

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



PRINTED: 04/30/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355037	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/23/2012
NAME OF PROVIDER OR SUPPLIER ST ALOISIUS MEDICAL CENTER NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 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 findings that follow demonstrate noncompliance with these standards. The nursing facility was comprised of two separate additions (Units A and B) with a connecting corridor. Unit A was constructed in 1973 and Unit B was constructed in 1978. 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 attached to the nursing facility at the east end of Unit B (C Wing). There was a two-hour fire-rated barrier between the nursing facility and the independent living apartments. 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. Note: Heat detectors, which only initiate an alarm and have no extinguishing function, are redundant devices when used in conjunction with sprinklers. In areas protected by automatic sprinklers, heat	K 000			

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

TITLE

(X6) DATE

PRESIDENT/CEO

5-9-2012

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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FORM CMS-2567(02-99) Previous Versions Obsolete