

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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. The nursing facility was separated from an attached apartment building by an occupancy separation wall having a two-hour fire resistance rating.	K 000			
K 321 SS=E	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 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 or 19.3.5.9. 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, 19.3.5.9	K 321			4/9/20

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

TITLE

(X6) DATE

Electronically Signed

04/06/2020

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: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 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 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: 1) The east door to Kitchen had a kick down doorstop installed on the door that required a manual releasing action to close. 2) The north door to Kitchen had a magnetic doorstop installed on the door that required a manual releasing action to close.	K 321	Preparation and execution of this response and plan of correction does not constitute an admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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 allegations that the facility is not in substantial compliance with Federal requirements of participations, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual 1. Facility will remove the kick down doorstop to the east door to the kitchen. The facility will remove the magnetic doorstop on the north door to the kitchen to ensure that is closed at all times. Door to the store room will remain closed at all		

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 321	Continued From page 2 The Kitchen was used to store combustible materials and was larger than 50 square feet. 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	times to ensure safety due to combustible materials being stored. 2. This deficiency has the potential to affect numerous hazardous areas in the facility. 3. Kitchen staff will be re-educated on what is the proper procedure to keep doorways propped open and to ensure understanding. Maintenance or designee will remove all doorstop to ensure compliance. 4. Maintenance or designee will audit kitchen doors to ensure they are closed and remain closed for safety reasons. Audits will be completed 5 times a week for 2 weeks, than weekly for 6 weeks, and then monthly for 4 months. QA committee will monitor audits to ensure compliance due the QA process.		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 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 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.	K 324		4/9/20	

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 324	Continued From page 3 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 REQUIREMENT is not met as evidenced by: The facility failed to test and maintain the wet chemical extinguishing system in the Kitchen in accordance with NFPA 17A, Standard for Wet Chemical Extinguishing Systems. On a monthly basis, inspection shall be conducted in accordance with the manufacturer's listed installation and maintenance manual or the owner's manual. At a minimum, this quick check or inspection shall include verification of the following: 1) The extinguishing system is in its proper location. 2) The manual actuators are unobstructed. 3) The tamper indicators and seals are intact. 4) The maintenance tag or certificate is in place. 5) No obvious physical damage or condition exists that might prevent operation. 6) The pressure gauge, if provided, shall be inspected physically or electronically to ensure it is in the operable range. 7) The nozzle blowoff caps, where provided, are intact and undamaged. 8) Neither the protected equipment nor the	K 324	1. The facility installed proper tagging system to mark monthly checks as per state procedures. 2. This deficiency has the potential to affect 1 of 1 wet chemical extinguishing system in the facility. 3. Maintenance or designee will inspect wet chemical extinguishing system per state regulations. 4. Maintenance or designee will complete monthly audits for 6 months. QA committee will monitor audits to ensure compliance due the QA process.		

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 324	Continued From page 4 hazard has not been replaced, modified, or relocated. If any deficiencies are found, appropriate corrective action shall be taken immediately. Where the corrective action involves maintenance, it shall be conducted by a trained service technician. Personnel making inspections shall keep records for those extinguishing systems that were found to require corrective actions. At least monthly, the date the inspection is performed and the initials of the person performing the inspection shall be recorded. The records shall be retained for the period between the semiannual maintenance inspections. 7.2.1 through 7.2.6 Review of documentation and interview with staff determined the monthly inspection of the wet chemical extinguishing system in the Kitchen had not been completed during January 2020. Failure to conduct monthly inspections of the wet chemical extinguishing system increases the risk of injury or death due to fire. This deficiency affected one (1) of one (1) wet chemical extinguishing system in the facility.	K 324			
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	K 353			4/9/20

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 5 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 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 5.3.2.1, 5.3.2.2, 8.2, 8.2.1, 8.2.2 The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25. Record review and interview with staff determined: 1) Observation determined five (5) of five (5) sprinkler system gauges were dated 01/16/2015 had not been replaced or calibrated within the last five (5) years.	K 353	1. ON 3-4-2020 Nova Fire replaced and ensured they were calibrated on all 5 sprinkler system gauges that were dated 1-16-15. Weekly inspections of the electric motor driven fire pump will be documented per code. 2. This deficiency has the potential to affect the complete automatic sprinkler system within the facility. 3. Maintenance or designee will ensure documentation for the weekly inspections of the electric motor-driven fire pump. They will also log the replacement and calibration of the 5 sprinkler system gauges. 4. Maintenance or designee will provide QA committee with weekly reports of the inspections for the electric motor driven fire pump. QA committee will monitor reports to ensure compliance due the QA process.		

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 6 Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. NFPA 25 5.3.2.1, 5.3.2.2 2) Weekly inspections of the electric motor-driven fire pump were not documented. Fire pump inspections shall be conducted as follows: The pertinent visual observations specified in the following checklists shall be performed weekly: (1) Pump house conditions as follows: (a) Heat is adequate, not less than 40°F (5°C) for pump room with diesel pumps without engine heaters. (b) Ventilating louvers are free to operate. (2) Pump system conditions as follows: (a) Pump suction and discharge and bypass valves are fully open. (b) Piping is free of leaks. (c) Suction line pressure gauge reading is within acceptable range. (d) System line pressure gauge reading is within acceptable range. (e) Suction reservoir is full. (f) Wet pit suction screens are unobstructed and in place. (g) Waterflow test valves are in the closed position. (3) Electrical system conditions as follows: (a) Controller pilot light (power on) is illuminated. (b) Transfer switch normal pilot light is illuminated. (c) Isolating switch is closed - standby (emergency) source. (d) Reverse phase alarm pilot light is off, or	K 353			

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	Continued From page 7 normal phase rotation pilot light is on. (e) Oil level in vertical motor sight glass is within acceptable range. (f) Power to pressure maintenance (jockey) pump is provided. (4) Diesel engine system conditions as follows: (a) Fuel tank is at least two-thirds full. (b) Controller selector switch is in auto position. (c) Batteries' (2) voltage readings are within acceptable range. (d) Batteries' (2) charging current readings are within acceptable range. (e) Batteries' (2) pilot lights are on or battery failure (2) pilot lights are off. (f) All alarm pilot lights are off. (g) Engine running time meter is reading. (h) Oil level in right angle gear drive is within acceptable range. (i) Crankcase oil level is within acceptable range. (j) Cooling water level is within acceptable range. (k) Electrolyte level in batteries is within acceptable range. (l) Battery terminals are free from corrosion. (m) Water-jacket heater is operating. (5) Steam system conditions: Steam pressure gauge reading is within acceptable range. 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 the complete automatic sprinkler system, which serves the entire facility.	K 353			
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric	K 511		4/9/20	

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 511	Continued From page 8 Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Ground-fault circuit-interruption for personnel shall be provided as required. The ground-fault circuit-interrupter shall be installed in a readily accessible location. All 125-volt, single-phase, 15- and 20-ampere receptacles located in bathrooms, kitchens and where receptacles are installed within 6 ft. of the outside edge of the sink shall have ground-fault circuit-interrupter protection for personnel. 19.5.1.1, 9.1.2, NFPA 70, 210.8, 210.8(B)(1), 210.8(B)(2), 210.8(B)(5) The facility failed to ensure electrical wiring and electrical equipment met the requirements of NFPA 70, National Electrical Code. Observation determined: 1) One (1) electrical receptacle in the Mechanical Room within 6 ft. of a floor sink was not ground-fault circuit-interrupter protected. 2) Numerous electrical receptacles in the Kitchen were not ground-fault circuit-interrupter protected.	K 511	1. One (1) electrical receptacle in the Mechanical Room within 6 ft. of a floor sink was not ground-fault circuit-interrupter protected. Numerous electrical receptacles in the Kitchen were not ground-fault circuit-interrupter protected. GFC1 receptacles were installed on March 3 and 4th of 2020. 2. The deficiency has the potential to affect numerous electrical receptacles in the facility. 3. Maintenance or designee will monitor to ensure proper electrical wiring and electrical equipment met the requirements of NFPA 70. 4. QA committee will review and monitor during QA process.		

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 511	Continued From page 9 Failure to provide electrical wiring and equipment in accordance with NFPA 70 increases the risk of injury or death due to fire.	K 511			
K 712 SS=F	The deficiency affected numerous electrical receptacles in the facility. Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined no fire drills were conducted on the AM Shift during the fourth quarter of 2019. 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 712			4/9/20
K 918	Electrical Systems - Essential Electric Syste	K 918	1. The facility failed to conduct fire drills as required. Did fire drill on 1-1-2020 due to wanting to do one on holiday but didn't think about it being a new year. 2.The deficiency affected one (1) of twelve (12) drills in the past year. 3. Maintenance or designee will ensure fire drills are conducted in compliance with regulations. 4. QA committee will review all monthly drills to ensure compliance.		4/9/20

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 918 SS=F	Continued From page 10 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, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the 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:	K 918			

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

PRINTED: 04/27/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355109		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/24/2020	
NAME OF PROVIDER OR SUPPLIER SOURIS VALLEY CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 918	Continued From page 11 The facility failed to ensure the emergency generator was in compliance with NFPA 99 and NFPA 110. Record review and interview with staff determined the emergency generator was not exercised under load for 4 continuous hours in the past 36 months. Failure to inspect, test and maintain the emergency generator in accordance 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 918	1. Education was provided with Maintenance on ensuring the emergency generator was in compliance with NFPA 99 and NFPA 110. Generator was ran for 4.5 hours on 3-5-2020 for compliance 2. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility. 3. Maintenance or designee will ensure record review and that emergency generator will run a load test for 4 continuous hours per regulation. 4. QA Committee will be given written record of each load test ran to ensure compliance.		