STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	03/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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E 000	Initial Comments A recertification survey conducted on 03/20/2023 found Eventide Jamestown was not in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 42 CFR 483.73 et seq. (Emergency Preparedness).	E 000		
E 009 SS=F	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis	E 009		5/3/23

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

Electronically Signed | 03/29/2023

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E 009	Continued From page 1 facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on review of facility policy and staff interview, the long-term care facility failed to develop and maintain a comprehensive emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation for 1 of 1 emergency plan (Emergency Preparedness Plan) reviewed. Failure to develop and maintain a comprehensive emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation limited this facility's ability to ensure all residents' safety in the event of an emergency. Findings include: Review of the facility's policy manual "Emergency Preparedness Plan" occurred 03/20/23. This manual, revised July 2022, failed to include evidence to show the facility had developed the comprehensive emergency preparedness plan to include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials. During interview on the afternoon of 03/20/23,	E 009	It is the policy of the facility to develop and maintain an emergency preparedness plan that is reviewed and updated at least annually. This will also include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facilities efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The facility will contact the local coalition and set up a meeting to address full scale community based exercises. The facility will work with the local emergency services to conduct a facility based exercise which includes the facility s emergency preparedness plan. Facility Director or Executive Director will review annually to ensure community based exercise needs are met.	

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E 009	Continued From page 2 the Facility Administrator confirmed the facility failed to develop a comprehensive emergency preparedness plan which included a process for cooperation and collaboration with local emergency preparedness officials.	E 009		

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K 000	INITIAL COMMENTS 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, Standard for 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. The building was protected with a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems and a corridor smoke detection system. Note: A Fire Safety Evaluation System (FSES) was conducted as a result of the 03/20/2023 Life Safety Code survey. The FSES was specifically used as an alternative safety method for K 241 (Number of Exits) and K 271 (Discharge From Exits). The facility passes the FSES upon correction of all other deficiencies.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by:	K 211		3/20/23

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K 211	Continued From page 1 The facility failed to maintain the means of egress in accordance with Chapter 7. Observation determined not all sidewalks to the public way from the exterior exits in the facility had been cleared of snow after recent snow fall events. 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 two (2) of thirteen 13) exterior exits from the facility.	K 211	Sidewalk was cleaned of all snow and ice on 3/20/2023. All other sidewalks were reviewed prior to date of compliance to ensure they were appropriate for life safety code standards. All emergency exit sidewalks will be reviewed every business day during winter months to ensure they are free of snow/ice and up to life safety code standards.	
K 241 SS=B	Number of Exits - Story and Compartment CFR(s): NFPA 101 Number of Exits - Story and Compartment Not less than two exits, remote from each other, and accessible from every part of every story are provided for each story. Each smoke compartment shall likewise be provided with two distinct egress paths to exits that do not require the entry into the same adjacent smoke compartment. 18.2.4.1-18.2.4.4, 19.2.4.1-19.2.4.4 This REQUIREMENT is not met as evidenced by: Not more than 50 percent of the required number of exits, and not more than 50 percent of the required egress capacity, shall be permitted to discharge through areas on the level of exit discharge. The facility failed to arrange at least 50 percent of exits to discharge directly to the exterior of the building.	K 241	A Fire Safety Evaluation System (FSES) was conducted as a result of the 03/20/2023 Life Safety Code survey. The FSES was specifically used as an alternative safety method for K 241, (Number of Exits). The facility passes the FSES upon correction of all other deficiencies.	3/20/23

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K 241	Continued From page 2 Observation determined two (2) of two (2) stair enclosures from the partial basement discharged into the first-floor corridor of the building rather than into an exit passageway or to the exterior of the building. Failure to provide exits in accordance with NFPA 101 increases the risk of injury or death due to fire. This deficiency affected two (2) of two (2) designated exits from the basement.	K 241		
K 271 SS=B	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Exits must terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge must be of required width and size to provide all occupants with safe access to a public way. To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. CMS Survey and Certification Letter 05-38. Observation determined the two (2) exterior exits from the Chapel traverse the lawn to get to a	K 271	A Fire Safety Evaluation System (FSES) was conducted as a result of the 11/02/2021 Life Safety Code survey. The FSES was specifically used as an alternative safety method for K 271 (exterior exits to public ways). The facility passes the FSES upon correction of all other deficiencies.	3/20/23

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K 271	Continued From page 3 public way. Failure to provide asphalt or concrete surfaces from exterior exits increases the risk of injury or death due to fire. The deficiency affected two (2) of twelve (12) exterior exits from the building.	K 271		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Ground-fault circuit-interruption for personnel shall be provided as required. The ground-fault circuit-interrupter shall be installed in a readily accessible location. All 125-volt, single-phase, 15- and 20-ampere receptacles located in bathrooms, kitchens, rooftops, outdoors, indoor wet locations, locker rooms with associated showering facilities, garages and where receptacles are installed within 6 ft. of the outside edge of the sink shall have ground-fault circuit-interrupter protection for personnel. 19.5.1.1, 9.1.2, NFPA 70, 210.8, 210.8(B)	K 511	An FGCI outlet was ordered on 3/20/2023. Outlet replaced on 3/29/2023. In order to stay in compliance with this regulation, each hopper room will be thoroughly inspected to ensure FGCI outlets are provided where needed. If any deficiencies of this nature are discovered, a maintenance request will be submitted and the outlet will be replaced immediately in order to comply with life safety code standards. Bath and hopper rooms will be reviewed 1 X per week for 4 weeks. 1 X per month	3/29/23

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K 511	Continued From page 4 The facility failed to ensure electrical wiring and electrical equipment met the requirements of NFPA 70, National Electrical Code. Observation determined one (1) electrical receptacle in the Wing 3 Soiled Utility Room within 6 ft. of a floor sink was not ground-fault circuit-interrupter protected. Failure to provide electrical wiring and equipment in accordance with NFPA 70 increases the risk of injury or death due to fire. The deficiency affected one (1) of numerous electrical receptacles in the facility.	K 511	for 3 months and then quarterly until 100% compliance is achieved.	
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 all fire drills did not include the simulation of an emergency phone call to the fire department.	K 712	Fire drill check list was reviewed. New fire drill sheet has been created to ensure checklist is followed. Facility Director or Incident Commander will verify during drills that the check lists are completed in their entirety to ensure compliance.	3/22/23

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K 712	Continued From page 5 Failure to conduct fire drills as required increases the risk of death or injury due to fire. The deficiency affected seven (7) of twelve (12) required drills in the past year.	K 712		