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 _____	**05/16/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PARK RIVER	**301 SOUTH COUNTY ROAD 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		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. 19.3.6.3.2	K 018	1. Automatic latching hardware has been installed on the linen doors on the 100, 200, and 400 wings.	6/27/16

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

Electronically Signed | 05/27/2016

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K 018	Continued From page 1 The facility failed to ensure the corridor doors were provided with automatic latching hardware to keep the doors closed. Observation determined the following doors were not equipped with automatic latching hardware. 1) The south door leaf of the double doors to the Linen Closet in the 100 Wing. 2) The west door leaf of the double doors to the Linen Closet in the 200 Wing. 3) The south door leaf of the double doors to the Linen Closet in the 400 Wing. Failure to equip corridor doors with automatic latching hardware capable of keeping the door closed increases the risk of injury or death. This deficiency affected three (3) of numerous doors in the building.	K 018	2. All corridor doors have been checked to ensure proper closure. 3. The quarterly maintenance schedule will be revised to include checking for any penetrations in hazardous areas 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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: Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating	K 029	1. Penetrations in the ceiling on the Boiler Room were sealed with fire proof	6/27/16

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K 029	Continued From page 2 or shall be provided with an automatic extinguishing system. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. 19.3.2.1 The facility failed to ensure hazardous areas in fully sprinklered existing health care occupancies were separated from other spaces by smoke-resisting partitions. Observation determined there were multiple unsealed penetrations in the ceiling of the Boiler Room. Failure to ensure hazardous areas are separated from other spaces by smoke-resisting partitions increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous hazardous areas in the facility.	K 029	chalk. 2. All hazardous areas will be checked for penetrations. 3. The quarterly maintenance schedule will be revised to include checking for any penetrations in hazardous areas 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: The facility failed to ensure exit access was readily accessible at all times. Observation determined: 1) Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Delayed-egress locks shall be permitted, provided that not more than one such device is	K 038	1. Categorical waiver until July 5, 2016 for the north smoke compartment through the north exit enclosure. 2. Policy for Categorical waiver for north smoke compartment 3. Policy for Categorical waiver for north smoke compartment 4. Policy for Categorical waiver for north smoke compartment 5. Completed by June 6, 2016	6/27/16

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K 038	Continued From page 3 located in any egress path. 19.2.2.2.4(2) Observation determined egress from the north smoke compartment through the north exit enclosure required traveling through the cross corridor door in the north smoke compartment corridor that was equipped with a delayed-egress magnetic lock and through the north exit enclosure east door that was equipped with a delayed-egress magnetic lock. 2) Delayed-egress doors locked in the means of egress must display on the door adjacent to the releasing device visible signage in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads the following: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS 19.2.2.2.4(2), 7.2.1.6.1(d) All delayed-egress doors in the facility lacked visible signage on the door. 3) During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 inches into the required width of an aisle, corridor, passageway, or landing, when fully open. 7.2.1.4.4. Observation determined the corridor door to the Oxygen Storage Room opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened.	K 038	K038 1. Signage in letters not less than 1 high and not 1/8th in stroke width on a contrasting background reading Push until alarm sounds door can be opened in 15 seconds has been placed adjacent to all delayed egress locked doors. 2. The proper signs have been placed on all egress doors. 3. The quarterly maintenance schedule will be revised to include checking for proper signage on all egress doors. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis. 1. 180 degree swing automatic door closure has been installed on the Oxygen Storage Room. 2. All doors that open outward into the exit corridor have been checked for proper extension of no more than 7 inches from the wall when fully opened. 3. The quarterly maintenance schedule will be revised to include checking all doors that open outward in an egress area do not project more than 7 inches from the wall. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis.	

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K 038	Continued From page 4 Failure to maintain the means of egress to be available at all times increases the risk of death or injury due to fire. The deficiency affected egress from four (4) of four (4) smoke compartments in the facility.	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 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. 19.2.9.1, 7.9.3 Review of records indicated the facility failed to conduct monthly 30 second tests and annual 1 1/2-hour tests on emergency battery pack lights in the past year. 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	1. Monthly 30 second and annual 1 ¿ hour test on all emergency battery pack lights has been completed 2. All emergency battery pack lights have been checked. 3. Education provided on the importance of completing the test and documentation of the testing. 4. Environmental Services Director or designee will audit emergency battery pack documentation 1 time month times 3 months than as deemed necessary by QA and Safety Committee.	6/27/16
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures	K 050		6/27/16

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K 050	Continued From page 5 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Drills shall be conducted quarterly on each shift to familiarize facility personnel with the signals and emergency action required under varied conditions. 19.7.1.2 The facility failed to conduct fire drills as required. On 05/16/2016, fire drill records indicated the last four (4) fire drills for the AM shift occurred at 10:50, 10:30, 10:30 and 11:00 am and the last four (4) fire drills for the PM shift occurred at 3:55, 3:30, 3:22 and 3:35 pm. Fire drills are required to be conducted under varied conditions. The condition of the time of the day was not varied. Fire drills in the past year all occurred at times within 35 minutes of each other in an 8 hour shift. Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected eight (8) of twelve (12) drills in the past year.	K 050	1. The requirement of varied conditions for fire drills was reviewed. 2. Education on Life Safety Code requirements of varied conditions for fire drills given to those responsible for completing fire drills. 3. Administrator or designee will audit fire drills for varied conditions one x quarterly times 4 quarters. 4. Administrator or designee will audit fire drills for varied conditions one x quarterly times 4 quarters.	
K 054 SS=E	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	K 054		6/27/16

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K 054	Continued From page 6 This STANDARD is not met as evidenced by: Smoke detectors must not be located in a direct airflow nor closer than 3 ft. (1 m) from an air supply diffuser or return air opening. 19.3.4.5.1, 9.6.2.10.1, NFPA 72 2-3.5.1 The facility failed to ensure the smoke detection system was in compliance with NFPA 72, National Fire Alarm Code. Observation determined that ten (10) smoke detectors located throughout the facility were installed within three feet of an air supply diffuser. Failure to install the smoke detection system as required increases the risk of death or injury due to fire. This deficiency affected ten (10) of numerous smoke detectors in the facility.	K 054	1. Samson Electric relocated 14 smoke detectors to the proper distances of 3 feet or more of an air supply diffuser. 2. All areas where smoked detectors are located have been inspected for proper placements of 3 feet or more from air diffusers. 3. The quarterly maintenance schedule will be revised to include checking all smoke detectors for proper distance from air diffusors. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis.	
K 062 SS=F	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: Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 25, 1-11 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	K 062	1. a) Suspended ceiling in the IT closet was removed. All open areas of the original ceiling were fire proofed, smoke detector moved to proper distance from air diffuser and sprinkler placed at proper height. (b) The escutcheon plate has been placed on the sprinkler in the 200 Wing Mechanical Room. c) The sprinkler system gauge on the automatic sprinkler system has been replaced.	6/27/16

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K 062	Continued From page 7 Systems. Observation determined: 1) There were tiles missing from the suspended ceiling in the IT Closet in the Activity Room that may result in a delayed activation of the automatic fire sprinkler system. 2) There was an escutcheon plate missing on a sprinkler in the 200 Wing Mechanical Room. 3) Observation and record review determined one (1) of two (2) sprinkler system gauges on the automatic sprinkler system dated 2008 had not been replaced or calibrated within the last five (5) years. Failure to 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 the automatic sprinkler system which serves the entire facility.	K 062	2. (a) All areas have been checked for missing ceiling tiles. (b) All sprinkler heads have been checked for escutcheon plates. c) All sprinkler system gauges checked for replacement or calibrated within last five years. 3. The quarterly maintenance schedule will be revised to include checking for missing ceiling tiles in hazardous areas, checking all sprinkler heads have escutcheon plates, sprinkler system gauges checked for need of replacement or calibrated within last 5 years. 4. The quarterly maintenance schedule will be performed by maintenance personnel, monitored by the director of environmental services, and reported to the quality assurance committee on an annual basis.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: 1) A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. NFPA 99 3-4.1.1.15	K 144	1. Plans for installing a new generator to be installed June 29, 2016 to address the issue of a remote annunciator. (b) Generator was inspector and documentation done on May 22, 2016 (c)Plans to install new generator by June	6/27/16

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K 144	Continued From page 8 The facility failed to ensure the emergency generator was in compliance with NFPA 99, Standard for Health Care Facilities. Observation determined there was no remote annunciator located outside of the Generator Room at a work site readily observable by personnel. 2) Level 1 and Level 2 EPSSs, including all appurtenant components, shall be inspected weekly and shall be exercised under load at least monthly. NFPA 110 6-4.1 The facility failed to inspect the emergency generator on a weekly basis. Review of generator test records identified the lack of documentation of weekly inspections from 04/29/2016 through 05/16/2016. 3) Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes under normal operating temperature conditions. NFPA 110 6-4.2 The facility failed to ensure the emergency generator was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Review of generator test records could not verify that monthly 30-minute load tests were conducted as required. The hour meter records for the generator indicated that the total run time each month was 20 minutes which included the 5 minutes minimum cool-down time.	K 144	29, 2016 that will run for 30 minutes plus cool down (d) Interstate diesel has inspected the transfer switch. 2. Education given to maintenance on the need for testing on a weekly basis and the importance of documentation. 3. May 19, 2016 Education given to maintenance on the need for testing on a weekly basis and the importance of documentation. 4. The Environmental Services Director will audit documentation of generator 1 time monthly 3 months than as deemed necessary by QA and Safety Committee.	

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K 144	Continued From page 9 4) Transfer switches must be subjected to a 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 6-3.5 The facility failed to ensure the emergency generator transfer switch was in compliance with NFPA 110, Standard for Emergency and Standby Power Systems. Review of generator test records could not verify that annual transfer switch maintenance was conducted as required. Failure to ensure emergency generators and transfer switches are in compliance 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 and one (1) of one (1) transfer switch which provide all emergency power to the facility.	K 144		
K 146 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1 1/2 hour after loss of the normal source 3-6. (NFPA 99) This STANDARD is not met as evidenced by: The emergency system shall be so arranged that, in the event of failure of normal power source, the alternate source of power shall be automatically connected to the load within 10	K 146	1. Plans for installing a new generator June 29, 2016 to address the issue of power source automatically connecting to load within 10 seconds.	6/27/16

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K 146	Continued From page 10 seconds. NFPA 99, 3-6.3.1.2 The facility failed to provide an alternate source of power that complies with NFPA 99. Review of generator test records indicated that the emergency generator did not connect to the load within 10 seconds when tested for twelve (12) of the past twelve (12) months. Failure to ensure the emergency generator automatically connected to the load within 10 seconds 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 146	2. May 19, 2016 education given to maintenance on the importance of the source of power automatically connecting to load within 10 seconds. 3. Plans for new generator to be installed June 29, 2016 to address the issue of power source automatically connecting to load within 10 seconds 4. The Environmental Services Director will audit documentation of generator 1 time monthly 3 months than as deemed necessary by QA and Safety Committee.	