

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments A recertification survey conducted on 10/08/2024 found Good Samaritan Society - Oakes in compliance with the requirements of 483.73 Long-Term Care Facilities Emergency Preparedness.			E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/18/2024

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.

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES				STREET ADDRESS, CITY, STATE, ZIP CODE 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			K 000			
K 293 SS=D	This survey used the 2012 edition of NFPA 101, Life Safety Code, Chapter 19-Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code in compliance with 42 CFR 483.70(a)(b). The findings that follow demonstrate noncompliance with these standards. The facility was located in a one-story building of Type V (000) construction with a dry automatic fire sprinkler system designed to meet the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. 7.10.1.2.1. The facility failed to ensure exits were marked by approved signage that was readily visible from any direction of exit access and that obviously and clearly identified the exit.			K 293	1. Maintenance put the light in for the two arrows on the hallway exit signage to illuminate so that it points towards the exit door. An exit sign was also placed in the middle of the exit door to show as an exit on 10/08/2024. 2. All residents have the potential to be affected by this deficient practice.		10/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

10/18/2024

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.

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 293	Continued From page 1 Observation determined no directional exit sign was provided on the east side of the west exterior exit door to identify the direction of travel to the exterior of the facility. Failure to provide exit signage as required increases the risk of death or injury due to fire. The deficiency affected exiting from one (1) of four (4) smoke compartments in the facility.	K 293	3. Education was provided by Administrator to maintenance to check the emergency lighting monthly per Tels schedule. 4. Administrator will audit the emergency lighting for 3 months to ensure following of the Tels schedule and compliance with emergency lighting exits. 5. This deficiency was corrected on 10/09/2024.	10/23/24	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and 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. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to conduct fire drills as required. Fire drill records review determined: 1) The December 2023, March, and August 2024 fire drills did not include the simulation of an emergency phone call to the fire department.	K 712	1. Administrator/Maintenance will conduct monthly fire drills as outlined in the Tels system to ensure proper compliance with first, second, and third shifts. 2. All residents have the potential to be affected by this deficient practice.		

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 712	Continued From page 2 2) No fire drill was conducted on the Night Shift during the fourth quarter in the past year. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected four (4) of twelve (12) drills in the past year.	K 712	3. Required fire drills will be completed by maintenance or designee to ensure proper fire drill schedule is being followed according to the Tels schedule. 4. Administrator will complete audits monthly x3 and review audits with the QAPI committee monthly to ensure compliance. 5. These deficiencies will be corrected by 11/01/2024.	10/23/24	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the	K 918			

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 918	Continued From page 3 components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to ensure the emergency generator was in compliance with NFPA 99, Health Care Facilities Code and NFPA 110, Standard for Emergency and Standby Power Systems. The EPSS shall be maintained to ensure to a reasonable degree that the system is capable of supplying service within the time specified for the type and for the time duration specified for the class. NFPA 110 8.3.1 Observation determined the emergency generator remote annunciator panel located at the West Nurses Station was indicating a trouble condition for low battery voltage and had not been corrected at the time of the survey. Failure to inspect, test and maintain the emergency generator in accordance with NFPA 99 and NFPA 110 increases the risk of death or injury due to fire. The deficiency affected one (1) of one (1) emergency generator which provides all	K 918	1. Maintenance will conduct weekly generator testing and inspections as required per the Tels system. 2. all residents have the potential to be affected by this deficient practice. 3. Maintenance called Cummins to replace the batteries for the generator on 10/08/2024. Cummins had been to the facility on 10/01/2024 for the annual servicing of the generator. Cummins returned on 10/23/2024 and replaced the batteries and now the annunciator panel does not show a trouble condition. Maintenance will check the voltage of the batteries with the weekly generator testing and report back to Administrator if batteries go below voltage or into trouble mode. 4. Maintenance will complete audits weekly x4 and monthly x2 and bring to the QAPI committee monthly for review.		

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

PRINTED: 10/25/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355095	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - OAKES			STREET ADDRESS, CITY, STATE, ZIP CODE 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 918	Continued From page 4 emergency power to the facility.	K 918	5.This deficiency will be corrected on 10/23/2024.		