STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355059	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSOURI SLOPE LUTH CARE CTR	2425 HILLVIEW AVE BISMARCK, ND 58501

(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 structure constructed in 1967. There were six additions (1973, 1980, 1985, 1997, 2003 and 2007) with partial basements under the 1967, 1980 and 1997 additions. The facility is Type II (000) construction. These buildings are protected throughout by a wet or dry automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. The partial basement of the original 1967 building was separated from the rest of the structure by two-hour fire resistive construction. The Boiler Room and Maintenance Shop was located in the basement. An independent living apartment complex (Valleyview) was attached to the east side of the nursing facility. This independent living apartment complex was of Type V (000) construction and was separated from the health care occupancy by an occupancy separation wall having a two-hour fire resistance rating.	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	K 029	**K 029-How the corrective action will be accomplished;** Self-closures will be placed on the elevator door of the main lobby. **How the facility will identify other portions of the facility having the**	

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

Robert R. Thompson President/CEO 9-27-11

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.

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K 029	Continued From page 1 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: The facility failed to separate hazardous areas from other spaces with smoke resistive partitions and self-closing doors. Observation determined the door to the Main Lobby Elevator Equipment Room was not equipped with a self-closing device.	K 029	**potential to be affected by the same deficient practice;** A walk-thru of the facility will be completed during the week of September 26, 2011 to ensure other parts of the building meet code. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;** The Fire and Smoke barrier door checklist will be updated to include the elevator equipment doors and will be completed every four months and will be placed in the Maintenance Log Book. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.** The inspections will be completed by the maintenance department and monitored by the Director of Maintenance.	10-27-11
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Kitchens must be equipped with a K-extinguisher and an operational sign for the portable fire extinguisher mounted by the K-extinguisher. NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 11.1 Interview with staff members indicated annual training had not been provided to dietary staff on	K 064	**K 064-How the corrective action will be accomplished;** Annual training on the K-extinguisher will be provided for dietary staff through our dietary department meetings. The training will be added to the dietary employee's orientation checklist. Current staff will be in-serviced October 26, 2011. **How the facility will identify other portions of the facility having the potential to be affected by the same deficient practice;** We currently have three K-extinguishers in our kitchens. All dietary staff will be in-serviced.	

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K 064	Continued From page 2 the operation of the portable K-extinguisher.	K 064	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** K-extinguisher in-service will be added to the dietary department annual in-service calendar and to the dietary orientation checklist. **How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur;** Records will be monitored by the Nutritional Services Personnel Coordinator. (See attached copies)	10-27-11