

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 comprised of three separate buildings: 1) The original 1957 four-story building was of Type II (222) construction with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. Attached to the east side of the original four-story building was a three-story addition which was constructed in 1988. The three-story structure was of Type III (211) construction equipped with an automatic sprinkler system designed to meet the requirements of NFPA 13. This addition had a wood roof. The wood framed roof has two layers of 5/8" Type "X" gypsum board attached to the bottom of the rafters. This downgrades the construction from Type II (222) to Type III (211). 2) Attached to the north side of the original four-story building was a one-story building of Type II (111) construction with a wet automatic sprinkler system designed to meet the requirements of NFPA 13. The two buildings were separated by a wall having a two-hour fire resistance rating. 3) Attached to the north end of the one-story building was a one-story addition built in 2006 of	K 000			

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

TITLE

(X6) DATE

Electronically Signed

05/25/2017

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: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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	Continued From page 1 Type V (111) construction with an automatic sprinkler system designed to meet the requirements of NFPA 13. The buildings were separated by a wall having a two-hour fire resistance rating. Note: A Fire Safety Evaluation System (FSES) was used as an alternative safety method for Tag K 161 Building Construction Type and Height for the 05/17/2017 Life Safety Code survey. The facility passes the FSES upon correction of all other deficiencies.	K 000			
K 161 SS=E	Building Construction Type and Height CFR(s): NFPA 101 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1. I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2. II (111) One story non-sprinklered. Maximum 3 stories sprinklered 3. II (000) Not allowed non-sprinklered 4. III (211) Maximum 2 stories sprinklered 5. IV (2HH) 6. V (111) 7. III (200) Not allowed non-sprinklered 8. V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)	K 161			5/30/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 161	Continued From page 2 Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Buildings of Type III (211) construction sprinklered throughout by an approved, supervised automatic sprinkler system must not exceed the allowed maximum 2 stories. 19.1.6.1. The facility failed to provide a structure that meets the requirements of the Life Safety Code. Observation determined the 1988 three-story addition of Type II (222) construction with an automatic sprinkler system was built with a wood framed roof. The wood framed roof has two layers of 5/8" Type "X" gypsum board attached to the bottom of the rafters. This downgrades the construction to Type III (211). The three-story addition with a wood framed roof exceeded the allowable height for the construction type. Failure to provide a structure that meets the construction requirements of the Life Safety Code increases the risk of injury or death due to fire. This deficiency affected one (1) of three (3) buildings separated by a wall having a two-hour fire resistance rating. Previously, this deficiency passed the Fire Safety Evaluation System (FSES). However, with the use of the edition of NFPA 101A associated with	K 161	1. A full inspection into the wood roof and the construction type on the multi-level building was completed. 2. All new construction plans will be approved by the health department prior to construction. 3. The multi-level building architectural plans showed that the ceiling deck is made up of 4 layers of "X" gypsum board which provides a 2 1/2 inch thickness at the bottom of the rafters/ceiling deck. Our ESC verified this by physically measuring the thickness of the ceiling deck. We also have a dry sprinkler system located in the rafters and is inspected annually by NOVA. Attached is a copy of the blue print showing in detail 3 & 6 which indicates 4 layers of 5/8 inch "X" gypsum board at the lid separating the occupied space from the attic space. 4. The administrator will monitor all new construction. 5. 5/30/2017		

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 161	Continued From page 3 the 2012 Life Safety Code, the methods of determining a passing score have changed. The use of the FSES for compliance is no longer an option for this deficiency.	K 161			
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 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 REQUIREMENT 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 opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened. 1) The corridor door to the Men's Restroom by the Chapel. 2) The corridor door to the Mechanical Room in the 2006 addition.	K 211	1. Handrails in the corridors to the men's restroom and mechanical room in the 2006 addition will be adjusted to permit the door to not extend more than 7" from the wall when fully opened. 2. We will do a facility assessment on all aisles, passageway, corridors, exit discharges exit locations and access to ensure we are free of all obstruction to fully use the corridors in case of emergency. 3. Q.A. will be put in place to monitor all door installations prior to installing. 4. The ESC (Environmental Service Coordinator) will approve all door installation prior to installing. 5. 5/31/2017	5/31/17	

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 211	Continued From page 4 Failure to ensure exit access was readily available at all times increases the risk of death or injury due to fire.	K 211			
K 321 SS=D	This deficiency affected two (2) of numerous corridor doors in the means of egress throughout the facility. Hazardous Areas - Enclosure CFR(s): NFPA 101 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)	K 321			6/1/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 321	Continued From page 5 g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating 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 and self-closing doors. Observation determined the corridor door to the North Soiled Utility Room on the 3rd Floor failed to self-close and latch. Failure to ensure hazardous areas were separated from other spaces by smoke-resisting partitions increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous hazardous areas in the facility.	K 321	1. Soiled utility room door on 3rd floor will be repaired/replaced to ensure the door will self-close and latch. 2. Maintenance will do a facility wide check on all doors to ensure that all corridor doors will self-close and latch. 3. Q.A. on all doors will be completed to ensure corridor doors will self-close. 4. ESC will monitor Q.A. report. All discrepancies will be reported to administrator. 5. 6/1/2017		
K 347 SS=E	Smoke Detection CFR(s): NFPA 101 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 REQUIREMENT is not met as evidenced	K 347			6/1/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 347	Continued From page 6 by: In spaces served by air-handling systems, detectors shall not be located where airflow prevents operation of the detectors. Detectors should not be located in a direct airflow or closer than 36 in. 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, A.17.7.4.1 The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm and Signaling Code. Observation determined thirteen (13) smoke detectors throughout the facility were installed within 36 in. 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 thirteen (13) of numerous smoke detectors in the facility. The smoke detection system serves the entire facility.	K 347	1. All 13 smoke detectors will be moved at least 36" away from all air supply diffusers and return air openings. 2. ESC will educate all maintenance employees of the smoke detector placement. Maintenances will survey all smoke detectors within the facility to ensure they are 36" away from air diffusers and air openings. 3. ESC will access and approve all new smoke detector installations to ensure 36" distance from all air supplies and air returns are in compliance. 4. ESC will approve all new fire detector installations. 5. 6/1/2017		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353			6/15/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 353	Continued From page 7 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 REQUIREMENT is not met as evidenced by: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. The property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test, and maintenance required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. 19.7.6, 4.6.12, NFPA 25 A main drain test shall be conducted annually at each water-based fire protection system riser to determine whether there has been a change in the condition of the water supply piping and control valves. In systems where the sole water supply is through a backflow preventer and/or pressure reducing valves, the main drain test of at least one system downstream of the device shall be conducted on a quarterly basis. NFPA 25, 13.2.5, 13.2.5.1 The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25.	K 353	1. Testing of the two automatic sprinkler system will be conducted by NOVA. 2. ESC will train all maintenance on the requirement of testing of the automatic sprinkler system and the number of test that need to be completed within a year and documented. 3. Q.A. of the report will be completed by the ESC (semi-annually) 4. ESC will monitor all Q.A. reports and will notify administrator of discrepancies. 5. 6/15/17		

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 353	Continued From page 8 Record review determined quarterly main drain tests of two (2) of two (2) automatic sprinkler systems equipped with backflow preventers were not completed as required. Records did not indicate main drain tests were conducted during the first quarter of 2017, and second and fourth quarters of 2016. The main drain test is conducted in the following manner: 1) Record the pressure indicated by the supply water gauge. 2) Close the alarm control valve on alarm valves. 3) Fully open the main drain valve. 4) After the flow has stabilized, record the residual (flowing) pressure indicated by the water supply gauge. 5) Close the main drain valve slowly. 6) Record the time taken for the supply water pressure to return to the original static (nonflowing) pressure. 7) Open the alarm control valve. 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. The deficiency affected two (2) of two (2) automatic sprinkler systems, which serve the entire facility.	K 353			
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire	K 712			6/1/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 712	Continued From page 9 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 REQUIREMENT 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 first quarter of 2017. 2) The times of the fire drills were not varied: a) The last three (3) fire drills for the AM shift occurred at 7:20 am, 8:07 am and 8:03 am. b) The last four (4) fire drills for the PM shift occurred at 3:19 pm, 4:15 pm, 7:30 pm and 3:45 pm. Fire drills are required to be conducted under varied conditions. The condition of the time of the day was not varied. Six (6) fire drills in the past year all occurred at times within 60 minutes of each other in an 8 hour shift.	K 712	1. Fire drills will be conducted during the A.M> time frame. 2. Education and training on the fire drills will be completed with all maintenances staff to ensure quarterly fire drills are completed correctly in a timely manner at varying time frames. 3. ESC will conduct a Q.A. check quarterly for the next year to ensure compliance. 4. ESC will monitor fire drills and report to administrator any discrepancies. 5. 6/1/201		

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 712	Continued From page 10	K 712			
K 918 SS=F	Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected seven (7) of twelve (12) drills in the past year. Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 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 and readily identifiable. Minimizing the possibility of damage of the	K 918			6/15/17

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072		
(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 11 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: Generator sets shall be tested 12 times a year, with testing intervals of not less than 20 days nor more than 40 days. Generator sets serving essential electrical systems shall be tested in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. EPSSs, including all appurtenant components, shall be inspected weekly and exercised under load at least monthly. Diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (1) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. (2) Under operating temperature conditions and at not less than 30 percent of the EPS nameplate kW rating. Diesel-powered EPS installations that do not meet the requirements shall be exercised monthly with the available EPSS load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. NFPA 99 6.4.4.1.1.4, NFPA 110 8.4.1, 8.4.2, 8.4.2.3	K 918	1. both generators will be run at the appropriate exhaust temperature provided by manufacture. 2. Education and training will be completed with maintenance to ensure compliance with NFPA 99 and NFPA 110. 3. ESC will conduct a Q.A., quarterly on all documentation on generators testing and will review the performance of the annual supplemental load when exercised to ensure compliance is achieved. 4. ESC will monitor and report discrepancies to the administrator. 5. 6/15/2017		

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

PRINTED: 11/20/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355077		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2017	
NAME OF PROVIDER OR SUPPLIER SHEYENNE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 979 CENTRAL AVE N VALLEY CITY, ND 58072			
(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 12 The facility failed to ensure the emergency generators were in compliance with NFPA 99 and NFPA 110. Review of generator test records did not indicate: 1) That the minimum exhaust temperature provided by the manufacturer was achieved and that the monthly exercise of the Kohler diesel generator loaded the generator to at least 30% (180 kW) of the nameplate rating. The nameplate rating of the generator was 600 kW. 2) That the minimum exhaust temperature provided by the manufacturer was achieved and that the monthly exercise of the Katolite diesel generator loaded the generator to at least 30% (75 kW) of the nameplate rating. The nameplate rating of the generator was 250 kW. The facility did not perform annual supplemental load exercises as required when diesel generators are not loaded to 30% of nameplate rating or manufacturer's recommended temperature during the required monthly exercises. Failure to inspect and maintain emergency generators in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury due to fire. The deficiency affected two (2) of two (2) emergency generators which provide all emergency power to the facility.			K 918			