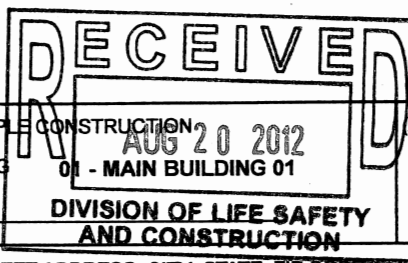


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355052	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 01 - MAIN BUILDING 01 DIVISION OF LIFE SAFETY AND CONSTRUCTION	(X3) DATE SURVEY COMPLETED 07/30/2012
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NAME OF PROVIDER OR SUPPLIER NELSON COUNTY HEALTH SYSTEM CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 108 E NYHUS AVE MCVILLE, ND 58254
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(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 one-story building of Type II (000) construction that was protected by a wet automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
K 015 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: The facility failed to ensure interior wall finishes for rooms and spaces not used for corridors had a Class C rating. Documentation review indicated the facility did not have interior finish documentation for the vinyl folding partition in the Community Room.	K 015	1. The contractor was contacted for the information and it was received – attach. #1. 2. There are no other areas of our facility that this applies to, as no further remodeling has occurred. 3. If another remodeling project is scheduled, a check of the proper documentation that is required for any changes in order to comply with LSC will be done as part of the QA process. 4. N/A. 5. 08/01/2012 (see attachment).	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

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

TITLE

(X6) DATE

Heather Swenson, CEO

8/17/2012

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.

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NAME OF PROVIDER OR SUPPLIER NELSON COUNTY HEALTH SYSTEM CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 108 E NYHUS AVE MCVILLE, ND 58254		
(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 144	Continued From page 1 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 facility failed to inspect the emergency generator. Review of records determined documentation of the weekly inspections of the generator was not available.	K 144	1. Generator checks with documentation of all information was completed- see attachment #2. 2. There are no other areas this would apply to. 3 & 4.: Completion of reports and receipt of the completed reports on a weekly basis has been assigned to the department and are to be received by Adminstration for both weekly and as required for monthly documentation. A weekly monitor is done to ensure this is completed as required, On the day they are due. . 4. N/A. 5. 08/09/2012 (see attachment).		