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

PRINTED: 03/02/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. BUILDING 02 - MAPLE MANOR CARE CENTER B. WING	02/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CARE CENTER	1116 9TH AVE LANGDON, ND 58249

(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 18 New Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (111) construction. The building had a wet and dry automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. An occupancy separation wall having a two-hour fire resistance rating was located between the independent living apartments attached to the south and the Maple Manor business occupancy attached to the north and west side of the Maple Manor Care Center. The Activity Room and Chapel were constructed and attached to the original nursing facility in 1997. The Activity Room and the Chapel were of Type II (111) construction with automatic sprinklers installed during the 2010 building project. The Activity Room and Chapel were included as areas used by residents during this survey.	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. 18.1.1.4.1, 18.1.1.4.2	K 011	1) The doorway through the two-hour fire resistant rated occupancy separation wall from the Activity Room to the auxiliary kitchen area will be closed and sealed. The materials and construction method will be compliant with applicable requirements.	

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

Connie DeRanson — Administrator — 03-24-15

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.

emailed
3-26-15

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K 011	Continued From page 1 This STANDARD is not met as evidenced by: The facility failed to ensure communicating openings through a two-hour fire resistant rated occupancy separation wall occur only in corridors. 18.1.1.4.2 Observation determined a doorway through the two-hour fire resistant rated occupancy separation wall from the Activity Room to a Kitchen area. Failure to ensure communicating openings through two-hour fire resistant rated occupancy separation walls occur only in corridors increases the risk of death or injury due to fire. This deficiency affected one (1) of two (2) two-hour fire resistant rated occupancy separation walls in the facility.	K 011	2) There are two two-hour fire resistant rated occupancy separation walls in the facility. Both walls have been surveyed by a NDDoH Life Safety Code Surveyor and only this communicating opening was alleged to be non-compliant with the referenced document. Recurrence of this nature will not happen without significant construction activity to the facility. All construction activities involving these separations must be reviewed and approved by NDDoH. 3) When correction is made, it will become a permanent part of the affected wall. Any construction changes to the referenced walls need approval from NDDoH prior to work commencement. Periodic surveys will be conducted to identify potential concerns.	
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Smoke detectors should not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. NFPA 72 A-2-3.5.1 The facility failed to ensure smoke detectors were	K 054		

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K 054	Continued From page 2 installed in accordance with NFPA 72, National Fire Alarm Code. Observation determined that the smoke detectors located in the following areas were located within three (3) feet of a ceiling fan: 1) The corridor in the 200 Wing near Room 211. 2) The corridor in the 400 Wing near the Sun Room. 3) The corridor in the 400 Wing near the Storage Room. Failure to install smoke detectors in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected three (3) of numerous smoke detectors in the facility.	K 054	3) When corrections are made they become part of the permanent detection system. Changes to the system are not made routinely or through recurring maintenance efforts. Any future device relocations necessary will be approved my Maple Manor administrative staff to assure proper placement in accordance with referenced directives, periodic surveys will be conducted to identify potential concerns. 4) Maple Manor QA Coordinator will monitor corrective actions to ensure the alleged deficient practice is corrected in accordance with referenced documents. Corrections made become part of the permanent fire detection system. Changes to the system are not made routinely or through recurring maintenance efforts. Any future modifications will be approved by Maple Manor administrative staff to assure compliance with referenced directives.	

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