STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	6084	A. BUILDING: 01 - GOOD SAMARITAN SOCIETY B. WING	05/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BISMARCK	316 VERSAILLES AVE BISMARCK, ND 58503

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K 000	INITIAL COMMENTS This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 33 Existing Residential Board and Care Occupancies (Large), in compliance with NDAC 33-03-24.2. The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type V (111) construction that was protected by an automatic sprinkler system designed to meet the requirements of NFPA 13R Standard for the Installation of Sprinkler Systems in Residential Occupancies up to and Including Four Stories in Height. The building was separated from the nursing home by an occupancy separation wall having a two-hour fire resistance rating. The lower floor was basic care and the main floor was assisted living. The assisted living was surveyed in addition to the basic care due to the absence of a two-hour fire rated separation between the basic care and the assisted living unit. Resident evaluation determined a Prompt level of evacuation difficulty. The E-Score was .64.	K 000	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegations that the facility is not in substantial compliance with the standards set forth in this statement of deficiencies, this response and plan of correction constitutes the facilities allegation of compliance.	
K 238	EXIT SYSTEM Means of egress from resident rooms and resident dwelling units to the outside of the building shall be in accordance with Chapter 7 and this chapter. 33.3.2.1.1	K 238	K238 1) The handrails of the corridor where the doors to the Linen Closet and Storage Closet on the 1st Floor were cut back and shortened on 6-14-16. Doors no longer extend more than 7 inches from the wall when fully opened. 2) All doors during their swing in a means of egress have the potential to be affected by this practice.	

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

North Dakota Department of Health

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K 238	Continued From page 1 This state licensing rule is not met as evidenced by: During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 inches into the required width of an aisle, corridor, passageway, or landing, when fully open. 7.2.1.4.3.1. Observation determined the corridor doors to the Linen Closet and Storage Closet on the 1st Floor opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened. This deficiency affected two (2) of numerous corridor doors in the means of egress throughout the facility. Failure to ensure exit access was readily available at all times increases the risk of death or injury due to fire.	K 238	3-4) The Director of Environmental Services inspected the Linen Closet and Storage Closet doors on the 1st Floor following shortening of the hand rails to ensure they do not project more than 7 inches from the wall when fully opened per 7.2.1.4.3.1. 5) Corrective action(s) were completed by 6/14/2016.	6/14/16
K 244	Emergency Egress and Relocation Drills Emergency Egress and Relocation Drills. Emergency egress and relocation drills shall be conducted in accordance with 33.7.3.1 through 33.7.3.6. 33.7.3 This state licensing rule is not met as evidenced by: Fire drills must be held monthly with a minimum of twelve drills per year, alternating with all work shifts. Residents and staff, as a group, shall	K 244	K244 1) Fire drills will be conducted monthly with a minimum of 12 drills per year, alternating with all work shifts. 2) All areas of the facility have the potential to be affected by this practice.	

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K 244	Continued From page 2 either evacuate the building or relocate to an assembly point identified in the fire evacuation plan. At least once a year, a fire drill must be conducted during which all staff and residents evacuate the building. Written records of fire drills must be maintained. These records must include dates, times, duration, names of staff and residents participating and those absent and why, and a brief description of the drill, including the escape path used and evidence of simulation of a call to the fire department. Each resident shall receive an individual fire drill walk-through within five days of admission. Any variation to compliance with the fire safety requirements must be approved in writing by the department. Residents of facilities meeting a greater level of fire safety must meet the fire drill requirements of that occupancy classification. NDAC 33-03-24.2-08. The facility failed to conduct fire drills as required. Fire drill records review determined the facility failed to conduct fire drills on the first shift during the second and fourth quarters of 2015. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected two (2) of twelve (12) required drills in the past year.	K 244	3) The Director of Environmental Services and all Environmental Services Assistants will be educated on the importance of proper shift rotation for fire drills on 6-15-16. A first shift fire drill was conducted in the facility on 1/13/2016. 4) Completion of monthly fire drills alternating with all work shifts will be audited by the Administrator and/or designee for 3 months and then one quarter thereafter to ensure compliance. 5) Corrective action was completed by 6/15/2016.	6/15/2016
K 309	SMOKE DETECTION AND ALARM All living areas, as defined in 3.3.21.5, and all corridors shall be provided with smoke detectors that comply with NFPA 72, National Fire Alarm and Signaling Code, and are arranged to initiate	K 309		

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K 309	Continued From page 3 an alarm that is audible in all sleeping areas, as modified by 33.3.3.4.8.2 and 33.3.3.4.8.3. 33.3.3.4.8.1 This state licensing rule 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. 33.3.3.4.7, 9.6.2.10.1.1, NFPA 72 17.7.4.1 The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm Code. Observation determined that fifty five (55) smoke detectors located throughout the facility were installed within three feet of ceiling fans, air supply diffusers or return air openings. Failure to install the smoke detection system as required increases the risk of death or injury due to fire. This deficiency affected fifty five (55) of numerous smoke detectors in the facility.	K 309	K309 1) Smoke detectors throughout the facility will be located no closer than 3 ft from ceiling fans, air supply diffusers or return air openings, to ensure the smoke detection system is compliant with NFPA 72, National Fire Alarm Code. 2) All smoke detectors installed in the facility have the potential to be affected by this practice. 3) Bids are currently being sought from various electrical contractors and Simplex Grinel to complete work and ensure compliance. 4) The Director of Environmental Services will inspect all non-compliant smoke detectors following completion of work order to ensure none are located closer than 3 ft (1m) from an air supply diffuser or return air opening. 5) Above corrective action(s) will be completed by 7/30/2016.	7/30/16
K 321	Inspection of Door Openings Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually in accordance with 7.2.1.15.	K 321		

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K 321	Continued From page 4 33.7.7 This state licensing rule is not met as evidenced by: Door assemblies for which the door leaf is required to swing in the direction of egress travel shall be inspected and tested not less than annually. 33.7.7, 7.2.1.15 The facility failed to inspect and test door assemblies as required. Review of records and interview of staff determined annual door assembly inspections were not completed. Failure to inspect and test door assemblies in the means of egress increases the risk of death or injury due to fire. This deficiency affected all required door assemblies throughout the facility.	K 321	K321 1) The Director of Environmental Services or designee shall inspect and test door assemblies as required, to include documentation of findings no less than annually. 2) All required door assemblies throughout the facility have the potential to be affected by this practice. 3) The Director of Environmental Services and all Environmental Service's Assistants will be educated on the importance of the documentation, inspection and testing of door assemblies in the means of egress not less than annually by 6/15/2016. 4) Documentation of the inspection and testing of door assemblies in the means of egress will be audited by the Administrator and/or designee to ensure compliance during the month of July and not less than annually thereafter. 5) Corrective action(s) will be completed by 7/30/2016.	7/30/16