STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355079	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/13/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VILLA MARIA	**3102 S UNIVERSITY DR** **FARGO, ND 58103**

(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 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building with a partial basement. The original building was of Type I (332) construction and the 1993 and 1994 additions are Type II (111) construction. A two-story addition of Type II (222) construction on the west side of the building and a one-story addition of Type II (000) construction on the east side of the building were constructed in 2008. The two-story addition was attached to the original building. The second floor of this addition was a business occupancy and was separated from the health care occupancy with an occupancy separation having a two-hour fire resistance rating. Due to the lack of two-hour fire rated separation between the 2008 one-story addition and the remainder of the building, the entire facility was classified as Type II (000) construction. The entire building was equipped with a wet automatic sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. The basement areas were separated from the main floor by two-hour fire resistive construction and were being used by staff only. The integrity of the basement's floor/ceiling assembly was included in this survey but the basement area was not.	K 000		

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

Electronically Signed | 10/21/2016

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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 shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: The facility failed to ensure a two-hour fire resistant rated occupancy separation between the first floor and the basement. Observation determined two (2) copper pipe penetrations of the concrete floor/ceiling assembly between the first floor and the basement had unsealed spaces filled with insulation materials in the "Old Elevator Equipment Room". Failure to ensure sealed communicating openings through two-hour fire resistant rated 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	1.Corrective Action: It is the practice of the facility to maintain a safe environment. The corrective action for the copper pipe penetrations of the concrete floor/ceiling assembly between the first floor and the basement is as follows: a.An engineer from Hilti Corporation has been consulted and was provided photos of the current configuration. Hilti will be supplying an engineered repair that will meet compliance by 11/27/2016. 2.Identify other areas: a.All copper pipe penetrations have the potential to be affected. The entire basement was inspected by the Director of Environmental Services on 10/17/16 and was found to be in compliance as identified in 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2. There will also be a Hilti engineer out to the facility for a second inspection of the basement. 3.Measure put in place:	11/27/16

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K 011	Continued From page 2	K 011	a.The Director of Environmental Services or his designee will monitor the basement ceiling penetrations for compliance and make adjustments as necessary. 4.Monitoring: a.The basement ceiling penetrations will be inspected to ensure the communicating openings through 2 hour fire resistant rated separations are sealed. This will be done monthly X 3 months and then quarterly for the remainder of the year. This audit will be completed by the Environmental Services Department Staff. 5.The facility will be in substantial compliance by November 27th, 2016.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than one-half hour. 19.3.7.3 The facility failed to ensure two (2) of five (5) smoke barriers were least one-half hour fire resistant and smoke resistant.	K 025	1.Corrective Action: It is the practice of the facility to maintain a safe environment. The corrective action for the smoke barriers/compartments above the cross corridor doors adjacent to Resident Room #202 and #402 is as follows: a.The unsealed spaces around the data cables near the smoke barriers	11/27/16

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K 025	Continued From page 3 Observation determined unsealed spaces around a data cable through-wall penetration of: 1) The smoke barrier above the cross corridor doors adjacent to Resident Room #202. 2) The smoke barrier above the cross corridor doors adjacent to Resident Room #402. Failure to maintain smoke barriers as required increases the risk of death or injury due to fire. The deficiency affected two (2) of five (5) smoke barriers and four (4) of five (5) smoke compartments in the building. Note: The unsealed spaces around these data cables were sealed with fire caulk prior to the exit conference.	K 025	aformentioned were sealed with fire caulk prior to the exit conference. 2.Identify other areas: a.All smoke barriers/compartments throughout the facility have potential to be affected. All other 3 smoke barriers were inspected by the Director of Environmental Services on 10/14/16 looking for any other similar unsealed spaces around data cable. There were no others areas of unsealed spaces found and met the standards identified in 8.3, 19.3.7.3, 19.3.7.5. 3.Measure put in place: a.The Director of Environmental Services or his designee will monitor the 5 smoke barriers/compartments for any through-wall penetrations for compliance and make adjustments as necessary. 4.Monitoring: a.The 5 smoke barriers/compartments will be inspected to ensure there are no unsealed spaces around data cables that would cause the smoke barriers to be less that one half hour fire and smoke resistant. This will be done monthly X 3 months and then quarterly for the remainder of the year. This audit will be completed by the Environmental Services Department Staff. 5.The facility will be in substantial compliance by November 27th, 2016.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		11/27/16

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K 054	Continued From page 4 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 must not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. 19.3.4.5.1, 9.6.2.10.1, NFPA 72 2-3.5.1. The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm Code. Observation determined smoke detectors throughout the facility were installed within 3 ft. of an air supply diffuser or air supply vent. Failure to install the smoke detection system as required increases the risk of death or injury due to fire. This deficiency affected numerous smoke detectors in the facility. The smoke detection system serves the entire facility.	K 054	1.Corrective Action: It is the practice of the facility to maintain a safe environment. The corrective action for the smoke detectors that were located within 3 feet from an air supply diffuser or return air opening is as follows: a.All the smoke detectors identified during the Life Safety Code Survey have been moved no closer than 3 feet from an air supply diffuser or return air opening. 2.Identify other areas: a.All other smoke detectors throughout the facility have potential to be affected. All other smoke detectors throughout the facility were inspected by the Director of Environment Services on 10/14/2016 and were found to meet the standards identified in 19.3.4.5.1, 9.6.2.10.1, NFPA 72 2-3.5.1. 3.Measure put in place: a.The Director of Environmental Services or his designee will monitor the smoke detectors to assure they meet NFPA 72, National Fire Alarm Code and make adjustments as necessary. 4.Monitoring: a.The smoke detectors will be inspected to assure they are not located in a direct air flow nor closer than 3 feet from an air supply diffuser or return air opening. This	

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K 054	Continued From page 5	K 054	will be done monthly for the entire year. This audit will be completed by the Environmental Services Department Staff. 5. The facility will be in substantial compliance by November 27th, 2016.	
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: The facility failed to ensure transferring of liquid oxygen from one container to another occurred in a location separated from any portion of a facility wherein residents were housed, examined, or treated by a fire barrier of 1-hour fire-resistive construction. Observation determined the door to the Liquid Oxygen Transfilling Room failed to meet the	K 143	1.Corrective Action: It is the practice of the facility to maintain a safe environment. The corrective action for the door to the Oxygen Transfilling Room that lacked a self-closing device is as follows: a.A self-closing device was installed on the door of the Oxygen Transfilling Room on 10/13/16 prior to the exit conference.	11/27/16

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K 143	Continued From page 6 requirements for one-hour fire-resistive construction. The door to the Transfilling Room lacked a self-closing device. Failure to equip the door to the Liquid Oxygen Transfilling Room with a self-closing device increases the risk of injury or death. This deficiency affected one (1) of five (5) smoke compartments.	K 143	2.Identify other areas: a.There are no other Oxygen Transfilling stations within the facility. 3.Measure put in place: a.The Director of Environmental Services or his designee will monitor the self-closing device on the door of the Oxygen Transfilling Room to assure it is functioning properly and repair as necessary. 4.Monitoring: a.The self-closing device on the Oxygen Transfilling Room will be inspected to assure it is functioning properly in order to maintain a 1-hour fire-resistive construction. This will be done monthly X 3 months and then quarterly for the remainder of the year. This audit will be completed by the Environmental Services Department Staff. 5.The facility will be in substantial compliance by November 27th, 2016.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: When electrical hazards are identified, measures to abate such conditions shall be taken. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. 33.2.5.2, 9.1.2 NFPA 70, 517.20.	K 147	1.Corrective Action: It is the practice of the facility to maintain a safe environment. The corrective action for the 7 identified Ground Fault Circuit Interrupters is as follows: a.All 7 of the identified Ground Fault	11/27/16

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K 147	Continued From page 7 Seven (7) of numerous Ground Fault Circuit Interrupter (GFCI) protected receptacles located throughout the facility failed to trip when tested. Failure to ensure the electrical wiring complies with NFPA 70 increases the risk of injury and death due to fire. The deficiency affected seven (7) of numerous (GFCI) protected receptacles in the facility.	K 147	Circuit Interrupters were replaced and in working order on 10/13/16 prior to the exit conference. 2.Identify other areas: a.All other Ground Fault Circuit Interrupters have the potential to be affected. All other Ground Fault Circuit Interrupters throughout the facility were inspected by the Director of Environmental Services on 10/14/16 and they were in compliance when tested according to NFPA 70, National Electric Code. 33.2.5.2, 9.1.2 NFPA 70, 517.20. 3.Measure put in place: a.The Director of Environmental Services or his designee will inspect the Ground Fault Circuit Interrupters and will be replaced as necessary. 4.Monitoring: a.The Ground Fault Circuit Interrupters will be inspected to assure they trip when tested. This will be done monthly X 3 months and then quarterly for the remainder of the year. This audit will be completed by the Environmental Services Department Staff. 5.The facility will be in substantial compliance by November 27th, 2016.	