STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355082	A. BUILDING 01 - MAIN BUIDLING B. WING _____	08/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVE MARIA VILLAGE	501 19TH ST NE JAMESTOWN, ND 58401

(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 and Chapter 19 Existing Health Care Occupancies, in compliance with 42 CFR 483.70(a). The facility was located in a one-story building of Type V (000) construction with a partial basement. An addition of Type II (000) construction was attached to the south end of the Service Wing in 2014. The building was equipped with a wet automatic sprinkler system with quick response sprinklers designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. The facility was divided into three smoke zones; A & B Wing (resident sleeping rooms), C & D Wing (resident sleeping rooms), and Service Wing (central nurses station, dining room, therapy, and kitchen).The 2014 addition (garage, chapel, and family suite) attached to the south end of the Service Wing was surveyed under Chapter 18 New Health Care Occupancies. An assisted living complex was attached to the west side of the nursing facility and was separated by an occupancy separation wall having a two-hour fire resistance rating. Note: At the conclusion of the 08/26/2014 Life Safety Code survey, it was determined the facility was in compliance with the provisions of NFPA 101, Life Safety Code.	K 000		

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

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing 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 ıys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.