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 _____	05/15/2024

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

(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 An Emergency Preparedness (EP) and a Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 15, 2024 following a North Dakota Department of Health survey, that was conducted on April 8, 2024. At this comparative Federal Monitoring Eventide Jamestown, CCN 355078, was found in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.73 Emergency Preparedness. The building is described in the K000 section for the Life Safety Code survey. Emergency backup power to the building was supplied by a 52KW natural gas generator with a propane backup inside the facility. The facility generator is stated to be tied to the building fire alarm control panel, emergency facility lighting, red outlets and life safety components utilized for preservation of life. The facility is approximately a mile from a local paid and volunteer fire department. The facility did not admit residents on life support and stated they do admit bariatric residents per the limit of medical equipment. The facility has a capacity of 81 beds with a census of 77 at the time of the survey. The requirement at 42 CFR Subpart 483.73 is MET:	E 000		

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

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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	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2024**

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K 000	INITIAL COMMENTS A Life Safety Code (LSC) comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on May 15, 2024 following a North Dakota Department of Health survey, that was conducted on April 8, 2024. At this comparative Federal Monitoring Eventide Jamestown, CCN 355078, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.90(a), Life Safety from fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancies. The nursing facility is determined to be one story with a partial basement, peaked roof but no attic space, non-combustible construction type (concrete and metal stud) Type II(000). The building was constructed in the 1950's with additions to the wings in 1990's or 2000 with no current major renovations. A special feature of the building is a dedicated 16 bed memory care unit. The fire alarm system is an addressable system with smoke detection in the corridors and habitable spaces. The HVAC system is tied to the fire alarm system with duct detectors which shuts down upon detection of smoke. The new fire alarm panel is tied to monitoring company. The nursing home was fully sprinkler protected with a wet sprinkler system. The sprinkler system is on domestic water with no fire pump. Emergency backup power to the building was supplied by a 52KW natural gas generator with a propane backup inside the facility. The facility generator is stated to be tied to the building fire	K 000		

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EVENTIDE JAMESTOWN	**1300 2ND PL NE** **JAMESTOWN, ND 58401**

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K 000	Continued From page 1 alarm control panel, emergency facility lighting, red outlets and life safety components utilized for preservation of life. The facility is approximately a mile from a local paid and volunteer fire department. The facility did not admit residents on life support and stated they do admit bariatric residents per the limit of medical equipment. The facility has a capacity of 81 beds with a census of 77 at the time of the survey. The requirement at 42 CFR Subpart 483.90(a) is NOT MET as evidenced by:	K 000		
K 241 SS=D	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: Based on observation and interview, the facility failed to provide one of two exits from the partial basement story to exit to the exterior of the facility in accordance with LSC Section 19.1.7, 19.2.4.1 through 19.2.4.4. This deficient practice could affect two smoke zones, 0 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on 05/15/2024 at approximately	K 241		

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K 241	Continued From page 2 2:30pm during the facility tour identified the facility partial basement floor had two stairway from the basement floor to the first floor corridor with no direct exits to the exterior of the building. Interview on 05/15/2024 at approximately 9:00am during the entrance conference with the facility Maintenance Director and Administrator identified the facility had a waiver for this situation of having both exits discharge to the first floor. Observation and interview with the Maintenance Director at the time of observation confirmed two partial basement exit stairways discharged into the interior of the facility on the first floor. The finding was verified by the Maintenance Director at the time of observation.	K 241		
K 271 SS=D	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: Based on observation and interview, the facility failed to provide a hard path discharge from a facility designated exit in accordance with CMS Survey and Certification Letter 05-38, LSC 7.1.6, 7.1.7, 7.7 and 19.2.7. This deficient practice could affect exiting from one smoke zone, approximately 10 residents, as well as an indeterminable number of staff and visitors.	K 271		

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K 271	Continued From page 3 Findings Include: Observation on 05/15/2024 at approximately 3:00pm during the facility tour identified the facility designated exit from the chapel, designated with an illuminated exit sign, exited to the uneven ground with no hard path to the public way. Interview on 05/15/2024 at approximately 9:00am during the entrance conference with the facility Maintenance Director and Administrator identified the facility had a waiver for this situation of having no exit discharge hard path to the public way. Observation and interview with the Maintenance Director at the time of observation confirmed the designated exit had no hard path to the public way. The finding was verified by the Maintenance Director at the time of observation.	K 271		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____	K 353		

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K 353	Continued From page 4 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the sprinklers from loading/paint in accordance with LSC Section 19.3.5.1, Section 4.6.12, Section 9.7, NFPA 13, 2010 Edition, and NFPA 25, 2011 Edition, Section 5.2.1. The deficient practice could affect one smoke zone, 20 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on 05/15/2024 at approximately 2:00pm during the facility tour identified the sprinkler in room 204 had paint on the sprinkler. Interview with the Maintenance Director at the time of observation confirmed the sprinkler had paint on the sprinkler potentially reducing the activation response time of the rated sprinkler. The finding was verified by the Maintenance Director at the time of observation.	K 353		
K 712 SS=C	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	K 712		

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K 712	Continued From page 5 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: Based on record review and interview, the facility failed to conduct fire drills at varied dates and times and once per quarter for each shift in accordance with LSC Sections 19.7.1.4 through 19.7.1.7. This deficient practice could affect all smoke zones, 77 residents, as well as an indeterminable number of staff and visitors. Findings Include: Record review on 05/15/2024 at approximately 9:45am identified documented fire drills for all fire drills in the past year failed to document fire drills for the second shift from 02/26/203 to 07/10/2023 and the second shift from 10/09/2023 to the time of survey. In addition, record review on 05/15/2024 at approximately 9:45am identified documented fire drills for all fire drills in the past year with a pattern of fire drills being conducted at the same time (not varied), making fire drills predicable. For the first shift, two fire drills were conducted at 11:00am (12/15/2023 and 01/27/2024). Three first shift fire drills were conducted between 2:00pm and 2:20pm (First Shift)(01/16/2023 at 2:20pm, 05/31/2023 at 2:18pm, and 11/30/2023 at 2:00pm. For the third shift five of five fire drills were conducted between 4:30am and 6:00am (03/30/2023 at 5:23am, 06/30/2023 at 6:00am, 08/03/2023 at 5:00am, 02/17/2024 at 4:30am and 03/29/2024 at 6:00am) with two fire drills conducted at 6:00am (06/30/2023 and 03/29/2024). Interview	K 712		

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K 712	Continued From page 6 on 05/15/2024 at approximately 8:50am at the facility entrance conference with the facility Maintenance Director and Administrator stated that the facility has three shifts and stated the shifts are 7:00am to 3:00pm, 3:00pm to 11:00pm and 11:00pm to 7:00am. The findings were verified with the Maintenance Director at the time of record review.	K 712		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		

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K 920	Continued From page 7 Based on observation and interview, the facility failed to protect electrical wiring from becoming potential hazards in accordance with NFPA 70, 2011 Edition Section 400-8, Section 590.3(D), NFPA 99, 2012 Edition, Section 10.2.4 and LSC Section 9.1.2. The deficient practice could affect one smoke zone, 20 residents, as well as an indeterminable number of staff and visitors. Findings Include: Observation on 05/15/2024 at approximately 2:20pm during the facility tour identified an office had a power strip with a high draw refrigerator plugged into the power strip acting as an extension cord utilized as a temporary outlet instead of hard wired electrical outlet. Interview with the Maintenance Director confirmed the use of the power strip and extension cord at the times of observation. The findings were verified by the Maintenance Director at the times of observation.	K 920		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if	K 923		

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K 923	Continued From page 8 sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide storage of cylinders so empty cylinders are segregated from full cylinders in accordance with NPFA 99, 2012 Edition Sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient practice could affect all oxygen storage areas, two smoke compartments, as well as 20 residents, staff and visitors. Findings Include:	K 923		

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K 923	Continued From page 9 Observation on 05/15/2024 at approximately 1:45pm to 3:40pm during the facility tour identified storage rooms used to store oxygen cylinders failed to segregate full from empty cylinders to ensure the proper cylinders are available in an emergency situation. Interview with the Maintenance Director at the times of observations confirmed the cylinders in the oxygen storage closets were not segregated and not marked to identify which were full or empty. The findings were verified by the Maintenance Director at the times of observation.	K 923		