

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

PRINTED: 06/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355111	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/29/2013
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NAME OF PROVIDER OR SUPPLIER

ST LUKES SUNRISE CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

705 SE 4TH ST
CROSBY, ND 58730

(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
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K 000 INITIAL COMMENTS

K 000

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 requirements.

The facility is located in a one-story building of Type V (000) construction that is protected by a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems and smoke detection throughout the corridor system.

K 062 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

K 062

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by:
The facility failed to ensure the automatic sprinkler system was continuously maintained in a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems.

- 1) Review of sprinkler records could not verify that the quarterly tests of the automatic sprinkler system were conducted in the 2nd and 3rd quarter of 2012.
- 2) Review of sprinkler records could not verify that the annual test of the automatic sprinkler

K 062

1. RFS Sprinklers has been contacted to correct the error on their reports so that they indicate that quarterly and annual tests were done. They completed their inspections and reports on June 11, 2013.
2. Environmental Services Director will review reports from RFS Sprinklers to ensure that they are accurate and reflect whether it was a quarterly or annual visit.
3. Environmental Services Director has been coached and counseled on how to review the report from RFS Sprinklers and to ensure that quarterly and annual tests are done by RFS Sprinklers.
4. We will do a QA audit of RFS Sprinkler reports to ensure that they are correct.
5. July 1, 2013

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

TITLE

(X6) DATE

[Signature]

Administrator

6/05/13

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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 ST LUKES SUNRISE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 705 SE 4TH ST CROSBY, ND 58730		
(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 062	Continued From page 1 system was conducted in the past twelve (12) months.	K 062			