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	11/07/2011

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 a dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000	**General Disclaimer** 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 Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	
K 038 SS=F	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 width of corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes must be maintained. The facility failed to maintain clear and unobstructed exit corridors. Observation determined the exit corridor width was obstructed by two chairs and a couch by the Day Room, two lamp tables by Activities, and a chair and a med cart by the Northeast Nurses Station.	K 038	**K 038 Maintain clear and unobstructed exit corridors.** **This is how we corrected the problem that was found.** The two chairs and couch by the Day Room on the 100 wing were moved so not to obstruct the exit corridor. The two lamp tables by the activities were removed and will not be allowed to be returned. The chair by the Northeast Nurse Station was removed and will not be allowed to be returned (The facility refers to this area as the	
K 074	NFPA 101 LIFE SAFETY CODE STANDARD	K 074		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mark D Nordby — TITLE: Administrator — (X6) DATE: 11-28-2011

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

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 _____	11/07/2011

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 074 SS=D	Continued From page 1 Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: The facility failed to ensure that loosely hanging fabrics were flame resistant. Review of documentation determined the lack of flame resistant documentation for the quilt that was hung on the east wall of Office 513.	K 074	West Nurse Station). The med cart will be stored in the West Nurse Station when not being used. All changes were completed by 11-23-11. **This is what the facility will do to identify and correct any problems found in other areas.** All other exit corridors were checked by the Environmental Services Supervisor to make sure staff have not placed any obstructions. Problems were corrected immediately. Completed by 11-30-11 **This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.** The Environmental Services Supervisor has educated all Department Supervisors on the need to keep exit corridors free of any obstructions. The Department Supervisors will be responsible to keep their areas in compliance. Completed by 12-6-11 **This plan of correction is continued on the attached sheet of paper. This attachment includes the plan of correction for K 074**	

Continued from CMS form 2567 dated 11-07-11

This is how the facility will monitor to make sure the changes continue and the problem is prevented.
The Environmental Services Supervisor/Designee will complete an audit of all exit corridors one time per week looking for any obstructions. Problems will be corrected immediately and the appropriate Department Supervisor will be notified so follow up can be completed within the department. Weekly audits will continue and a monthly report will be submitted to the Continuous Quality Improvement (CQI) committee. The CQI committee will follow up as needed. This process will continue for 90 days and then as directed by the CQI committee. Completed by 12-22-11.

K 074 Loosely hanging fabrics must be flame resistant.

This is what the facility will do to correct the specific problems found.
The quilt wall hanging located on the east wall outside of office 513 was removed. Completed 11-8-11

This is what the facility will do to identify and correct any problems found in other areas.
The Environmental Services Supervisor completed a walk through to make sure any other cloth wall hanging was treated to make it flame resistant. If there was no tag identifying the flame resistant treatment and date of the treatment the item was removed. Completed by 11-30-11.

This is what the facility will do or changes it will make to the systems that will prevent this problem from reoccurring in the future.
The Environmental Services Supervisor educated all Department Supervisors on the need to treat any cloth wall hanging to make it flame resistant. The education also included the need to label the item with: name of product used to treat the item, date item was treated and the name of the staff completing the treatment. The Department Supervisors will be responsible to make sure all fabric items in their areas are appropriately treated and labeled. Completed by 11-30-11

The Environmental Services Supervisor treated the quilt that was hung on the east wall of Office 513 and labeled the treatment on the back of the quilt. The other items were identified as needing treatment or labeling were treated, labeled and returned to their original placement. Completed by 12-7-11

This is how the facility will monitor to make sure the changes continue and the problem is prevented.
The Environmental Services Supervisor/Designee will complete a walk through audit of all resident areas once per week looking for any unlabeled/untreated fabrics. Problems will be corrected immediately and the appropriate Department Supervisor will be notified so follow up can be completed within the department. Weekly audits will continue and a monthly report will be submitted to the Continuous Quality Improvement (CQI) committee. The CQI committee will follow up as needed. This process will continue for 90 days and then as directed by the CQI committee. Completed by 12-22-11.

Mark D Hoeper Administrator 11-28-2011