STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

(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 four-story building of Type II (222) construction. One-story additions constructed in 1971 and 1974 were attached to the west wall of the original building. The 1971 addition was Type II (111) construction. The 1974 addition was Type II (000) construction. Other additions included a one-story activity area in 1982 of Type II (000) construction and a garage and van entrance in 1994 of Type II (000) construction. Attached to the 1982 activity addition was a Basic Care Facility of Type II (000) construction. The facility was sprinklered throughout with a wet automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems. Note: A Fire Safety Evaluation System (FSES) was conducted as a result of the 07/22/2014 Life Safety Code survey. Tag K038-1 Exit Access was specifically addressed by and will pass the FSES upon correction of all other deficiencies.	K 000	K018 K 018-1 1. The northeast door to the activity room from Main Street was adjusted and now self closes to the latch position. 2. All corridor doors in the facility have the potential to be affected. 3. All corridor doors in the facility have been checked to assure proper functioning of self-closure to the latched position. 4. The Maintenance Supervisor (or designee) will monitor all corridor doors in the facility on a monthly basis to assure proper functioning of self-closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, then quarterly thereafter. 5. August 21, 2014. K 018-2 1. The door to the small storage room in Pine View Court was adjusted and now latches. 2. All corridor doors in the facility have the potential to be affected. 3. All corridor doors in the facility have been checked to assure proper functioning of self-closure to the latched position. 4. The Maintenance Supervisor (or designee) will monitor all corridor doors in the facility on a monthly basis to assure proper functioning of self-closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, then quarterly thereafter. 5. August 21, 2014. K 018-3 1. The north door to the physical therapy room was adjusted and now self closes to the latched position. 2. All corridor doors in the facility have the potential to be affected. 3. All corridor doors in the facility have been checked to assure proper functioning of self-closure to the latched position.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kat Stuner	Administer	8/22/14

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 8-26-14 to Cust 7.

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K 018	Continued From page 1 those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: The facility failed to ensure the corridor doors latched into their frames and resisted the passage of smoke. Observation determined: 1) The northeast door to Activities failed to self-close to the latched position. 2) The door to the small storage room in Pineview Memory Care failed to latch. 3) The north door to Physical Therapy failed to self-close to the latched position. Failure to ensure corridor doors were latched properly increases the risk of death or injury due to fire.	K 018	4. The Maintenance Supervisor (or designee) will monitor all corridor doors in the facility on a monthly basis to assure proper functioning of self-closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, then quarterly thereafter. 5. August 21, 2014.	

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K 018	Continued From page 2 The deficiency affected three (3) of numerous corridor doors.	K 018	K020 1. The 90 minute fire rated door between the main street portion of the nursing facility and Horizon Tower's stairwell was repaired and now self closes and latches into frame. 2. All 90-minute fire rated doors in the facility have the potential to be affected. 3. All 90-minute fire rated doors in the facility have been checked to assure proper functioning of self-closure and latch into frame. 4. The Maintenance Supervisor (or designee will monitor all 90-minute fire rated doors in the facility on a monthly basis to assure proper functioning of self- closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, the quarterly thereafter. 5. August 21, 2014.	
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: The facility failed to ensure complete two-hour fire rated wall assemblies between the Main Street portion of the nursing facility and the adjoining Horizon Towers stairs. Observation determined the 90-minute fire rated door in the stair separation failed to self-close and latch into its frame. Failure to maintain the means of egress in stairways as required increases the risk of death or injury due to fire. The deficiency affected one (1) of two (2) vertical paths of egress from Horizon Towers.	K 020	K029 K 029 - 1 1. The door to Legacy Square soiled linen room was adjusted and now self-closes to the latched position. 2. All doors to hazardous areas in the facility have the potential to be affected. 3. All doors to hazardous areas in the facility have been checked to assure proper functioning of self-closure to the latched position. 4. The Maintenance Supervisor (or designee) will monitor all doors to hazardous areas in the facility on a monthly basis to assure proper function of self-closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, then quarterly thereafter. 5. August 21, 2014.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	K 029-2 1. The door to the Wheatland Square clean linen storage room was adjusted and now self-closes to the latched position. 2. All doors to hazardous areas in the facility have the potential to be affected. 3. All doors to hazardous areas in the facility have been checked to assure proper functioning of self-closure to the latched position.	

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K 029	Continued From page 3 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: The facility failed to ensure the doors to hazardous areas latched into their frames and resisted the passage of smoke. Observation determined: 1) The door to Legacy Square Soiled Linen Room failed to self-close to the latched position. 2) The door to Wheatland Square Clean Linen Storage Room failed to self-close to the latched position. Failure to ensure doors to hazardous areas were latched properly increases the risk of death or injury due to fire. The deficiency affected two (2) of numerous doors to hazardous areas.	K 029	4. The Maintenance Supervisor (or designee) will monitor all doors to hazardous areas in the facility on a monthly basis to assure proper function of self-closure to the latched position. The Maintenance Supervisor will report to the QA committee on a monthly basis for 3 months, then quarterly thereafter 5. August 21, 2014 K038 K 038-2 1. The keypad located by the north exit door on Nelson Manor was replaced to allow access out of the building. 2. All egress doors with key pads have the potential to be affected. 3. All egress doors with keypad codes have been checked to assure the doors are operational. 4. The Maintenance Supervisor (or designee) will check monthly all egress doors with keypads to ensure exit out of facility. The Maintenance Supervisor will report to the QA Committee monthly for three months, then quarterly thereafter. 5. August 21, 2014. K 038-3 1. The west exit door on Pine View Court was adjusted to allow access out of the building. 2. All egress doors have the potential to be affected. 3. All egress doors have been checked to assure the doors are operational. 4. The Maintenance Supervisor (or designee) will check all egress doors on a monthly basis to ensure exit out of facility. Maintenance supervisor will report to the QA Committee monthly for three months, then quarterly thereafter. 5. August 21, 2014 K 038-4 1. All keypad codes were updated with the correct code. 2. All egress doors with key pads have the potential to be affected. 3. All keypad codes were updated with the correct code. Checklist will be used to facilitate procedure when codes are/or if and when to be changed.	
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	K 038		

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1 To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. Observation determined: 1) The north exterior exit from Nelson Manor traverses the lawn to get to a public way. 2) The north exit door from Nelson Manor was secured/locked in the closed position by a magnetic lock. Maintenance staff disconnected the keypad control from the magnetic lock to allow the opening of the door. 3) The west exit door from Pineview Court was secured in the closed position and was not openable from inside the building. Staff used excessive force to open the door from the outside. A portable hydraulic jack was used by maintenance staff to spread the door frame apart to allow the door to be opened without use of force. 4) Numerous keypad codes were not updated with the correct code to release the magnetic locks installed on exit doors. Failure to maintain the means of egress as required increases the risk of death or injury due to fire.	K 038	A Fire Safety Evaluation System (FSES) was conducted for deficiency Tag K 038-1 of the 07/22/2014 Life Safety Code survey to allow exits to public ways to traverse grassy surfaces. The facility passes the FSES upon correction of all other deficiencies. 4. The Maintenance Supervisor (or designee) will check the code of the key pad the following day after key pad codes have been changed. The Maintenance Supervisor will report the results to the QA committee. 5. August 21, 2014.	

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K 038	Continued From page 5 The deficiency affected numerous paths of egress from the facility. Ref: 2000 NFPA 101 Section 19.2.1, 7.1.6.2	K 038	K046 1. The annual emergency battery back-up light testing for 90 minutes was completed on July 24, 2014. 2. All emergency battery back-up lights have the potential to be affected. 3. Preventative maintenance will include annual 90 minute emergency battery back-up light testing. 4. The Maintenance Supervisor (or designee) will review preventative maintenance reports. The Maintenance Supervisor will report results to the QA committee on an annual basis. 5. August 21, 2014.	
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: A functional test must be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test must be conducted for 1 1/2-hour duration. Written records of testing must be kept by the owner for inspection by the authority having jurisdiction. The facility failed to provide emergency lighting as required. Records review indicated the last 1 1/2-hour test on emergency battery pack lights was in April 2013. This exceeded the annual requirement. Ref: 2000 NFPA 101 Section 19.2.9.1, 7.9.3 Failure to provide emergency lighting as required increases the risk of death or injury due to fire. This deficiency affected all emergency battery back-up lights throughout the building.	K 046		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is	K 052	K052 K 052-1 1. Facility was well aware fire alarm system was in a trouble mode. Facility has a contract with AVI of Bismarck, ND to maintain and inspect system and had been in conversation with technicians prior to arrival of surveyor. In fact service technician from AVI was in facility at the time of the survey. Part of maintaining a fire alarm system is to fix any issues that arise, facility was in the process of this at the time of the survey. According to AVI the fire alarm system has been and continues to be fully functional, that is if fire/smoke is detected the sprinkler system would activate. 2. Any area in the skilled nursing facility has the potential to be affected. 3. The fire alarm system is under contract with AVI to maintain the system in a functional status. The fire alarm system has been and will continue to be tested on a monthly basis. 4. The Maintenance Supervisor (or designee) will continue to complete fire drills on a monthly basis to assure proper functioning of the fire alarm system. Results of these drills will be reported monthly to the QA committee by the Maintenance Supervisor for three months, then quarterly thereafter. The fire alarm system is inspected annually. Results of the annual inspection will be reported to the QA committee. 5. September 5, 2014	

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K 052	Continued From page 6 installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 1) Fire alarm systems and their components are to be inspected, tested and maintained in accordance with NFPA 72, National Fire Alarm Code. The facility failed to maintain the fire alarm system in a reliable operating condition. Observation determined the fire alarm control panel was displaying a non-restorable trouble signal. The deficiency affected one (1) of one (1) fire alarm system serving the entire building. 2) Fire alarm connections to the light and power service must be on a dedicated branch circuit. The circuit and connections must be mechanically protected. Circuit disconnection means must have a red marking, be accessible only to authorized personnel, and be identified as Fire Alarm Circuit Control. The facility failed to provide a fire alarm system in	K 052	K 052-2 1. Three of three fire alarm circuit breakers have been secured. 2. All fire alarm circuit breakers have the potential to be affected. 3. All fire alarm circuit breakers have been checked and are secured. 4. The Maintenance Supervisor (or designee) will monitor fire alarm circuit breakers on a monthly basis for three months, then quarterly to assure secured. Results will be reported monthly to the QA committee by the Maintenance Supervisor for three months, then quarterly thereafter. 5. August 21, 2014.	

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K 052	Continued From page 7 compliance with NFPA 72, National Fire Alarm Code. Observation determined the lack of a locking device on three (3) of three (3) fire alarm electrical circuit breakers. Failure to secure electrical circuit breakers for the fire alarm system increases the risk of injury and death. The deficiency affected one (1) of one (1) fire alarm system serving the entire building.	K 052	K056 1. The ceiling tiles in the Wheatland Dining Room, the second floor Horizon Tower dining room, and the second floor Horizon Tower tub room were replaced. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. Maintenance staff have been re-educated on ensuring ceiling tiles are in place. Nursing staff were re-educated on July 24 & 25, 2014 to contact maintenance staff if a ceiling tile requires replacement. All staff will be re-educated on August 13, 2014. All areas in the Skilled Nursing Facility have been checked to assure ceiling tiles are in place. 4. Maintenance Supervisor (or designee) will monitor on a monthly basis intactness of ceiling tiles. The Maintenance Supervisor will report to the QA committee monthly for three months, then quarterly thereafter. 5. August 21, 2014.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Automatic fire sprinkler systems must be installed in accordance with NFPA 13. The facility failed to install the automatic sprinkler system in accordance with NFPA 13 to provide	K 056		

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K 056	Continued From page 8 adequate coverage for all portions of the building. Observation determined missing ceiling tiles in the Wheatland Dining Room, the 2nd floor Horizon Towers Dining Room, and the 2nd floor Horizon Towers Tub Room. Missing ceiling tiles create ceiling penetrations that could delay the activation of the sprinkler system. Failure to ensure there is no delay in time for the activation of the sprinkler system for all portions of the building increases the risk of injury and death due to fire. The deficiency affected four (4) of numerous areas in the facility.	K 056	K062 1. Facility was aware of regulation for backflow testing. Contractor that installed the sprinkler system does not have qualified technician. Largest fire protection company in North Dakota was contacted and Bethel Lutheran Nursing & Rehabilitation Center was informed that due to large volume of requests of current Long Term Care providers the company is unable to perform this test in a timely manner. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. Administrator is presently working on a contract with NOVA to provide annual backflow testing. 4. The Maintenance Supervisor (or designee) will monitor annually. The Maintenance Supervisor will report to the QA committee annually. 5. Bethel Lutheran Nursing & Rehabilitation Center respectively requests an extension to December 31, 2014.	
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, 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. On 07/22/2014, no record of the required annual backflow preventer test was available for five (5) of five (5) backflow preventers.	K 062	K064 K 064-1 1. The fire extinguisher located in the Pine View Court Mechanical Room has had the annual service completed. 2. All fire extinguishers have the potential to be affected. 3. All fire extinguishers have been checked in the facility to assure the monthly and annual checks have been completed. A checklist has been developed to identify the location of the fire extinguishers in the facility 4. The Maintenance Supervisor (or designee) will monitor monthly annual fire extinguisher checks. The Maintenance Supervisor will report checks monthly for three months then quarterly thereafter. The annual checks will be reported annually to QA committee by the Maintenance Supervisor. 5. August 21, 2014.	

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K 062	Continued From page 9 The deficiency affected one (1) of numerous required tests of the automatic sprinkler system. The backflow preventer is a component of the complete automatic sprinkler system. The deficiency affected the entire building. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-6.2	K 062	K 064-2 1. The fire extinguisher located in the second floor Horizon Tower dining room has had the annual service completed. 2. All fire extinguishers have the potential to be affected. 3. All fire extinguishers have been checked in the facility to assure that the monthly and annual checks have been completed. A checklist has been developed to identify the location of the fire extinguishers. 4. The Maintenance Supervisor (or designee) will monitor monthly annual fire extinguisher checks. The Maintenance Supervisor will report checks monthly for three months then quarterly thereafter. The annual checks will be reported annually to QA committee by the Maintenance Supervisor. 5. August 21, 2014.	
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: The owner or occupant of a property in which fire extinguishers are provided for the protection of the structure and the hazardous combustible contents, must give proper attention to the inspection, maintenance and recharging of the fire protection equipment. NFPA 10, Standard for Portable Fire Extinguishers The facility failed to inspect the portable fire extinguishers located in the building on a monthly basis. Observation determined: 1) The inspection tag on the fire extinguisher located in the Pineview Court Mechanical Room had its last annual service in March 2012. The timeframe between service exceeded 12 months.	K 064	K147 K 147-1 1. All Resident rooms have been observed and power strips have been removed unless utilized for a flat screen television or computer. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. Maintenance/Nursing/ Housekeeper/ Therapy staff were re-educated on July 23 & 24, 2014, and all staff will be re-educated on August 13, 2014, in regards to the requirements for the use of power strips. Information was placed in the Resident newsletter and billing statements to inform Residents/families that power strips can only be used with flat screen televisions and computers. The requirements for use of the power cords will be added to new employee orientation as well as added to the orientation check list for housekeeping, maintenance, and nursing. Electrician has been contacted to increase the number of GFCI receptacles in the facility and resident rooms. 4. Laundry/Housekeeping Supervisor (or designee) will monitor monthly Resident rooms/offices ensuring that power strips are utilized for flat screen televisions/ computers. The Laundry/Housekeeping Supervisor will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1515 2ND AVE WEST WILLISTON, ND 58801

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K 064	Continued From page 10 2) The inspection tag on the fire extinguisher located in the 2nd floor Dining Room in Horizon Towers had its last annual service in February 2013. The timeframe between service exceeded 12 months. Failure to ensure portable fire-extinguishers comply with NFPA 10 increases the risk of death or injury due to fire. This deficiency two (2) of numerous portable fire extinguishers.	K 064	report to the QA committee meeting on a monthly basis for three months, then quarterly for three months. 5. August 21, 2014 K 147-2 1. The two receptacles located in the Beauty Shop are now GFCI protected. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. All receptacles in the facility have been checked to assure GFCI protected. 4. The Maintenance Supervisor (or designee) will monitor newly installed receptacles to assure GFCI protected. The Maintenance Supervisor will report monitoring of newly installed receptacles to the QA committee monthly. 5. August 21, 2014 K 147-3 1. The power strip has been removed for the aquarium adjacent to the Electrical Room in the Main Street Area and replaced with a new GFCI receptacle. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. Maintenance/Nursing/ Housekeeper/ Therapy staff were re-educated on July 23 & 24, 2014, and all staff will be re-educated on August 13, 2014, in regards to the requirements for the use of power strips. The requirements for use of the power cords will be added to new employee orientation as well as added to the orientation check list for housekeeping, maintenance, and nursing. Electrician has been contacted to increase the number of GFCI receptacles in the facility. 4. Laundry/Housekeeping Supervisor (or designee) will monitor monthly ensuring power strips are only utilized for flat screen televisions/computers. The Laundry/ Housekeeping Supervisor will report to QA committee meeting on a monthly basis for three months, then quarterly for there after. 5. August 21, 2014. K 147-4 1. The multi-plug adapter has been removed from the aquarium located in the lounge area on Wheatland Square with a new GFCI receptacle. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. Maintenance/Nursing/ Housekeeper/ Therapy staff were re-educated on July 23 & 24, 2014,	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Flexible cords and cables must not be used as a substitute for fixed wiring of a structure. NFPA 70, National Electrical Code, 400-8 The facility failed to ensure electrical wiring and electrical equipment met NFPA 70 requirements. Observation determined: 1) Numerous multiplug adapters and power strips in use in place of permanent wiring to provide electricity to lift-chairs, refrigerators, microwave ovens, radios, lamps and telephones. These were located in multiple resident rooms throughout the facility. 2) Two (2) of four (4) receptacles in the Beauty	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355070	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL LUTHERAN NURSING & REHABILITATION CENTER	1516 2ND AVE WEST WILLISTON, ND 58801

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K 147	Continued From page 11 Shop were not protected by a ground fault circuit interrupter (GFCI). The two (2) newly installed surface-mounted receptacles were not GFCI protected. 3) A power strip was in use in place of permanent wiring to provide electricity to the aquarium lighting, pump, and heater for the aquarium adjacent to the Electrical Room in the Main Street area. 4) A multiplug adapter was in use in place of permanent wiring to provide electricity to the aquarium lighting, pump, and heater for the aquarium on the Wheatland Wing. 5) The GFCI protected electrical receptacle in the bathroom of Resident Room #313 (Horizon Towers 3rd floor) had a damaged reset button with no electricity detected when tested. 6) The cord for the tub in the Bathing Room on 2nd floor in Horizon Towers had an extension cord attached. Failure to ensure electrical wiring is in accordance with NFPA 70 requirements increases the risk of death or injury due to fire. The deficiency affected the entire facility.	K 147	and all staff will be re-educated on August 13, 2014, in regards to the requirements for the use of power strips. The requirements for use of the power cords will be added to new employee orientation as well as added to the orientation check list for housekeeping, maintenance, and nursing. Electrician has been contacted to increase the number of GFCI receptacles in the facility and resident rooms. 4. Laundry/Housekeeping Supervisor (or designee) will monitor lounge areas monthly ensuring that power strips are utilized only for flat screen televisions/computers. The Laundry/Housekeeping Supervisor will report to QA committee meeting on a monthly basis for three months, then quarterly thereafter 5. August 21, 2014. K 147-5 1. The GFCI receptacle has been replaced in the bathroom room 313 Horizon Towers third floor. 2. Any area in the Skilled Nursing Facility has the potential to be affected. 3. All receptacles in the facility have been checked to assure GFCI protected. 4. The Maintenance Supervisor (or designee) will monitor newly installed receptacles to assure GFCI protected. The Maintenance Supervisor will report monitoring of newly installed receptacles to the QA committee monthly. 5. August 21, 2014. K 147-6 1. The extension cord for the tub in the Bathing Room on 2nd floor Horizon Towers has been removed and a longer permanent cord has been installed. 2. All bathing tubs located in the Skilled Nursing Facility have the potential to be affected. 3. The Maintenance Staff have been re-educated on permanent cords that are utilized on the bathing tubs. 4. The Maintenance Supervisor (or designee) will monitor bathing rooms in the facility monthly for intactness of permanent electrical cords. The Maintenance Supervisor will report monthly to the QA Committee for three months, then quarterly thereafter. 5. August 21, 2014.	