, and test result as required. The Director of Maintenance was present when	K 345	1. Contacted AVI who does our Annual Fire Alarm Testing to add locations of all 35 horn strobes and 8 strobes to the Annual Testing Form. 2. All 35 horn strobes and 8 strobes in the building will be included in this testing and form. 3. The Maintenance Department staff or Administrator will review the form and sign off for completion after each annual test. Next Annual Inspection to be completed by the end of February 2018. 4. The Interdisciplinary Quality Assurance team will review on the month following the annual test for completion as well.	2/28/18	

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

PRINTED: 05/22/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355110	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/15/2017
NAME OF PROVIDER OR SUPPLIER ELM CREST MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELM AVE NEW SALEM, ND 58563		
(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 the deficiency was identified. Failure to test the fire alarm system as required increases the risk of death or injury due to fire. The deficiency affected one of numerous testing requirements of the fire alarm system. Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Table 14.4.5 Item 20 Ref: 2012 NFPA 101 Section 19.3.4.1, 9.6.1.5; 2010 NFPA 72 Section 14.6.2.4, Figure 14.6.2.4 Section 7.12-7.14 and page 11 of 11	K 345			