STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2015**

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
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 42CFR 483.70(a). 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 partial basement. The facility had a wet automatic sprinkler system designed to meet the requirements of NFPA 13, Standard for Installation of Sprinkler Systems, 1999 edition. Note: A Fire Safety Evaluation System (FSES) was conducted as a result of the 11/17/2015 Life Safety Code survey. The FSES was specifically used as an alternative safety method for K038-1 (exterior exits to public ways), K 038-2 (exit discharge to the exterior of the building), and K038-3 (Means of egress obstructions). The facility passes the FSES upon correction of all other deficiencies.	K 000		
K 029 SS=D	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 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	K 029		12/7/15

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

Electronically Signed | 12/01/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2015**

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
K 029	Continued From page 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 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 doors to hazardous areas in fully sprinklered existing health care occupancies were equipped with self-closing/automatic latching hardware. Observation determined the door to the Special Care Unit Linen Storage Room did not have self-closing hardware. Failure to ensure doors to hazardous areas self-close and latch to the door frame increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous hazardous areas in the facility.	K 029	1. Facility will install self-closing hardware on the Linen Storage Room door located in the Special Care Unit. 2. The Director of Maintenance will evaluate the facility to ensure all doors to hazardous areas are secured and are in proper working order. 3. Facility Maintenance Staff will be educated on properly securing hazards areas with appropriate mechanisms. 4. Director of Facilities or Designee will monitor on a monthly basis that all hazardous areas are secured and are in proper working order. 5. Date of Compliance: 7th December 2015	
K 038 SS=E	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	K 038		1/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2015**

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
K 038	Continued From page 2 This STANDARD is not met as evidenced by: 1) 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. 7.7.1 To ensure adequate exit capability, CMS requires asphalt or concrete surfaces from exterior exits to public ways. Observation determined the two (2) exterior exits from the Chapel traverse the lawn to get to a public way. The deficiency affected two (2) of twelve (12) exterior exits from the building. 2) 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. 7.7.2 The facility failed to arrange at least 50 percent of exits to discharge directly to the exterior of the building. Observation determined two (2) of two (2) stair enclosures from the suite in 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. This deficiency affected two (2) of two (2) designated exits from the basement.	K 038	A Fire Safety Evaluation System (FSES) was conducted as a result of the 11/17/2015 Life Safety Code survey. The FSES was specifically used as an alternative safety method for K038-1 (exterior exits to public ways), K 038-2 (exit discharge to the exterior of the building), and K038-3 (Means of egress obstructions). The facility passes the FSES upon correction of all other deficiencies. 1. Facility will repair the doors identified in order to maintain a minimum of seven inches between the wall and the door of the exit corridor. 2. Director of Maintenance will evaluate the facility to ensure all doors which open out to the exit corridor do not extend more than seven inches from the wall when fully opened. 3. Facility Maintenance Staff will be educated on the need to maintain an exit corridor in the proper fashion. 4. Director of Facilities or Designee will monitor on a monthly basis that all doors which open out to the exit corridor do not extend more than seven inches from the wall when fully opened. 5. Date of Compliance: 1st January 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2015**

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
K 038	Continued From page 3 3) Means of egress must be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration. Exception: Projections not more than 3 1/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below. 7.1.10.1, 7.3.2 The facility failed to keep corridors free of obstructions. Observation determined a water fountain in the 400 Wing extended approximately sixteen (16) inches from the corridor wall and protruded into the exit corridor. This deficiency affected exit access to one (1) of six (6) exits from the facility. 4) 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 following doors opened outward into the exit corridor and extended more than 7 inches from the wall when fully opened. 1) The corridor door to the Linen Room in the 100 Wing. 2) The corridor door to the Linen Room in the	K 038		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/17/2015**

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
K 038	Continued From page 4 200 Wing. 3) The corridor door to the Clean Utility Room in the 200 Wing. 4) The corridor door to the Housekeeping Room in the 200 Wing. 5) The west corridor door to the Staff Lounge. 6) The east corridor door to the Staff Lounge. 7) The corridor door to the Linen Room in the 400 Wing. 8) The north corridor door to the Air Handler Room in the Special Care Unit. This deficiency affected eight (8) of numerous corridor doors in the means of egress throughout the facility. Failure to ensure exit access is readily available at all times increases the risk of death or injury due to fire.	K 038		