STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355095	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - OAKES	213 N 9TH ST OAKES, ND 58474

(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 non compliance with these standards. The facility is located in a one-story building of Type V (000) construction that is protected by a dry automatic fire 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 separate hazardous areas from other spaces with smoke resisting partitions and self-closing door assemblies. Observation determined: 1) The self-closing device on the door to the 700 Wing Housekeeping Storage Room was	K 029	1. a) A self closing device on the door to the 700 Wing Housekeeping room will be replaced. b) The Activity storage room will be adjusted to the latched position. c) The hole in the South wall behind the gas dryers in the Laundry room will be repaired. 2. a-b) The storage areas with closures will be checked to make sure they close and latch properly. c) Facility audit will be done to assure one hour fire rated construction in hazard areas. 3. We will do facility audits monthly three times, quarterly once, then as deemed necessary by the QA Coordinator to make sure this will not happen again. 4. Audits will be reviewed by the QA Coordinator or designee for separate hazard areas and other spaces with re-setting partitions and self-closing door assemblies.	08/09/2013

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

David Carda | Administrator | 7-17-13

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 disconnected and the door would not self-close to the latched position. 2) The door to the Activities Storage Room would not self-close to the latched position. 3) There was a four (4) inch by twenty four (24) inch hole in the south wall behind the gas dryers in the Laundry Room.	K 029	5. The Plan of Correction will be completed by August 9, 2013.	
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: The facility failed to ensure smoke detectors were maintained, inspected and tested in accordance with NFPA 72, National Fire Alarm Code. Review of the fire alarm test results indicated the smoke detection system was not sensitivity tested at frequencies in compliance with the minimum requirements of NFPA 72. If the smoke detection system does not meet the allowance for five (5) years between testing, the system must be tested at least every two (2) years. The test records indicated the smoke detectors have not been tested for sensitivity since 2009. The only smoke detector sensitivity test the facility had on record was done in 2009. The smoke detector sensitivity test results were not adequate to determine the use of the five-year	K 054	1. The Facility will contact vendor to do a sensitivity test annually to meet NFPA 72, National Fire Alarm Code. 2. This practice will affect the whole Facility but will be corrected when completed. 3. We will conduct this sensitivity testing annually per requirements, then after per compliance with requirements of NFPA 72 with a vendor contract. 4. QA Coordinator or designee will do an audit yearly since it is already being done yearly. 5. The Plan of Correction will be completed by August 9, 2013.	08/09/2013

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K 054	Continued From page 2 interval. The two-year interval required smoke detector sensitivity testing in 2011.	K 054		
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 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) The ceiling in the Social Services Office closet had a hole. The hole in the ceiling would allow heat to rise above the sprinklers and delay activation. 2) The escutcheon plate was missing on the sprinkler in the sleeping area of Resident Room 501.	K 062	1. a) The hole in the ceiling in the Social Services Office closet will be fixed so the sprinkler system will operate correctly. b) The escutcheon plate will be placed in resident Room 501. 2. The entire facility has a potential to be affected by this deficiency. 3. A facility walk through will be completed to see if other areas are affected by this deficiency. 4. An audit will be done by QA Coordinator or designee for holes in ceiling or escutcheon plates that may need to be corrected. The sprinkler head audit will be done monthly one time, then quarterly two times, then as deemed necessary by the QA Coordinator. 5. The Plan of Correction will be completed by August 9, 2013.	08/09/2013
K 130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Transfer switches must be subjected to a	K 130	1. Documentation will be done quarterly regarding checking and maintaining emergency generator's electrical transfer switch. 2. This deficiency doesn't affect other portions of the Facility. 3. Audits will be done by the QA Coordinator or designee by collecting evidence	08/09/2013

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K 130	Continued From page 3 maintenance program including connections, inspection or testing for evidence of overheating and excessive contact erosion, removal of dust and dirt, and replacement of contacts when required. NFPA 110, Standard for Emergency and Standby Power Systems. Based on record review, the facility failed to provide evidence of the quarterly check and maintenance of the emergency generator electrical transfer switch during the 4th quarter of 2012.	K 130	quarterly regarding checking maintenance of the emergency generator electrical transfer switch. 4. Audit will be done quarterly two times to assure documentation of this deficiency is corrected or done. Audits will be submitted to the QA Committee, then done as often as deemed necessary by the QA Committee. 5. The Plan of Correction will be completed by August 9, 2013.	
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) The facility failed to inspect the emergency generator on a weekly and monthly basis. Review of generator test records identified the lack of documentation of weekly and monthly inspections from July 2012 through December 2012. 2) The facility failed to exercise the emergency generator on a monthly basis.	K 144	1. The emergency generator documentation will be done on a monthly basis under load for thirty minutes. 2. This doesn't affect other portions of the Facility. 3. Audits will be done by QA Coordinator or designee to see if documentation was completed when the emergency generator was tested for 30 minutes. 4. Audits will be done monthly for three months, then done quarterly or as deemed necessary by the QA Committee. The QA Coordinator or designee will complete the audit. 5. This plan of correction will be completed by August 9, 2013.	08/09/2013

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K 144	Continued From page 4 Review of generator test records could not verify the emergency generator was being exercised under load for 30 minutes monthly from July 2012 through December 2012.	K 144		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: The facility failed to ensure electrical wiring and electrical equipment met NFPA 70 requirements. Observation determined multiple power strips and extension cords located throughout the facility were used in place of permanent wiring.	K 147	1. Power strips and extension cords will not be used for permanent wiring so we meet NFPA 70 National Electrical Code 9.1.2. 2. The entire Facility has potential to be affected by this deficient practice. 3. Facility-wide audit will be conducted to assure no other non-compliant use of power strips or no extension cords are used. 4. An audit will be done by QA Coordinator or designee to see that power strips and electrical cords are not being used as permanent wiring monthly three times, then quarterly once, then as deemed necessary by the QA Committee. 5. The plan of correction will be completed by August 9, 2013.	08/09/2013