EPARTMENT OF HEALTH AND HUMAN SERVICES
ENTERS FOR MEDICARE & MEDICAID SERVICES

ITEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355093	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/24/2014

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OOD SAMARITAN SOCIETY - BOTTINEAU	725 E 10TH ST BOTTINEAU, ND 58318

(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 standards. The facility was located in a one-story building of Type V (000) construction that was protected by a wet automatic fire sprinkler system designed in accordance with the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems.	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 allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	
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 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 separate hazardous areas from other spaces with smoke resisting partitions and self-closing and latching door assemblies. Observation determined: 1) The door to the Southeast Wing Soiled Utility Room did not self-close and latch into the door	K 029	constitutes the center's allegation K029 Part 1and 2 1. We adjusted the door closures so that they shut into the door frame on July 3rd, 2014. 2. We will check all doors in the facility for positive latch into door frame on July 7th, 2014. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
J. Hanson	Administrator	7-17-14

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

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K 029	Continued From page 1 frame. 2) The door to the Southwest Wing Soiled Utility Room did not self-close and latch into the door frame. 3) The door to the Southeast Wing Linen Room (exceeding fifty (50) sq feet with a combustible load) did not have a self-closing device. 4) The door to the Southwest Wing Linen Room (exceeding fifty (50) sq feet with a combustible load) did not have a self-closing device. 5) The door Storage Room 101 (exceeding fifty (50) sq feet with a combustible load) did not have a self-closing device. The deficiency affected five (5) of eighteen (18) hazardous areas.	K 029	assurance committee for further recommendations. 5. August 8th, 2014 K 029 Parts 3, 4, and 5 1. We ordered door closures on July 3rd, 2014, so that we will comply with K 029, regarding self-closing devices in hazardous areas. 2. We will check all hazardous areas for self-closing devices on doors. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality assurance committee for further recommendations. 5. August 8th, 2014 K 056 Part 1 1. We removed the closet in the front vestibule on June 30th, 2014. 2. All areas of the facility have sufficient sprinkler coverage.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		

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K 056	Continued From page 2 This STANDARD is not met as evidenced by: Automatic fire sprinkler systems must be installed in accordance with NFPA 13. The facility failed to install the automatic sprinkler system in accordance with NFPA 13 to provide adequate coverage for all portions of the building. Observation determined: 1) The closet in the Main Entrance Vestibule lacked adequate sprinkler coverage. 2) The Main Entrance Vestibule had a sprinkler that was located 39 inches from the ceiling. The deficiency affected two (2) of numerous areas in the facility.	K 056	3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality assurance committee for further recommendations. 5. June 30th, 2014 K 056 Part 2 1. The ceiling was constructed on July 3rd, 2014, in order to comply with K 056 regarding adequate sprinkler coverage.	
K 062 SS=F	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 a reliable operating condition as required by NFPA 25, Standard for the Inspection, Testing and Maintenance of Water-based Fire Protection Systems. On 6/24/14, no record of the required annual	K 062	2. All areas of the facility have sufficient sprinkler coverage. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality assurance committee for further recommendations.	

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K 062	Continued From page 3 back flow preventer test was available. The deficiency affected one (1) of numerous required tests of the automatic sprinkler system. Ref: 2000 NFPA 101 Section 19.3.5.1, 9.7.5, 1998 NFPA 25 Section 9-6.2	K 062	5. July 3rd, 2014 K062 1. On July 1st, 2014, the facility notified Viking Sprinkler in order to communicate to them that they need to test the back-flow preventer on an annual basis. Viking Sprinkler Verbally agreed to check the preventer annually. The date has yet to be determined, but it will be completed by August 8th, 2014. 2. We have one back flow preventer, thus we do not need to identify other portions of the facility. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality assurance committee for further recommendations. 5. August 8th, 2014 K 076 Part 1 1. The oxygen will be moved to the North oxygen storage room and will have	
K 076 SS=E	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: The facility failed to ensure nonflammable medical gas equipment and systems were in compliance with NFPA 99. Observation determined: 1) Combustible plastic tubing and supplies were stored closer than five (5) feet from the oxygen cylinders in the north Oxygen Storage Room. 2) Combustible plastic tubing and supplies were stored closer than five (5) feet from the oxygen	K 076		

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K 076	Continued From page 4 cylinders in the south Oxygen Storage Room. 3) The south Oxygen Storage Room contained fifty (50) 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. The deficiency affected two (2) of three (3) smoke compartments. Ref: 2000 NFPA 101 Section 19.3.2.4; 1999 NFPA 99 Section 16-3.8.1, 8-3.1.11.2(c)2, 8-3.1.11.2(f)	K 076	a one hour separation, vented to the exterior, and all supplies will be removed. 2. We only have one oxygen storage room. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of the audits will be reported to the quality assurance committee for further recommendations. 5. August 8th, 2014 K 076 Part 2 and 3 1. We removed all oxygen tanks from the South oxygen storage room and placed in the North oxygen Storage room. 2. We only have one oxygen storage room. 3. Education will be completed for maintenance staff on July 18th, 2014. 4. A focus audit will be created. The audit will be completed by the Environmental Service Director or designee weekly for four weeks, then monthly for two months. The results of	