North Dakota Health and Human Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	8045	A. BUILDING: _____ B. WING _____	C 10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREENS OF FARGO	1405 W GATEWAY CIRCLE FARGO, ND 58103

(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) COMPLETE DATE
B 000	INITIAL COMMENTS For the unannounced onsite complaint survey for houses 8045B, 8039B, and 8042B started on 10/14/25 and completed on 10/15/25, the facility was found noncompliant with regulatory requirements.	B 000		
B1540	33-03-24.1-15,4 PHARMACY/MED ADM SERVICES 4. All medications used by residents which are administered or supervised by staff must be: a. Properly recorded by staff at the time of administration. b. Kept and stored in original containers labeled consistently with state laws. c. Properly administered. This State Licensing Rule is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure proper administration of medication for 1 of 2 sampled residents (Resident #2) observed during medication pass. Failure to ensure residents take the entire dose of medication may cause subtherapeutic effects for the residents. Findings include: Review of the facility policy titled "Medication Administration" occurred on 10/14/25. This undated policy stated, ". . . Medication administration that may be delegated to a Medication Assistant 1 includes routine, regularly	B1540	Ecumen Evergreens Plan of Correction Received deficiencies from Jennifer Kelly on 11/19/25 Submitted initial POC on 11/21/25 Resubmission on 12/1/25 To: ND Department of Health From: Ashley Lehn, CD 1. What corrective action will be accomplished for those residents affected by the deficient practice. RA/MA was given verbal coaching and provided education on 11/20/2025 regarding following proper orders and ensuring 6 rights of medication administration on were conducted. RA/MA was also provided with verbal coaching of 6 rights of mediation administration after surveyor identified medication left unattended and not witnessed. RA/MA confirmed understanding and medication pass was observed by license nurse without deficiency. 2. How will you identify other residents having the potential to be affected by the same deficient practice? All RAs/MAs were provided education on following physician orders and 6 rights of medication administration on 11/20/2025. 3. How the deficiency was or will be corrected. Include not only how the facility will correct the existing condition cited for the specific issues(s) but also how the system wide process will be corrected to ensure the problem does not recur. Please see attached education. Ashley, CD and Amy, LPN will perform routine audits to ensure proper medication administration is completed. Will conduct 3 medication pass audits weekly until closure. If there are identified gaps, education, corrective action, and or review of performance will be conducted. Medication Administration Error policy/guideline will be followed. 4. When the deficiency was or will be corrected. The date of correction must be at least the day after the survey completion date and should be no later than forty-five (45) days from the last date of the survey, which is November 29, 2025. We received the deficiency notification on 11/20/2025. Education will be completed by 11/24/25 and auditing will be initiated in the week of 11/24/25. 5. Who (job titles, not individual names) will monitor the corrective action. Clinical Director and LPN will monitor and be responsible for performing auditing, education, and ensuring compliance. If you have additional questions or need clarification, please contact me at ashleylehn@ecumen.org or by phone at 701-239-4524. If you send an email, please call to verify that it was received as we have noticed experience with receiving your emails. Thank you, Ashley Lehn, CD	

Health Repsonse and Licensure
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Ashley Lehn RNCD
12/1/25

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B1540	Continued From page 1 scheduled medication for residents with stable conditions which are administered on a routine basis. . . . A medication error may be any violation of the six rights (right individual, right time, right medication, right dose, right route, and right documentation) or incorrect medication procedure. . . . Observe the resident swallowing the medication. . . ." Review of Resident #2's medical record occurred on 10/14/25. Physician's orders included acetaminophen (pain medication) ES (extra strength) 500 milligrams (mg) 2 tablets three times a day. Observation on 10/14/25 at 11:55 a.m. showed a medication aide (MA) (#2) crushed two 500 mg acetaminophen tablets in a medication cup, added Ensure (a supplement), placed the medication cup on the dining table in front of Resident #2, and walked away. Observation at 11:58 a.m. showed Resident #2 and another resident at the table. The medication cup remained on the table with medication still present and an empty creamer container covered the medication cup. During an interview at 12:10 a.m. the MA (#2) stated, "the resident takes a while to take her medications" and confirmed she should have watched the resident take her medication. During an interview on 10/14/25 at 2:50 p.m., an administrative staff member (#3) confirmed she expected staff to observe resident's take their medications.	B1540		

Ashley Lehn RN CD
12/1/25