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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED
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DIVISION OF LIFE SAFETY AND CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355054	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SERVS	302 2ND ST NW BOWMAN, ND 58623

(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 42 CFR 483.70(a). This facility was located in a one-story building of Type V (000) construction with a partial basement. The building had a wet automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. An apartment building was attached to the facility and was separated by an occupancy separation wall having a two-hour fire resistance rating.	K 000		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: The emergency generator must be inspected weekly. Maintenance free batteries are not permitted. NFPA 110, 3-5.4.5 Review of records determined documentation of the weekly inspections did not include the battery fluid. Inspection of the battery revealed a maintenance free type without removeable caps was in use.	K 130	New batteries (not maintenance free) were installed on 8-17-10. The service company, TW Enterprises, has been notified that maintenance free batteries are not to be used on our generator anymore. Weekly inspection of the batteries will be added to our maintenance schedule.	8-17-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Becky Hansen | TITLE: Administrator | (X6) DATE: 9-16-10

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.