

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

PRINTED: 01/06/2017  
FORM APPROVED  
OMB NO. 0938-0391

|                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |  |                                                                                             |                                                                                                                          |                                                        |                            |
|---------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|--|---------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>355034</b> |  | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING <b>01 - MAIN BUILDING 01</b><br><br>B. WING _____ |                                                                                                                          | (X3) DATE SURVEY<br>COMPLETED<br><br><b>08/09/2016</b> |                            |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>TIOGA MEDICAL CENTER LTC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>810 N WELO ST</b><br><b>TIOGA, ND 58852</b>     |                                                                                                                          |                                                        |                            |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            |  | ID<br>PREFIX<br>TAG                                                                         | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |                                                        | (X5)<br>COMPLETION<br>DATE |
| K 000                                                               | <p><b>INITIAL COMMENTS</b></p> <p>The 2000 edition of NFPA 101, Life Safety Code, Chapter 18 New Health Care Occupancies and Chapter 19 Existing Health Care Occupancies, were used for this survey in compliance with 42 CFR 483.70(a).</p> <p>The Tioga Medical Center LTC was a combined hospital and skilled nursing facility located in a one-story building of Type II (000) construction with a basement. A clinic was attached to the west side of the Tioga Medical Center and was separated by an occupancy separation wall having a two-hour fire resistance rating. A one-story apartment building was attached to the east side of the facility and was separated by an occupancy separation wall having a two-hour fire resistance rating.</p> <p>Note:<br/>An addition and remodeling project to the hospital in 2015 was surveyed using Chapter 18.</p> <p>Observation and records review determined the facility to be in compliance with the minimum requirements of the 2000 Life Safety Code.</p> |                                                                            |  | K 000                                                                                       |                                                                                                                          |                                                        |                            |

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

TITLE

(X6) DATE

Electronically Signed

08/12/2016

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.