STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355057	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/26/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEMBILIER NURSING CENTER	**500 DELANO AVE** **WALHALLA, ND 58282**

(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 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. A garage and assisted living apartments were attached to the southwest end of the facility. A two-hour fire rated wall assembly separated the facility from the adjoining garage and assisted living building.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: The facility failed to ensure that exits and exit passageways in the means of egress were readily accessible at all times. 1) Means of egress must be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. 7.1.10.1, 7.3.2	K 038	1. Two water fountains located on the east and north corridor were removed from the building on October 3rd, 2016. The walls have been patched and handrails re-installed. The fixed water heater register down west hallway was removed from the building on October 5th, 2016 allowing proper egress in the corridor. Delayed egress will be added to the front double entrance and west hall entrance. 2. A walk through on all three corridors was conducted on 09/26/2016. No other	11/10/16

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

Electronically Signed | 10/06/2016

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K 038	Continued From page 1 Observation determined: a) A fixed heater located in the corridor by Resident Room 24 extended approximately nine (9) inches from the corridor wall and protruded into the exit corridor. b) A water fountain located in the corridor by Resident Room 44 extended approximately six (6) inches from the corridor wall and protruded into the exit corridor. c) A water fountain located in the corridor by Resident Room 45 extended approximately six (6) inches from the corridor wall and protruded into the exit corridor. The corridor was eight (8) feet wide at all three locations. Failure to maintain the means of egress to be available at all times increases the risk of death or injury due to fire. The deficiency affected egress from two (2) of two (2) smoke compartments in the facility. 2) Doors are required to be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side. 7.2.1.5.1. Observation determined the South Main Exit and the West Exit from the building were equipped with a magnetic locking device that required a keypad to override the lock from the egress side. The magnetic locks engaged with a Wander Guard system and did not have a delayed egress	K 038	areas were identified to be out of compliance. 3. The Maintenance Supervisor has updated the fire plan policy addressing obstructions in the hallway. Staff were informed of the changes on September 27th, 2016 during the Fire Safety Annual Training. All doors installed in the facility will be placed on the maintenance log and inspected monthly to ensure proper egress and that they are functioning in compliance with Life Safety Codes. 4. A QA study will be completed monthly for 6 months to ensure corridors are readily accessible for egress and all times. The maintenance man will perform quarterly assessments for 1 year on all corridor doors/exit doors to ensure proper egress compliance. Reports will be discussed at the quarterly QA meeting. 5. November 10th, 2016	

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K 038	Continued From page 2 feature. This deficiency affected two (2) of four (4) exits from the building. Failure to ensure the exits in the means of egress are readily accessible at all times increases the risk of death or injury due to fire.	K 038		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire 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. 18.7.1.2, 19.7.1.2 This STANDARD 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. 19.7.1.2 The facility failed to conduct fire drills as required. On 09/26/2016, fire drill records indicated the last four (4) fire drills for the PM shift occurred at 2:45pm, 2:20pm, 2:10pm and 2:12 pm. Fire drills are required to be conducted under varied conditions. The condition of the time of the day was not varied. Four (4) fire drills in the past year all occurred at times within 35 minutes of each	K 050	1. Fire Drills on the evening shift will now be varied to occur between 2:00 pm-9:00 pm. Maintenance staff will conduct these fire drills and document accordingly. 2. All fire drills on the other two shifts were found to be in compliance. 3. The Administrator will monitor times of all fire drills when she signs off on the fire drill forms and will have maintenance staff redo the fire drill training if times are not varied.	11/10/16

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K 050	Continued From page 3 other in an 8 hour shift. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected four (4) of twelve (12) drills in the past year.	K 050	4. A QA study will be completed every 3 months for one year to ensure the fire drills are being varied on shifts. 5. November 10th, 2016	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Health care occupancies shall be provided with a fire alarm system in accordance with Section 9.6. 19.3.4.1, 9.6.1.4, NFPA 72 7-3.2 The facility failed to test and maintain the fire alarm system as required by NFPA 72, National Fire Alarm Code. Review of fire alarm system test records indicated the annual test of the fire alarm system was not performed as required. The most current fire alarm system annual test was conducted on 04/22/2016 and the previous test was conducted on 03/30/2015, exceeding the required annual testing requirement. Failure to test and maintain the fire alarm system in accordance with NFPA 72 increases the risk of death or injury due to fire.	K 052	1. The annual fire alarm system inspection will be scheduled every year within one year from the previous inspection. A calendar which was created in 2006 will continue to be utilized and monitored for compliance. The contracted vendor will not be allowed to perform the testing one day past the due date. 2. All required annual testing will be kept on the Life Safety Code log and monitored for correct completion timelines. 3. The log will be reviewed by the maintenance supervisor, office secretary and Administrator for compliance. Areas which are reaching potential due date issues will be reported to the	11/10/16

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K 052	Continued From page 4 This deficiency affected one (1) of one (1) fire alarm system. The fire alarm system serves the entire facility.	K 052	Administrator immediately and a call will be placed to the vendor. 4. A QA check will be completed by the Maintenance Supervisor monthly to ensure all required Life Safety Code inspections are current and in compliance. 5. November 10th, 2016	
K 054 SS=E	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: Smoke detectors must not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. 19.3.4.5.1, 9.6.2.10.1, NFPA 72 2-3.5.1 The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm Code. Observation determined that four (4) smoke detectors located throughout the facility were installed within three feet of air supply diffusers or return air openings. Failure to install the smoke detection system as required increases the risk of death or injury due to fire. This deficiency affected four (4) of numerous smoke detectors in the facility.	K 054	1. The four smoke detectors where removed from their locations and placed at a distance greater than 3 feet from the air supply diffusers or return air openings. 2. A walk thru of the building was conducted on September 26th, 2016 and no further smoke detectors were found to be in non-compliance. 3. When smoke detectors are installed in the building. The maintenance supervisor will work with the vendor and ensure they are not installed within 3 feet of direct airflow. 4. A QA will be conducted semi annually for one year to monitor installation of new smoke detectors. If a smoke detector is installed it will be evaluated by the maintenance man for proper placement in	11/10/16

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K 054	Continued From page 5	K 054	the building. 5. November 10th, 2016	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. NFPA 99 3-4.1.1.15 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Standard for Health Care Facilities. Observation determined there was no remote annunciator for the emergency generator located outside of the Generator Room at a work site readily observable by personnel. Failure to ensure the emergency generator is in compliance with NFPA 99 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. A remote annunciator panel for the generator will be installed at the nurse's station. 2. No other portions of the building have the potential to be impacted by the code. 3. The maintenance man will monitor the nurse's station which will be the location of the remote generator annunciator panel to ensure it is operational at all times. 4. The maintenance man will perform a quarterly QA study on the generator annunciator panel for 6 months to ensure it is located at the front desk and operational. All findings will be discussed at the the quarterly QA meeting. 5. November 10th, 2016	11/18/16