STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355037	A. BUILDING **02 - MAIN BUILDING 02** B. WING _____	**07/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ALOISIUS MEDICAL CENTER NURSING HOME	**325 E BREWSTER ST** **HARVEY, ND 58341**

(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 one-story building of Type II (000) construction with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The St. Aloisius Hospital was attached to the nursing facility with two-hour fire-rated barriers at the west and south side of Unit A and at the north side of Unit B. An independent living unit was separated from the nursing facility by an occupancy separation wall having a two-hour fire resistance rating. The partial basement of Unit B was separated from the main floor with a two-hour floor/ceiling assembly and two-hour rated vertical shafts.	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 This STANDARD is not met as evidenced by:	K 011		8/26/16

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

Electronically Signed | 07/19/2016

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 011	Continued From page 1 The facility failed to ensure a two-hour fire resistant rated occupancy separation between the first floor and the basement storage occupancy. Observation determined two (2) unsealed openings in the concrete floor/ceiling assembly in the basement Mechanical Room #55 through the two-hour fire resistant rated occupancy separation to the first floor Restorative Therapy. Failure to ensure communicating openings through two-hour fire resistant rated occupancy separations increases the risk of death or injury due to fire. This deficiency affected one (1) of three (3) two-hour fire resistant rated occupancy separations in the building.	K 011	No resident was affected by this deficiency. The two (2) unsealed openings in the concrete floor/ceiling assembly in the basement Mechanical Room #55 will be sealed with an approved fire rated sealant. We will have a contractor seal all the penetrations through the concrete floor/ceiling assembly. The entire floor/ceiling assembly will be inspected for openings and any openings found will be sealed. A QI monitor will be done on the floor/ceiling assembly monthly for one quarter. All contractors will be instructed to seal all penetrations in the future. The Director of Plant Operations will be responsible for this.	
K 054 SS=F	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 are 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 installed in accordance with NFPA 72,	K 054	No resident was affected by this deficiency. All smoke detectors throughout the facility will be inspected to ensure they are installed in accordance with NFPA 72, National Fire Alarm Code. All fire	8/26/16

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K 054	Continued From page 2 National Fire Alarm Code. Observation determined numerous smoke detectors throughout the building were located within three (3) feet of a supply or exhaust air diffuser. Failure to install smoke detectors in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected numerous smoke detectors in the Unit-A and Unit-B.	K 054	detectors that are not in compliance will be moved into compliance by a qualified contractor. A QI monitor will be done on the smoke detectors monthly for one quarter. The Director of Plant Operations will be responsible for this.	