STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355063	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**10/14/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES HOME	**242 10TH ST W** **DICKINSON, ND 58601**

(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 42CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type II (111) construction and a one-story building of Type II (000) construction. A two-hour fire resistance rated construction barrier provided separation between the two-story building and the one-story building. The building was protected throughout by a wet/dry automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. A two-hour fire resistance rated occupancy barrier provides separation to an apartment building to the northeast.	K 000		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: The facility failed to ensure exit access was readily accessible at all times. Observation determined: 1) Doors within a required means of egress shall	K 038	For all deficiency referencing K038, we are using the CMS waiver Ref: S&C: 13-58-LSC	10/26/15

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

Electronically Signed | 10/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 038	Continued From page 1 not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Delayed-egress locks shall be permitted, provided that not more than one such device is located in any egress path. a) Observation determined egress from the southwest smoke compartment through the center smoke compartment on the main floor required traveling through the cross corridor doors to the center smoke compartment corridor that were equipped with delayed-egress magnetic locks and through the center stairway exit enclosure door from the center smoke compartment that was equipped with a delayed-egress magnetic lock. b) Observation determined egress from the northwest smoke compartment through the center smoke compartment on the main floor required traveling through the cross corridor doors to the center smoke compartment corridor that were equipped with delayed-egress magnetic locks and through the center stairway exit enclosure door from the center smoke compartment that was equipped with a delayed-egress magnetic lock. c) Observation determined egress from the southwest smoke compartment through the northwest smoke compartment on the second floor required traveling through the cross corridor doors to the northwest smoke compartment corridor that were equipped with delayed-egress magnetic locks and through the center stairway exit enclosure door from the northwest smoke compartment that was equipped with a delayed-egress magnetic lock.	K 038		

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K 038	Continued From page 2 d) Observation determined egress from the northwest smoke compartment through the center exit enclosure on the second floor required traveling through the cross corridor doors in the northwest smoke compartment corridor that were equipped with delayed-egress magnetic locks and through the center stairway exit enclosure door that was equipped with a delayed-egress magnetic lock. The deficiency affected egress from four (4) of six (6) smoke compartments in the facility. 2) Delayed-egress doors locked in the means of egress must display on the door adjacent to the releasing device visible signage in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads the following: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS All delayed-egress doors in the facility lacked visible signage on the door. This deficiency affected seventeen (17) of seventeen (17) delayed-egress doors in the facility. Failure to maintain the means of egress to be available at all times increases the risk of death or injury due to fire. Ref: 2000 NFPA 101 Section 18.2.2.2.4(2), 7.2.1.6.1(d)	K 038		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		10/26/15

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K 144 SS=F	Continued From page 3 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: Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days. NFPA 110 6-3.6 The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Record review determined the electrolyte levels of the emergency generator batteries were not checked at seven (7) day intervals as required. Failure to inspect and maintain the emergency generator in accordance with NFPA 110 increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 144	Generator batteries are checked weekly for fluid levels, we have purchased a hydrometer, and will be checking batteries electrolyte numbers weekly starting 10/26/15. ST Luke's Home has only one generator. 10/28/15 The Environmental Director added a line on our generator check list to write down the electrolyte levels, as well as adding this to our TELS monitoring tool. The Environmental director will be checking weekly to ensure the electrolyte levels have been taken, and recorded. 10/28/15 The QA Director added the electrolyte monitoring to our dash board for are QA monthly group to ensure this monitoring is being completed weekly, for the next year. 10/28/15	