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

PRINTED: 01/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355109	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOURIS VALLEY CARE CENTER	300 MAIN ST S VELVA, ND 58790

(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 NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies in compliance with 42CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction that was protected by a wet and dry automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. An occupancy separation wall having a two-hour fire resistance rating separated the attached apartment building on the south side from the nursing facility.	K 000	Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction is prepared and /or executed solely because it is required by the provisions of Federal and State law, For the purpose of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	1/24/2015
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined the facility failed to conduct an AM Shift fire drill during the fourth quarter of 2014.	K 050	1. Fire Drills will be conducted on each shift per regulation. 2. All residents have potential to be affected. It affected 1 of 12 drills in the past year. 3. Maintenance staff will be in serviced on Fire Drill regulation. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. 4. QA committee or Designee will audit Fire drills monthly to make sure we are in compliance. The audit report will be reviewed at QA meeting to determine if there is need for further auditing or training.	

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

Administrator — 1-16-15

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.

emailed 1-23-15

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K 050	Continued From page 1 Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected one (1) of twelve (12) drills in the past year.	K 050		
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: The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with the manufacturer's specifications. Observation determined the fire alarm panel was indicating a missing device for the smoke detector in Resident Room 217 that had failed and had not been replaced at the time of the survey. Failure to maintain smoke detectors as required increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous smoke detectors in the facility.	K 054	1. Smoke detector in resident room 217 has been fixed and operating properly. Fire panel is showing no missing device. 2. All residents have potential to be affected. It affected 1 of numerous smoke detectors in the facility. 3. Maintenance has ordered spare parts to be on hand. 4. QA committee or designee with audit monthly that ~~spare sprinkler~~ smoke detector heads are available. The audit report will be reviewed at QA meeting to determine if there is need for further auditing or training.	
K 062 SS=F	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,	K 062		

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K 062	Continued From page 2 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. Record review determined: 1) The sprinkler system gauges had not been replaced or calibrated within the last five (5) years. The deficiency affected five (5) of five (5) gauges. 2) The weekly fire pump churn test had not been conducted since 11/25/2014. The deficiency affected one (1) of one (1) fire pump. Failure to test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due to fire. The fire pump and gauges are components of the complete automatic sprinkler system, which serves the entire facility.	K 062	1. Nova is coming out to replace or calibrate the sprinkler system gauges. Fire pump churn test will be performed weekly. 2. All residents have potential of being affected. It affected 1 of 1 fire pumps. 3. Maintenance will be in-serviced on Sprinkler system and fire pump compliance. 4. QA committee or designee will audit weekly fire pump churn test for three months to ensure compliance. The audit report will be reviewed at QA meeting to determine if there is need for further auditing or training.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Record review determined the specific gravity of the emergency generator battery was not checked at seven (7) day intervals as required. Failure to inspect and maintain the emergency generators in accordance with 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 144	1. Emergency generator battery has been checked to determine that the specific gravity is in compliance. 2. All residents have potential of being affected. 1 of 1 emergency generator was affected. 3. Maintenance has been trained on emergency generator battery and the compliance with checking specific gravity for it. 4. QA committee or designee will audit weekly that the emergency generator battery is check for three months. The audit report will be reviewed at QA meeting to determine if there is need for further auditing or training.	
K 211 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.	K 211	1. The alcohol-based hand-rub dispenser was moved away from the handicapped door opener. 2. All residents have potential of being affected. 1 of numerous alcohol-based hand rub dispensers was affected. 3. All Staff have been educated on proper placement of where alcohol-based hand dispensers can be placed.	

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K 211	Continued From page 4 o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: The facility failed to ensure alcohol-based hand-rub dispensers were not installed over an ignition source. Observation determined an alcohol-based hand-rub dispenser was installed on the wall directly above the push plate for the handicap door opener at the front entrance. Failure to install alcohol-based hand rub dispensers as required increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous alcohol-based hand rub dispensers in the facility.	K 211	4. QA committee or designee will monitor monthly to make sure no alcohol-based dispensers are placed in appropriate places	