

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/09/2010
NAME OF PROVIDER OR SUPPLIER HEARTLAND CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 620 14TH AVE NE DEVILS LAKE, ND 58301		
(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). The 1962 and 1969 Heartland Care Center buildings are of Type II (111) construction. A Dining Room/Lobby Area addition of Type V (000) construction was built in 1993. A Rehabilitation addition of Type V (111) construction was built in 1998. Both of these additions have a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. Each addition is separated from the original building by occupancy separation walls having a two-hour fire resistance rating. A garage addition of Type II (000) was attached to the original building in 1993. This addition has no automatic sprinkler system and does not meet the requirements for a health care occupancy. According to staff, nursing facility residents do not receive treatment or services in this building. This building is separated from the nursing facility by an occupancy separation wall of two-hour fire resistance rating. This building was not reviewed as a component of this Life Safety Code survey. At the conclusion of the Life Safety Code survey it was determined the facility was in compliance with the standards.	K 000			

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

TITLE

(X6) DATE

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.