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

PRINTED: 02/27/2015
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
	355099	A. BUILDING 01 - MAIN BUILDING 01 B. WING	02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOTT	401 MILLIONAIRE AVE MOTT, ND 58646

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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. This facility was located in a one-story building of Type V (000) construction. The building was protected with one wet and one dry automatic sprinkler system designed to meet the requirements 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 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 018 SS=F	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	1) K 018-The corrective action that will be accomplished is that automatic latching hardware will be installed on the linen storage doors on Wings 100, 200 and 300 that is suitable for keeping the doors closed and resistant to the passage of smoke. 2) A visual inspection of the facility was completed by the maintenance supervisor on 2/24/2015 and there were no other areas identified as not meeting this standard.	3/20/15

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Administrator — 3-9-2015

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

emailed

3-9-15

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K 018	Continued From page 1 This STANDARD is not met as evidenced by: The facility failed to ensure corridor doors were equipped with automatic latching hardware suitable for keeping the door closed and resistant to the passage of smoke. Observation determined: 1) The 100 Wing Linen Storage Room corridor double doors did not have automatic latching hardware. 2) The 200 Wing Linen Storage Room corridor double doors did not have automatic latching hardware. 3) The 300 Wing Linen Storage Room corridor double doors did not have automatic latching hardware. Failure to ensure corridor doors are provided with suitable means for keeping the door closed increases the risk for death or injury due to fire. This deficiency affected six (6) of numerous corridor doors in the facility.	K 018	3) The deficient practice will not recur once the hardware is installed since there are no similarly affected areas. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that the correction has been completed. 1) K 052-The corrective action accomplished is that the fire alarm testing company contracted by the facility to perform the facility's annual inspection of the fire alarm system has been contacted and scheduled to complete the missed inspection of the fire alarm system by 3/10/2015. 2) The entire facility has been identified to be affected by not meeting this standard. There are no other alarm systems in this building. 3) The measures put into place to ensure that the practice will not recur is that the maintenance supervisor and administrator have reviewed information in NFPA 72 to ensure frequency, methods used and tests are done appropriately. The fire alarm system inspection task will be included in the	3/20/15
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		

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: The facility failed to test and maintain the fire alarm system as required by NFPA 72, National Fire Alarm Code. Review of fire alarm system test records indicated the last annual test of the fire alarm system was conducted on 08/15/2013, exceeding the required annual testing requirement. 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 one (1) fire alarm system. The fire alarm system serves the entire facility.	K 052	facility's maintenance plan listed within the facility's management software system. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that the fire alarm system test has been completed.	
K 054 SS=F	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: Sensitivity testing of smoke detectors is to be completed for all smoke detectors during the first year in service, and the alternate year following. After the second required calibration test, if the detector has remained within its listed and marked sensitivity range, the length of time	K 054		

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K 054	Continued From page 3 between calibration tests may be extended, not to exceed five years. The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with the manufacturer's specifications. Review of the fire alarm test results indicated the smoke detection system did not have sensitivity testing at frequencies in compliance with the minimum requirements of NFPA 72. On 02/23/2015, test records indicated the smoke detectors had not been tested for sensitivity since 10/13/2011. The only smoke detector sensitivity test the facility had on record prior to the 10/13/2011 test was conducted on 07/28/2009. The smoke detector sensitivity test results were not adequate to determine the use of the five-year interval. The two-year interval required smoke detector sensitivity testing in October 2013. Failure to maintain smoke detectors as required increases the risk of death or injury due to fire. This deficiency affected the entire building.	K 054	1) K 054-The corrective action accomplished is that the fire alarm testing company contracted by the facility to perform the facility's smoke detector sensitivity testing has been contacted and is scheduled to complete the missed testing by 3/10/2015. 2) The entire facility has been identified to be affected by not meeting this standard. There are no other alarm systems in this building. 3) The measures put into place to ensure that the practice will not recur is that the maintenance supervisor and administrator have reviewed information in NFPA 72 to ensure frequency, methods used and tests are done appropriately. The smoke detector sensitivity testing task will be included in the facility's maintenance plan listed within the facility's management software system. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that the smoke detector sensitivity testing has been completed.	3/20/15
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:	K 062		

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K 062	Continued From page 4 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. Observation determined: 1) Two (2) sprinklers at the Nurses Station were obstructed by a temporary construction barrier. 2) Two (2) sprinklers in the Computer Office were closer than the minimum of six feet apart. Failure to inspect, test and maintain the automatic sprinkler system in accordance with NFPA 25 increases the risk of death or injury due to fire. The deficiency affected two (2) of numerous areas in the facility.	K 062	1) K 062-The corrective action that was accomplished is that a) the temporary construction barrier at the Nurses Station has been removed and b) a panel has been placed between the two sprinkler heads in the Computer Office to prevent cross-contact of water between the two sprinkler heads that are closer than the minimum of six feet apart. 2) A visual inspection of the facility was completed by the maintenance supervisor on 2/24/2015 and there were no other areas identified as not meeting this standard.	3/6/15
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: The facility failed to inspect fire extinguishers in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Observation determined five (5) portable fire extinguishers in the 300 Wing had not been	K 064	3) The deficient practice will not recur since this panel has been installed and there are no similarly affected areas. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that the correction has been completed.	

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K 064	Continued From page 5 inspected during September 2014. Failure to ensure portable fire extinguishers comply with NFPA 10 increases the risk of death or injury due to fire. The deficiency affected five (5) of numerous portable fire extinguishers in the facility.	K 064	1) K 064-The corrective action that was accomplished is that all five (5) portable fire extinguishers in the 300 Wing have been examined and confirmed as being tested appropriately as of the survey date of 2/23/2015. Personnel testing the fire extinguishers in September 2014 forgot to sign the five (5) tags attached to the fire extinguishers indicating that the test had in-fact been done. 2) A visual inspection of the other portable fire extinguishers in the facility was completed by the maintenance supervisor on 2/24/2015 and there were no other areas identified as not meeting this standard. 3) The measures put into place to insure the practice will not recur is that the fire extinguisher inspection task will be included in the facility's maintenance plan listed within the facility's management software system to remind facility personnel responsible for fire extinguisher compliance testing to sign the fire extinguisher tag when the required inspection was completed.	3/6/15
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Fire extinguishing systems for commercial cooking operations must meet NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. NFPA 96 requires an inspection and servicing of the fire-extinguishing system be made at least every 6 months by properly trained and qualified persons. The facility failed to inspect and service the fire-extinguishing system as required by NFPA 96. Records review indicated: 1) Hazards under the range hood were not properly covered. 2) The electrical appliances under the range hood did not shut off when the extinguishing system was tested. 3) The kitchen hood extinguishing system did not activate the fire alarm system.	K 069		

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K 069	Continued From page 6 Failure to inspect and service the fire extinguishing system in accordance with NFPA 96 increases the risk of death or injury due to fire. This deficiency affected one (1) of one (1) fire extinguishing system for commercial cooking operations in the building.	K 069	4) The facility will monitor its corrective action by having the maintenance supervisor or designee audit monthly x 3 that fire extinguishers have tested and each tag has been signed. Results will be reported to the Quality Assurance/Performance Improvement team's monthly meetings with corrective action implemented.	
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: The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. 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	K 144	1) K 069-The corrective action accomplished is that the fire equipment testing company contracted by the facility to inspect and service the fire extinguishing system for commercial cooking operations has been contacted and is scheduled to inspect and service the equipment by 3/30/2015. The following will be corrected: a) that the hazards under the range hood are properly covered, b) that the electric appliances under the range hood shut down upon activation of the ANSUL system and c) that the kitchen hood extinguishing system activates the fire alarm system. 2) The facility has no other areas having a fire extinguishing system for cooking operations so no other areas are affected.	3/30/15

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K 144	Continued From page 7 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. Failure to ensure the emergency generator is in compliance with NFPA 110, Standard for Emergency and Standby Power Systems, increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all emergency power to the facility.	K 144	3) Measures put into place to ensure the practice will not recur is that the kitchen fire extinguishing system task will be included in the facility's maintenance plan listed within the facility's management software system. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that all three areas needing correction have been completed. 1) K 144-The corrective action that will be accomplished is that a remote manual stop station will be installed and appropriately identified outside the room housing the emergency generator. 2 & 3) The facility has only this one emergency generator so once the remote stop switch has been installed the deficient practice will not recur. 4) The facility will monitor its corrective action by having the maintenance supervisor or designee report to the Quality Assurance/Performance Improvement team's March 2015 meeting that the correction has been completed.	3/30/15