

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

PRINTED: 10/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OCT 31 2011	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/18/2011
---	--	---	--

NAME OF PROVIDER OR SUPPLIER

FOUR SEASONS HEALTH CARE INC

STREET ADDRESS, CITY, STATE, ZIP CODE

**483 4TH ST SW
FORMAN, ND 58032**

(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 findings that follow demonstrate noncompliance with these standards. The facility is located in a one-story building of Type V (000) construction. The building has a crawl space beneath. The building and crawl space are protected by a dry automatic fire sprinkler system designed to comply with the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
K 029 SS=D	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 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: Due to the presence of the automatic sprinkler system, the walls and ceilings of hazardous areas must resist the passage of smoke. The facility failed to separate hazardous areas from other spaces with smoke resistive partitions.	K 029	K029 The two unsealed holes will be sealed to resist passage of smoke. Work will be completed by Nov 1 2011. Maintenance dept will be responsible for completion of aforementioned work.	11-1-11

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

White Corbison, NTH

TITLE

Adm. N. St. Nat. N

(X6) DATE

10-28-11

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: 10/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2011
NAME OF PROVIDER OR SUPPLIER FOUR SEASONS HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 483 4TH ST SW FORMAN, ND 58032		
(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 029	Continued From page 1	K 029			
K 046 SS=D	Observation determined the ceiling of the Storage Room, one (1) of three (3) hazardous areas, had two (2) unsealed holes that would not resist the passage of smoke. 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: Battery emergency lighting must provide illumination for at least 90 minutes. The facility failed to ensure the battery backup emergency lighting at the Boiler Room was operational. Observation determined the battery backup emergency lighting in the Boiler Room (pit area) would not illuminate when tested.	K 046			
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the	K 143	K046 The backup light will be repaired by Nov 15, 2011. The backup light will be monitored and documented with 30-minute monthly tests and one 90-minute test yearly. Party responsible for monitoring will be Maintenance dept.	11-15-11	

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

PRINTED: 10/19/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355103	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/18/2011
NAME OF PROVIDER OR SUPPLIER FOUR SEASONS HEALTH CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 483 4TH ST SW FORMAN, ND 58032		
(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 143	Continued From page 2 immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: The Liquid Oxygen Transferring Room must be separated from any portion of the facility wherein residents are housed, examined, or treated by a fire barrier of 1-hour fire-resistive construction. The facility failed to ensure the transferring of liquid oxygen location met NFPA 99, Standard for Health Care Facilities. Observation determined three (3) conduit penetrations in the ceiling were not sealed with fire rated material to maintain the 1-hour fire rating of the ceiling.	K 143	K143 The three conduit penetrations will be sealed with fire rated caulking. This will ensure the one-hour fire rating of the ceiling. The work will be completed by Nov 1st 2011. The aforementioned work will be completed by maintenance dept.	11-1-11	