STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ND200	A. BUILDING 01 - EVENTIDE FARGO B. WING _____	05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE FARGO	3225 51ST ST S FARGO, ND 58104

(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 18 New Health Care Occupancies in compliance with 42 CFR 483.70(a). The findings that follow demonstrate noncompliance with these standards. The facility was located in a two-story building of Type II (111) construction. Resident sleeping rooms were located on both floors of the two-story building. An adjacent one-story building of Type IV (2HH) construction was separated from the two-story building with a fire barrier designed to have a two-hour fire resistance rating. The one-story building housed resident services to include a chapel, gift shop, lounge and cafeteria. The buildings were protected throughout by a wet automatic fire sprinkler system designed to meet the requirements of the 1999 edition of NFPA 13, Standard for the Installation of Sprinkler Systems. An assisted living building was attached to the west side of the two-story building and was separated by an occupancy separation wall having a two-hour fire resistance rating.	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Doors are required to be arranged to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side.	K 038	please see attached	

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

Administrator 5/19/16

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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Deficiency K038:
Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1.18.2.1, 19.2.1. Doors are required to be opened readily from the egress side. Locks, if provided, shall not require the use of special knowledge or effort for operation from the egress side.

Plan of Correction:
The doors which caused citation (Main Entrance on east side of building) have since been corrected to allow readily access at all times. The magnetic locks have been removed. These doors now allow egress at all times. Nothing will impede the egress of these doors as an exit. No special knowledge or effort for operation from the egress side will be needed. This correction was done on May 9th of 2016 while surveyors were on site. Director of Facilities will monitor the door functionality as needed.

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K 038	Continued From page 1 18.2.2.2.1, 7.2.1.5.1, 18.2.2.2.4, 7.2.1.6.2 The facility failed to ensure exit access was readily accessible at all times. Observation determined the exterior exit doors from the Main Entrance were equipped with access-controlled magnetic locks that required a code to be entered on a key pad or pushing a button on the adjacent wall to release. The doors were not equipped with a delayed egress feature. 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 one (1) of eight (8) exterior exits from the facility.	K 038		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A weekly test of electric motor-driven pump assemblies shall be conducted without flowing water. This test shall be conducted by starting the pump automatically. The pump shall run a minimum of 10 minutes. 18.7.6, 4.6.12, NFPA 25, 5-3.2.1 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 Systems.	K 062	please see attached	

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Deficiency K062:
Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12 NFPA 13, NFPA 25, 9.7.5. A weekly test of electric motor driven pump assemblies shall be conducted by starting the pump automatically. The pump shall run for ten minutes.

Plan of Correction:
A weekly preventive maintenance document will be generated through our work order system which will contain a description on how to do the fire pump churn test for no less than ten minutes as specified. A documented checklist along with the churn test instructions will be posted at the fire pump location for maintenance staff to record and follow. These forms are included with this document. The Director of Facilities will do a weekly audit to ensure completion of the fire pump churn test. This was instituted on May 12th of 2016.

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K 062	Continued From page 2 Record review determined the facility failed to conduct weekly no flow tests of the sprinkler system electric fire pump. 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 one (1) of numerous required tests of the automatic sprinkler system. The automatic sprinkler system serves the entire building.	K 062		
K 064 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6 This STANDARD is not met as evidenced by: Fire extinguishers shall be inspected when initially placed in service and thereafter at approximately 30-day intervals. 18.3.5.6, 9.7.4.1, NFPA 10, 4-3.1 The facility failed to inspect fire extinguishers in accordance with NFPA 10, Standard for Portable Fire Extinguishers. Observation determined the inspection tag on the fire extinguisher in the corridor by Room C209 had not been initialed to indicate a monthly inspection during April 2016. Failure to ensure portable fire extinguishers comply with NFPA 10 increases the risk of death or injury due to fire. The deficiency affected one (1) of numerous portable fire extinguishers in the facility.	K 064	Please see attached	

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Deficiency K064:
Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9-7-4.1, NFPA 10. 18.3.5.6, 19.3.5.6.

Plan of Correction:
A monthly preventive maintenance document (included with this form) will be generated through our work order system which will contain exact locations of each fire extinguisher. Maintenance staff will check each extinguisher at each location listed in this document ensuring that each extinguisher is inspected, dated and initialed. The Director of Facilities will do an audit each month to ensure completion of this task. This correction was instituted on May 10th 2016.

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