STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**750 MAIN ST E** **MAYVILLE, ND 58257**

(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 requirements. The facility was located in a one-story building of Type V (000) construction protected with a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: The facility failed to ensure doors to hazardous areas in fully sprinklered existing health care occupancies were equipped with self-closing/automatic latching hardware. Observation determined the door to the South D Wing Storage Room did not have self-closing hardware.	K 029	1. Corrective action was accomplished by installing an automatic closure on D-wing activities storage door on 06-03-2015. (see attachment #1) 2. All other areas in the facility are in compliance. 3. The facility put the following change in place: a new automatic closure was	7/18/15

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

Electronically Signed | 06/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**750 MAIN ST E** **MAYVILLE, ND 58257**

(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 029	Continued From page 1 Failure to ensure doors to hazardous areas self-close and latch to the door frame increases the risk or death or injury due to fire. The deficiency affected one (1) of an estimated eleven (11) hazardous areas in the facility.	K 029	installed on the D-wing storage room on 6-13-15. (see attachment #2) 4. The facility will do a weekly QA to monitor to see if automatic door is functioning properly (see attachment #2). 5. Corrective action will be accomplished by 7-18-2015	
K 038	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. 19.2.1 This STANDARD is not met as evidenced by: Doors are required to be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side. The facility failed to ensure exit access was readily accessible at all times. Observation determined the facility had not ensured that doors in the means of egress were not locked against egress when the building was occupied. On 06/03/2015, the following doors were equipped with locks or latches that required special knowledge and effort to operate from the egress side: 1) The exterior exit doors from B Wing, West C Wing, East C Wing, North D Wing, South D	K 038	1. Corrective action will be accomplished by having Electro Watchman Inc. come out and install all exit updates for the delayed egress on July 18th, 2015. (See attachment #3). The chains and locks were removed from the East D, West C, and D south on June 3, 2015. (See attachment 5, 6, 7). 2. There are 12 egress areas that have the potential to be affected by this. No other exterior gates have the potential to be affected by this. 3. The facility will put the following changes in place: See attachments 3,5,6, and 7. 4. The facility will monitor to ensure proper function after completion of the egress weekly for 3 months. (See attachment #2). For the chains and locks the facility will monitor weekly for 3 month.	7/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**750 MAIN ST E** **MAYVILLE, ND 58257**

(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 038	Continued From page 2 Wing, Service Wing and Main Lobby were equipped with access-controlled magnetic locks that required a blue fire alarm style pull handle to be operated or a code to be entered on a key pad to release. 2) The cross corridor-doors by Resident Room 35 and the Kitchen were equipped with access-controlled magnetic locks that required a blue fire alarm style pull handle to be operated or a code to be entered on a key pad to release. 3) The exit discharge gates from the West C Wing, East C Wing and South D Wing were equipped with chains and padlocks that required a key to release. Failure to maintain the means of egress available at all times increases the risk of death or injury due to fire. The deficiency affected egress from five (5) of six (6) smoke compartments in the facility. Ref: 2000 NFPA 101 Section 19.2.2.2.4, 7.2.1.6.2	K 038	(See attachment #2). 5. Corrective action for delayed egress will be July 18, 2015. Corrective action will be completed for the locks and chains July 18, 2015.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 062	1. Corrective action was accomplished by sprinkler backflow test done on	7/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355040	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**750 MAIN ST E** **MAYVILLE, ND 58257**

(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 3 a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. All backflow devices installed in fire protection water supply shall be tested annually at the designed flow rate of the fire protection system, including hose stream demands, if appropriate. Exception: Where connections of a size sufficient to conduct a full flow test are not available, tests shall be conducted at the maximum flow rate possible. On 06/03/2015, review of automatic sprinkler records determined the required annual back flow preventer test was last conducted on 05/07/2014, which exceeded twelve (12) months. The deficiency affected one of numerous required tests of the automatic sprinkler system. The automatic sprinkler system provides protection to the entire facility. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-6.2	K 062	06-04-2015. (See attachment #4). 2. No other areas have the potential to be affected by this. 3. The facility has had the sprinkler back flow test completed (see #4) 4. The facility will monitor be doing a monthly QA in April and May 2016 making sure the test is completed. (See attachment #2) 5. Corrective action will be accomplished by July 18, 2015.	