DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355104	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - LAKOTA	608 4TH AVE SW LAKOTA, ND 58344

(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 of Type III (211) construction with a wet/dry automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems.	K 000		
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 ensure doors to hazardous areas in fully sprinklered existing health care occupancies were equipped with self-closing/automatic latching hardware. Observation determined: 1) The west leaf of the Garage corridor doors did	K 029	K 029 1. To be compliant automatic door closers and latching hardware will be added to the west leaf of the garage corridor doors, the east leaf of the 100-wing linen storage room corridor doors, and the west leaf of the 300-wing linen storage room. 2. All hazardous area doors in the facility were surveyed and no other existing doors were identified as deficient. 3. All proposed building modifications will be coordinated in advance with the ND Dept. of Health Division of Life Safety and Construction as well as the Good Samaritan Society; Construction / Design / Environmental Services department to ensure compliance with all applicable NFPA codes. 4. Utilizing ND Dept. of Health and Good Samaritan Society construction departments as noted in item 3 above prior to facility modifications will help ensure code compliance and eliminate future deficiencies. Completion of this project will be reported to QAPI.	1-16-2015

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

Jean Buchman | Administrator | 12-16-14

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.

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K 029	Continued From page 1 not have self-closing/automatic latching hardware. 2) The east leaf of the 100 Wing Linen Storage Room corridor doors did not have self-closing/automatic latching hardware. 3) The west leaf of the 300 Wing Linen Storage Room corridor doors did not have self-closing/automatic latching hardware. Failure to ensure doors to hazardous areas self-close and latch to the door frame increases the risk or death or injury due to fire. The deficiency affected three (3) of nineteen (19) hazardous areas in the facility.	K 029		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: A functional test must be conducted on every required emergency lighting system at 30-day intervals for a minimum of 30 seconds. An annual test must be conducted for 1 1/2-hour duration. Written records of testing must be kept by the owner for inspection by the authority having jurisdiction. Review of records indicated the facility failed to conduct monthly thirty (30) second tests on emergency battery pack lights in the past twelve (12) months.	K 046	K 046 1. Monthly and annual tests of emergency lighting will be added to the monthly and annual Preventative Maintenance (PM) schedule. This will be done in TELS. our automated PM tracking system. The testing procedure will also be documented in TELS. Additionally, we will set up a folder to document and track individual emergency light tests. The Dec, 2014 and the 2014 annual tests will be completed during a survey of the facility to identify and mark the locations test procedures will be validated and all maintenance staff will be trained on these procedures during the survey. On completion of this survey, we will set up an Emergency Lighting Test Folder. 2. A complete survey of the facility will be conducted and the location of all emergency lighting will be marked on a facility floor plan. 3. Placing the monthly and annual test requirement in TELS and establishing an Emergency Lighting Test Folder will ensure all current emergency lights and any required. 4. Adding the PM tasks in TELS will provide the necessary reminders and tracking for this task. In addition this task will be added to our training task list. Completed tasks will be reported to QAPI.	1-14-2015

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K 046	Continued From page 2 Failure to provide emergency lighting as required increases the risk of death or injury due to fire. The deficiency affected all emergency battery back-up lights throughout the building.	K 046		
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined the facility failed to conduct an AM Shift fire drill during the second quarter of 2014. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected one (1) of twelve (12) drills in the past year.	K 050	K 050 1. This past performance cannot be corrected; however, item 3 below addresses the way forward to prevent a recurrence. 2. No other areas of the physical facility are affected by this deficiency. 3. To eliminate this deficiency in the future, a GSS Form 405 review checklist will be developed and included in the Fire Safety Binder and placed in the Charge Nurses area. Additionally, training will be conducted for all Charge Nurses to ensure they are completing the forms correctly. In the future, when the GSS Form 405 is completed by the Charge Nurse, it will be forwarded to Environmental Services for a second review, again using the local GSS 405 review checklist. If any errors or discrepancies are noted the GSS 405 will be returned to the Charge nurse for correction. Once the Environmental Services review is completed the form will be forwarded to the Administrator for review and signature. 4. Utilization of the GSS 405 review checklist, the three-level review process, and the quarterly PM schedule will help ensure this deficiency does not recur, and reports will be submitted to QAPI. 1-16-2015	
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	K 052	K 052 1. The past performance cannot be corrected. 2. There is no other fire alarm system in the facility; this deficiency does not exist anywhere else.	

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K 052	Continued From page 3 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: The facility failed to test the fire alarm system as required. Review of fire alarm system test records indicated the semiannual load voltage tests of the sealed lead acid batteries were not performed as required by NFPA 72, National Fire Alarm Code. Load voltage tests were conducted annually with the last test performed on 01/20/2014. Failure to test and maintain the fire alarm system as required increases the risk of death or injury due to fire. The deficiency affected one (1) of two (2) required load voltage tests of the batteries in the last year. The fire alarm system serves the entire facility. Ref: 2000 NFPA 101 Section 19.3.4.1, 9.6.1.4; 1999 NFPA 72 table 7-3.2 item 6.d.3.	K 052	3. The fire alarm system's next lead acid batter test is scheduled for Jan 2015 (date to be determined). The Jan 2015 test will be conducted by Nardini Fire Equipment Company. They were contacted on Dec 12, 2014 to confirm that this facility is on their schedule; they set their Jan 2015 schedule during the 3rd week of Dec. When the actual test date is scheduled we will also schedule a semiannual battery test for July 2014. Additionally, a semiannual Preventative Maintenance task will be added to TELS, our automated Preventative Maintenance (PM) tracking system. 4. By updating our contract with Nardini Fire Equipment Company and adding the semiannual task into our automated PM tracking system we will ensure that this deficiency does not recur and reports will be submitted to QAPI. 1-16-2015	
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved,	K 054	K 054 1. We will hire an electrician to move the ceilings fans. This will ensure that the appropriate smoke detector coverage and separation is maintained while keeping the ceiling fans. 2. All ceiling fan/smoke detector separation was reviewed with the state surveyor during this survey and no other units were deficient.	

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K 054	Continued From page 4 maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm Code. 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 1) Observation determined that the north smoke detector in the Commons Area was located approximately one (1) foot from the ceiling fan. 2) Observation determined that the north east and north west smoke detectors in the Dining Room were located approximately two (2) feet from the ceiling fan. This deficiency affected three (3) of numerous smoke detectors in the facility.	K 054	3. All proposed building modifications will be coordinated in advance with the ND Dept. of Health Division of Life Safety and Construction as well as the Good Samaritan Society; Construction / Design / Environmental Services department to ensure compliance with all applicable NFPA codes. 4. Utilizing ND Dept. of Health and Good Samaritan Society construction departments as noted in item 3 above prior to facility modifications will help ensure code compliance and eliminate future deficiencies. Project completion will be reported to QAPI.	1-15-2015
K 056 SS=D	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	K 056	K 056 1. Proper sprinkler coverage will be added. We will contact our current contractor and get a proposal for adding the necessary number of sprinkler heads into the storage room to ensure adequate coverage.	

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K 056	Continued From page 5 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 This STANDARD is not met as evidenced by: Automatic fire sprinkler systems must be installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. 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 the east side of the Storage Room located west of the Sprinkler Riser Room lacked adequate sprinkler coverage. Failure to install the automatic sprinkler system in accordance with NFPA 13 increases the risk of injury and death due to fire. The deficiency affected one (1) of numerous areas in the facility.	K 056	2. All facility rooms and storage areas were visited / observed by the state surveyor during this survey and no others were found to be deficient. 3. All proposed building modifications will be coordinated in advance with the ND Dept. of Health Division of Life Safety and Construction as well as the Good Samaritan Society; Construction / Design / Environmental Services department to ensure any future building modifications are in compliance with all applicable NFPA codes. 4. Utilizing ND Dept. of Health and Good Samaritan Society construction departments as noted in item 3 above prior to facility modifications will ensure code compliance and eliminate future deficiencies. Project completion will be reported to QAPI.	1-16-2015
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	K 076	K 076 1. To be compliant with NFPA and CMS guidance we will eliminate our single oxygen storage location and store our operational supply of oxygen in quantities of less than 300 cubic feet in each of our three resident wings and the fourth in our service area. Each of these areas is a separate four smoke compartment. The oxygen will be stored on carts that hold only 12 size-E cylinders (less than 300 cubic feet total.) This procedure complies with CMS S&C Memo 07-10 dated Jan 12, 2007. 2. There is only one oxygen storage room; no other areas of the facility are at risk for this deficient practice. 3. The following measures will be put in place to ensure this deficient practice does not recur: a. We will purchase oxygen supply storage carts that will hold only 12 size-E cylinders ensuring that we do	

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K 076	Continued From page 6 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. In oxygen storage rooms containing more than 300 cu. ft. of compressed gas, all electrical wall fixtures must be located at least five (5) feet above the floor. Observation determined the Oxygen Storage Room contained sixty (60) 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. This deficiency affected one (1) of four (4) smoke compartments in the facility. Ref: 2000 NFPA 101 Section 19.3.2.4; 1999 NFPA 99 Section 16-3.8.1, 8-3.1.11.2(f), 4-3.1.1.2(c)11d	K 076	not exceed the 300 cubic foot limit per smoke compartment. b. Daily checks of the four smoke compartment oxygen storage carts will be conducted by maintenance staff to ensure no more than 12 cylinders are stored in any one zone. c. Maintenance staff will ensure that all empty oxygen cylinders are collected and moved to smoke compartment four for all new cylinder deliveries, and return filled cylinders to each smoke compartment ensuring no more than 12 cylinders are stored in each area. d. All current nursing and maintenance staff will be trained on this new procedure. e. This procedure will be added to our facility training to ensure new staff are trained. 4. Monitoring will be accomplished through the daily maintenance staff checks of the operational oxygen supply carts. This daily check will be added to our daily checklist. Copies of the checklist will be ssubmitted to QAPI on a quarterly basis. 1-16-2015	
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.	K 144	K 0144 1. The remote stop switch for the generator is currently located inside the generator room. It will be moved outside of the room on the external building wall. 2. There is only one generator for this facility; there are no other portions of the facility where this deficiency could exist.	

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K 144	Continued From page 7 This STANDARD is not met as evidenced by: The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. 1) All Level 1 and Level 2 installations of an emergency generator shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover, where so installed, or located elsewhere on the premises where the prime mover is located outside the building. For Level 1 and Level 2 systems located outdoors, the manual shutdown should be located external to the weatherproof enclosure and should be appropriately identified. NFPA 110. Observation determined there was no remote stop switch for the generator located outside of the generator room. 2) Record review determined the specific gravity of the emergency generator battery was not checked at seven (7) day intervals as required. 3) Review of generator test records could not verify that monthly 30-minute load tests were conducted in the past twelve (12) months. Failure to inspect and maintain the emergency generators in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury	K 144	3. There is only one generator for this facility, however should a new/additional generator be installed all proposed modifications/construction will be coordinated in advance with the ND Dept. of Health Division of Life Safety and Construction as well as the Good Samaritan. Society; Construction / Design / Environmental Services department to ensure compliance with all applicable NFPA codes. 4. Coordinating any modifications/additions as discussed in item 3 above will ensure this deficiency does not recur. Completion of the project will be reported to QAPI.	1-16-2015

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K 144	Continued From page 8 due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 144	K 144 continued 6. Previous records of specific gravity tests cannot be recreated; however the tests will be conducted and documented weekly starting with the Dec 15, 2014 weekly checks. 7. There is only one generator for this facility; there are no other portions of the facility where this deficiency could exist. 8. All maintenance personnel will be trained and the tests will be conducted weekly and documented on the GSS Form 630A. The specific gravity test procedures will be added to the generator book. 9. Once all personnel are trained and the forms completed correctly this deficient practice will not recur. 1-16-2015 10. The generator is run every week and the problem here is with the documentation. The forms were being filled out incorrectly due to a training problem. In the future we will establish a monthly (not weekly) test run schedule. 11. There is only one generator for this facility; there are no other portions of the facility where this deficiency could exist. 12. All maintenance personnel will be trained on the proper completion of the GSS 608B. A sample form with explanations on its proper completion will be added to the book also. 13. Once all personnel are trained and the forms completed correctly this deficient practice will not recur. 1-16-2015	