STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

(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 requirements. Building 01 of 02 was one-story of Type III (200) construction with a wet automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems. The nursing facility was built in 1964. An addition was attached to the west of the original building in 1981. Attached to the nursing facility are a two-story rehabilitation/apartment building (east side) and a one-story hospital/special care facility (north side). These buildings were separated from the original nursing facility with walls of two-hour fire resistance rating. The south half of the west wing was converted to assisted living in 2009.	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: The facility failed to ensure the occupancy	K 011	K011 The separation between the hospital and nursing home at the boiler room will be sealed to meet two hour fire resistance. The other two hour fire walls in the facility will be inspected by the Manager of Facility Services to assure 2 hour fire resistance is being maintained. The facility has on its monthly safety committee agenda (SIR agenda) a routine line item called construction projects. The manager of facility services addresses any construction projects going on in the previous month or any that are scheduled to happen in the future. Once the project is completed, the manager of facility services reviews the project with the committee and reports on any penetration of smoke or fire barriers. He then attests to the committee that the barrier has been brought back to the required standard. See the attached agenda.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO 7-9-14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

(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 011	Continued From page 1 separation wall between the hospital and the nursing facility had a two-hour fire resistance rating. Observation determined the occupancy separation wall between the nursing facility Boiler Room (under construction) and the hospital had multiple unsealed through-wall penetrations. This was acknowledged by the Maintenance Director. The deficiency affected one (1) of one (4) two-hour fire rated occupancy separations.	K 011	This process works well and is understood by the manager of facility services and the safety committee. For example in June 2014, during a construction review, the manager of facility services identified the deficient area to the construction inspector at the time of his review. He specifically asked about the area identified and its compliance with regulations. The inspector noted it would be okay upon completion of the project. Thus we were prepared to fix the area, but thought we wouldn't need to. The barrier will be restored to the required two hour rating on or before August 2, 2014.	8/2/2014
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 facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Observation determined the lack of a remote stop switch for the emergency generator located outside of the Generator Room.	K 144	K 144 A remote stop switch will be installed for the emergency generator outside the generator room. This is the only generator in the facility so no others will be identified. The remote stop switch will be in a monitored location and tested at least annually. The manager of facility services will report the results of the annual test to the Safety (SIR) Committee. The remote stop switch will be installed on or before August 2, 2014.	8/2/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/18/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	**4 N PARK ST** **NORTHWOOD, ND 58267**

(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 2 This deficiency was acknowledged by the Maintenance Director. The deficiency affected one (1) of one (1) emergency generator.	K 144		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355076	A. BUILDING 02 - NORTHWOOD DEACONESS HEALTH CNT B. WING	06/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWOOD DEACONESS HEALTH CNT	4 N PARK ST NORTHWOOD, ND 58267

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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). Building 02 of 02 was one-story of Type III (200) construction with a wet automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems. Building 02 contained a hospital and a special care unit. The hospital was built and attached to the north of the nursing facility (Building 01 of 02) in 1970. The north wing of the hospital was converted to a special care unit in 1993. Documentation review and survey observation determined the facility was in compliance with these standards.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

CEO | 7-9-14

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emailed 7-10-14