STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/16/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	**302 7TH AVE NE** **DEVILS LAKE, ND 58301**

(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 requirements. The Good Samaritan Society-Devils Lake was located in a one-story building of Type V (000) construction with a partial basement. The facility was equipped with two (2) dry automatic sprinkler systems designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		12/31/15

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

Electronically Signed | 11/25/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/16/2015**

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Doors shall be provided with a means suitable for keeping the door closed. 19.3.6.3.2 The facility failed to ensure corridor doors were equipped with automatic latching hardware suitable for keeping the doors closed and resistant to the passage of smoke. Observation determined the double set of corridor doors to the 100 Wing, 200 Wing, 400 Wing and 500 Wing Linen Rooms were not automatic latching. The secondary doors were equipped with a manual latching lever. Failure to ensure corridor doors are provided with automatic latching hardware increases the risk for death or injury due to fire. This deficiency affected four (4) of numerous corridor doors in the facility.	K 018	The Environmental Services Director will ensure that doors protecting corridor openings will be equipped with means suitable for keeping the door closed by making the following corrective actions: 1. The double set of corridor doors in the 100 wing, 200 wing, 400 wing and 500 wing were measured and a new set of doors capable of resisting fire for at least 20 minutes were ordered by an outside contractor. The doors will be equipped with automatic self latching hardware to keep the doors closed. The doors have been ordered and will be installed when delivered. The facility reviewed doors in other portions of the facility and did not find any other doors that needed the automatic self latching hardware. The facility will keep and maintain these doors with their automatic self latching hardware to ensure the deficit practice will not recur. The Environmental Services Director will monitor the doors at least quarterly for the first year to ensure that the doors latch and close properly and then as necessary after that.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire	K 029		12/31/15

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K 029	Continued From page 2 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: Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. 19.3.2.1 The facility failed to ensure doors to hazardous areas in fully sprinklered existing health care occupancies were separated from other spaces by smoke-resisting partitions and doors equipped with self-closing/automatic latching hardware. Observation determined: 1) The door to the 200 Wing Nursing Supply Room did not have self-closing hardware. 2) The ceiling in the West Boiler Room had a 24" x 24" opening in the gypsum board. 3) There were unsealed conduit penetrations in	K 029	The facility will ensure hazardous area will be separated from other spaces by smoke resisting partitions and doors equipped with self closing/automatic latching hardware by making the following changes in its system: 1. The Environmental Services Director will place an automatic self closing latch on the 200 Wing Nursing Supply Room door. 2. The Environmental Service Director will patch the 24" by 24" opening in the gypsum board with 5/8 inch double layered fire rated sheetrock. 3.The Environmental Services Director will seal the conduit penetrations in the ceiling in the West Generator Room with 5/8" double layered fire rate sheetrock. The Environmental Services Director reviewed the facility and did not find other portions of the facility that had area that needed repair.	

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K 029	Continued From page 3 the ceiling and north wall of the West Generator Room. Failure to ensure hazardous areas are separated from other spaces by smoke-resisting partitions and doors equipped with self-closing/automatic latching hardware increases the risk of death or injury due to fire. The deficiency affected three (3) of numerous hazardous areas in the facility.	K 029	To ensure that the deficient practice will not recur the Environmental Services Director with make a review of hazardous areas on a quarterly basis for the first year and then as needed thereafter to ensure that smoke resistant areas are maintained with no penetration. The Environmental Services will report his findings to the Quality Assurance Committee for the first year to ensure that corrective actions are maintained and not recurring.	
K 038 SS=D	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: The facility failed to ensure exit access was readily accessible at all times. 1) 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. 7.2.1.4.4. Observation determined the south leaf of the 200 Wing Linen Room doors opened outward into the exit corridor and extended more than 7 inches	K 038	The facility will ensure exit accesses are readily accessible by making the following changes: 1. The south leaf of the 200 wing Linen Room door will be replaced so that it does not extend more than 7 inches from the wall when fully opened. An outside contractor has measured and placed the order for the door and it will be installed with the factory installed automatic closing latch when the door is delivered. 2. The North exit from the dining room is not needed per conversation with the life	12/31/15

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K 038	Continued From page 4 from the wall when fully opened. This deficiency affected one (1) of numerous corridor doors in the means of egress throughout the facility. 2) Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. 7.7.1 To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. Observation determined the north exit from the Dining Room traversed the lawn to get to a public way. The deficiency affected one (1) of nine (9) exits from the building. Failure to ensure exit access is readily available at all times increases the risk of death or injury due to fire.	K 038	safety inspector so it will be eliminated. There currently are two other viable exits available from the dining room. The Environmental Services Director reviewed the facility to ensure exit accesses are readily accessible and did not identify any other issues. This will be a permanent fix for our facility when the doors are changed and the Exit sign is eliminated so the deficit practice will not reoccur. The Environmental Services Director will monitor the facility doors and the exits on a quarterly basis for the first year and then as needed thereafter to ensure the exits are readily accessible at all times. He will then report this review to the Quality Assurance Committee so they can ensure the deficient practice is being corrected and will not recur.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		12/31/15

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K 052	Continued From page 5 This STANDARD is not met as evidenced by: Fire alarm system batteries shall be subjected to a load voltage test semiannually. NFPA 72 7-3.2 The facility failed to test the fire alarm system as required by NFPA 72, National Fire Alarm Code. Review of fire alarm system test records indicated the semiannual load voltage tests of the sealed lead acid batteries were not performed as required. The most current fire alarm system batteries load voltage test was conducted on 11/02/2015 and the previous test was conducted on 01/14/2015, exceeding the required semiannual testing requirement. Failure to test and maintain the fire alarm system in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected one (1) of two (2) required load voltage tests of the fire alarm batteries in the past year. The fire alarm system serves the entire facility.	K 052	The Director of Environmental Services will ensure the fire alarm system required for the life safety is installed, tested and maintained according to code by making the following changes in our practice: 1. Nordinini's, an outside contractor, has been hired to do our semi annual complete load voltage test of the sealed lead acid batteries. They were asked to place us on a semi annual rotation. We discovered the second missing test prior to the life safety inspection inspection so we asked them to complete a second test on 11/2/2015. The Environmental Services Director asked the outside contractor for a routine schedule for every 6 months preferably January and July to ensure continued compliance. In addition this will be placed on the Environmental Services preventative maintenance checklist(TELS) semiannually to ensure and monitor continued compliance. To monitor compliance, the Quality Assurance Committee will ask for a report semiannually from the Environmental Service Director to ensure the deficient practice is being corrected and will not recur.	

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K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 should not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. NFPA 72 A-2-3.5.1 The facility failed to ensure smoke detectors were installed in accordance with NFPA 72, National Fire Alarm Code. Observation determined the smoke detectors located in Resident Rooms 102, 104, 106, 108, 110 and 112 were mounted on the ceiling closer than three (3) feet from a ceiling fan. Failure to install detectors in accordance with NFPA 72 increases the risk of death or injury due to fire. This deficiency affected six (6) of numerous smoke detectors in the facility.	K 054	The facility will make the following adjustments to the structure to assure that smoke detectors will not be located in direct airflow nor closer that 3 ft. from an air supply diffuser or return air opening by: 1. The Environmental Services Director will remove the fan blades as discussed with the life safety inspector in Rooms 102, 104, 106 108, 110 and 112. 2. The facility plans to replace the smoke detectors in the upcoming year in these rooms and will move the smoke detectors or the fan so they are 3 feet from one another and then replace the fan blades. The Environmental Services Director reviewed the other rooms and did not find other issues in regards to smoke detectors being located in a direct airflow nor closer than 3 feet from an air supply diffuser or return air opening. The Environmental Service Director will monitor the placement of air supply diffusers or return air openings and not let them be closer then 3 feet on at least a quarterly basis for the first year and then	12/31/15

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K 054	Continued From page 7	K 054	as needed thereafter. The Environmental Services Director will give a quarterly report to the QA committee regarding the checks of smoke detectors not being located in a direct airflow or closer than 3 feet to an air supply diffuser on a quarterly basis for the first year and then as needed thereafter.	
K 062 SS=D	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 supply of spare sprinklers shall be inspected annually for the proper number and type of sprinklers and a sprinkler wrench for each type of sprinkler. 19.7.6, 4.6.12, NFPA 25, 2-2.1.3 The facility failed to ensure the automatic sprinkler system was continuously inspected, tested and maintained in a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. Observation determined a sprinkler wrench was not located in the spare sprinkler cabinet. Failure to inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due	K 062	The Environmental Services Director will ensure the required automatic sprinkler systems are continuously maintained and tested periodically by making the following changes in it's program: 1. A universal wrench has been purchased and placed in the spare sprinkler cabinet. No other deficiencies could be found at this time. The Environmental Services Director will ensure continued compliance with this by visibly checking the wrench placement on a quarterly basis for the first year and then as needed following.	12/31/15

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K 062	Continued From page 8 to fire. The automatic sprinkler system serves the entire building.	K 062	The Quality Assurance Committee will request an audit of the spare sprinkler cabinet each quarter for the first year to ensure that the wrench is in place in the spare sprinkler cabinet to ensure that the automatic sprinkler system is maintained.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. 7.1.10.1 The facility failed to maintain exit corridors free of all obstructions or impediments to exiting. Observation determined: 1) A wheelchair scale was installed in the corridor across from the Activity office. 2) Numerous items were stored throughout the basement exit corridors. Failure to maintain corridors free of obstructions increases the risk of death or injury due to fire.	K 072	The Environmental Services Director will ensure means of eqress are maintained by making the following changes in it's practice; 1. The wheelchair scale will be moved to another room so that it does not obstruct the cooridor. 2. Items will be removed from the basement exits cooridors so that they do not obstruct the corridor. No other portions of the facility could be identified to have deficient practice. An audit will be developed by the Administrator and will be completed on a quarterly basis by the Enviromental Services Director to make sure that	12/31/15

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K 072	Continued From page 9 This deficiency affected three (3) of eight (8) exit corridors.	K 072	corridors are free from all obstructions and impediments to exiting. The audit then will be reviewed by the Quality Assurance Committee on a quarterly basis for the first year and then annually as needed to ensure the deficit practice is being corrected and will not recur.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standards for Health Care Facilities. 19.3.2.4, NFPA 99 16-3.8.1, 8-3.1.11.2(c)2, 8-3.1.11.2(f) The facility failed to ensure nonflammable medical gas equipment and systems were in compliance with NFPA 99. Observation determined:	K 076	The facility will ensure that oxygen is placed in appropriate storage areas by making the following changes in it's practice: 1. The oxygen tanks will be placed in an area that will not have cabinets closer that five feet from the oxygen cylinders in the Oxygen Storage Room. 2. We will hire an electrical contractor to move the wall fixtures above 5 feet from	12/31/15

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K 076	Continued From page 10 1) There were combustible cabinets closer than five (5) feet from the oxygen cylinders in the Oxygen Storage Room. 2) The Oxygen Storage Room contained thirty-eight (38) E size oxygen cylinders and had electrical wall fixtures installed less than five (5) feet above the floor. This number of cylinders exceeds 300 cu. ft. and requires additional protection to the storage room. Failure to ensure nonflammable medical gas equipment and systems are in compliance with NFPA 99 increases the risk of death or injury due to fire. This deficiency affected one (1) of five (5) smoke compartments in the facility.	K 076	the floor in the oxygen storage room. The electrical change will be permanent as well as not having cabinets closer that five feet from oxygen cylinders. To ensure continued compliance the Environmental Services Director will check on a quarterly basis for the first year the oxygen room for compliance and then as needed thereafter. This audit then will be given to the Quality Assurance Committee to make sure continued compliance is achieved for the first year and then annually thereafter as needed.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 1) A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular	K 144	The facility will make the following changes in it's system to ensure generators are inspected weekly and excersied under a load for 30 minutes per	12/31/15

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(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 144	Continued From page 11 work station. NFPA 99 3-4.1.1.15 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Standard for Health Care Facilities. Observation determined there were no remote annunciators for the north and west generators located outside of the Generator Rooms at a work site readily observable by personnel. Failure to ensure emergency generators are in compliance with NFPA 99 increases the risk of death or injury due to fire. The deficiency affected two (2) of two (2) emergency generators which provide all emergency power to the facility. 2) Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes under normal operating temperature conditions. NFPA 110 6-4.2 The facility failed to ensure the west emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Review of generator test records could not verify that monthly 30-minute load tests were conducted as required. The hour meter records for the west generator indicated that the total run time each month was 30 minutes which included the 5 minutes minimum cool-down time. Failure to inspect and maintain the emergency generator in accordance with NFPA 110	K 144	month: 1. An outside contractor, Interstate Power System, has been hired to place a remote annunciator, storage battery powered, for our North and West Generator to our nursing station which is a worksite readily observable by personnel. 2. The Environmental Services Director will make a change to his way of recording the generator load tests to accurately record the full test time with the 30 minute load test and the 5 to 15 minute cool down time on the west generator. He will include in his documentation the total run time of the generator under load for 30 minutes plus the 5 to 15 minute cool down time as a total and then separately record the 30 minute time under load. No other deficit practices regarding the generator was found at this time. The annunciator will be a permanent fix. The Environmental Services Director was educated regarding the need to record the full time the generator is ran with both the time under load and the time for cool down and then how to record just the 30 minute time under load by our National Campus Environmental staff on November 24, 2015. To ensure continued compliance an audit will be developed for the Environmental Service Staff to implement on a quarterly basis. This will be then reviewed on a quarterly basis for the first year by the QA	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355100	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/16/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - DEVILS LAKE	**302 7TH AVE NE** **DEVILS LAKE, ND 58301**

(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 144	Continued From page 12 increases the risk of death or injury due to fire. The deficiency affected one (1) of two (2) emergency generators which provides all emergency power to the facility.	K 144	committee and then as needed thereafter.	