STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355067	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY ELDERCARE CTR	2900 14TH AVE S GRAND FORKS, ND 58201

(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) and NDAC 33-07-04.2-09(1)(c). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction with an automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: The emergency generator must be inspected weekly. NFPA 110, 3-5.4.5 Review of records and staff interview determined documentation of the weekly inspections of the generator did not include the battery fluid.	K 144	Maintenance personnel will conduct a Battery Level/Voltage Test (Item 3) weekly on the emergency generator batteries along with all of the required/recommended tests as seen on the attached Emergency Generator Inspection and Testing Log. The Battery Level/Voltage test will be reviewed monthly by the Director of Maintenance and the results will be reported to the Safety Committee monthly. The Battery Level/Voltage testing will begin on the week of August 15-19,2011 and will be conducted weekly there after.	08/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Greg Hanson — TITLE: PRES./CEO — (X6) DATE: 08/10/11

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.