STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355089	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	301 COUNTY RD 12B PARK RIVER, ND 58270

(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 requirements. The facility was located in a one-story building of Type V (000) construction with no basement. The building was protected with a 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 the provisions of Federal and State Law require it. For the purposes of any substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with NFPA 101, Life Safety Code, Chapter 19 Existing Health Care Occupancies in compliance with 42 CFR 483.70.	
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: The facility failed to ensure a complete two-hour fire rated wall assembly between the nursing home and the adjoining garage and senior living building. Observation determined the 90-minute fire rated door in the two-hour fire rated separation between the nursing home and the adjoining garage and senior living building was not latching into the door frame. Panic hardware was present on the fire door and the latch was dogged in the	K 011	1. The 90 minute fire rated door between the nursing home and the adjoining garage and the senior living building was repaired so it now latches. 2. All 90 minute fire rated doors will be checked to ensure they latch. 3. Monthly checking of 90 minute rated fire doors to ensure latching will be completed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joan Olson
TITLE: Administrator
(X6) DATE: 7-8-14

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.

emailed 7-10-14

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K 011	Continued From page 1 open position. The deficiency affected one (1) of one (1) two-hour fire rated occupancy separation.	K 011	4. Environmental Services or designee will audit 1 time monthly times 1 month. Quarterly times 2 quarters, then as deemed necessary by the QA and Safety Committee. 5.Completed July 24, 2014	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: The facility failed to ensure smoke barriers were at least one-half hour fire resistant and smoke resistant. Observation determined the 100 Wing smoke barrier had an unsealed data cable penetration on both sides in the attic space. The deficiency affected two (2) of four (4) smoke compartments.	K 025	1. 100 wing smoke barrier was sealed on 6-18-2014. 2. All spaces where data cable runs have been checked for penetrations and sealed with fir proof caulk. 3. Environmental Services Director or designee will inspect all areas when new data cables are installed. 4. Environmental Services Director or designee will audit 1 time then as deemed necessary by QA and Safety Committee. 5. Completed July 24, 2014	
K 029 SS=F	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	K 029		

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K 029	Continued From page 2 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 100 Wing Soiled Utility Room did not self-close and latch into the door frame. 2) The door to the 200 Wing Soiled Utility Room did not self-close and latch into the door frame. 3) The door to the 200 Wing Housekeeping Room did not self-close and latch into the door frame. 4) The door to the Soiled Laundry Room did not self-close and latch into the door frame. 5) The door to the Activity Storage Room did not self-close and latch into the door frame. 6) The east door to the Kitchen Storage Room was held open with a wooden wedge. 7) The door to the Maintenance Garage did not have a latch.	K 029	1. Doors to the 100 and 200 Wings Soiled Utility Rooms, 200 Wing Housekeeping Room, Soiled Laundry Room and Activity Storage Room have been adjusted so the latch into the door frame. Wooden wedge removed from Kitchen Storage Room Door. Latch installed on Maintenance Garage Door. 2. All doors that separate hazardous areas from other spaces have been checked and adjusted as appropriate. 3. Monthly Checking of Doors that separate hazardous areas from other spaces will be added to the Monthly check list. 4. Environmental Services Director or designee will audit 1 time monthly times 1 month, Quarterly times 2 quarters. Then as deemed necessary by the QA and Safety Committee. 5. Completed by July 24th.	

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K 029	Continued From page 3 The deficiency affected seven (7) of ten (10) hazardous areas.	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 an annual ninety (90) minute test on emergency battery pack lights. This deficiency affected all emergency battery back-up lights throughout the building.	K 046	1. All emergency battery pack lights have been tested for the required 90 minutes. 2. All battery pack lights have been checked for required 90 minute test. 3. Emergency Battery Pack testing has been added to the TELES program. 4. Environmental Service Director or designee will audit one time for 1 month then as deemed necessary by QA and Safety Committee. 5. Completed by 24, 2014	
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	1. Protection System did load voltage tests of the nickel-cadmium batteries on 4-9-2014 and will complete a second test before 10-9-14 to meet the semi annual requirement. 2. Protection System will complete voltage tests of the nickel cadmium batteries semi-annually.	

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K 052	Continued From page 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 nickel-cadmium batteries were not performed as required by NFPA 72, National Fire Alarm Code. The deficiency affected two (2) of two (2) required load voltage tests of the batteries in the last year.	K 052	3. Protection System will complete semiannual testing of the nickel cadmium batteries. 4. Environment Services or designee will audit 1 time monthly for 1 month, then 1 time semiannually then as deemed necessary by QA and Safety Committee. 5. Completed July 24, 2014	
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. Observation and record review determined: 1) There was no remote stop switch for the	K 144	1. Remote stop switch installed to the outside of the generator room. Specific gravity and water levels of the generator battery were checked. 2. Implemented usage of Generator Checklist GSS #630A. 3. Generator Checklist GSS #630A will be implemented. 4. Environment Services or designee will audit 1 time monthly times 2 months then 1time quarterly times 1 quarter, the as deemed necessary by QA and Safety Committee. 5. Completed July 24, 2014.	

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K 144	Continued From page 5 emergency generator located outside of the generator room. 2) The specific gravity and water levels of the emergency generator battery were not checked at 7 day intervals as required. The deficiency affected one (1) of one (1) emergency generator.	K 144		