STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/18/2025

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

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F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 09/15/25 and concluded 09/18/25. During the complaint investigation, the facility was found in compliance with regulatory requirements.	F0000		10/01/2025
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F0641	1.) Resident #7 MDS for section J1400 was reviewed and modified to reflect an accurate prognosis of life expectancy less than 6 months. Resident #7 MDS for section M0300F1 was reviewed and modified to reflect the presence of an unstageable pressure ulcer. Resident #8 MDS for section N0415-C1 was reviewed and modified to reflect accurate use of an antidepressant. 2.) All residents have the potential to be affected. 3.) Education has been provided to the MDS Coordinator by DON regarding accurate coding of the MDS utilizing the RAI Manual as of October 8th, 2025. 4.) The DON or designee will monitor MDS sections J1400, M0300F1, and N0415-C1 for compliance weekly for a month, monthly for three months, and quarterly as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: October 10th, 2025	10/10/2025

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 reverse for further 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.

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

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F0641 SS = D	Continued from page 1 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 22 sampled residents (Resident #7 and #8). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION J: HEATLH CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, pages J 27-28, stated, ". . . J1400 Prognosis: Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months? . . . Code 1, yes: if the medical record includes physician documentation: 1) that the resident is terminally ill; or 2) the resident is receiving hospice services. . . ." SECTION M: SKIN CONDITIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page M 23-24, stated, ". . . M0300F1: Enter the number of pressure ulcers that are unstageable related to slough [non-viable tissue] and/or eschar [dead or devitalized tissue]. . . ." Review of Resident #7's medical record occurred on all days of survey and identified a terminal illness, hospice services beginning on 05/22/25, and unstageable wounds to the right heel and great toe. A "Wound Care Flow Sheet," dated 07/23/25, stated, "Right heel - 3 [centimeters (cm)] x 2.7 [cm] x 0 [cm] unstageable, and R. [right] great toe is 0.6 [cm] x 0.6 [cm] x 0 [cm], unstageable. Eschar [thick, dry, crusty layer of dead tissue that forms over a wound]. . . ." The quarterly MDS, dated 07/26/25, failed to identify a prognosis of life expectancy less than 6 months and the presence of an unstageable pressure ulcer. During an interview on 09/17/25 at 10:44 a.m., an MDS nurse (#4) agreed staff failed to code life expectancy of less than six months and an unstageable pressure ulcer.	F0641		

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F0641 SS = D	Continued from page 2 SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2024, page N-4, stated, ". . . N0415: High-Risk Drug Classes . . . Check if the resident is taking any medications by pharmacological classification, not how it is used, during the last 7 days . . . C. Antidepressant . . ." Review of Resident #8's medical record occurred on all days of survey. A physician's order, dated 07/31/25, stated, "Venlafaxine [antidepressant medication] . . . one time a day for depression/anxiety." The significant change MDS, dated 08/05/25, failed to identify the resident received an antidepressant. During an interview on 09/17/25 at 4:06 p.m., an MDS nurse (#4) stated, "I must have just missed it [coding venlafaxine]."	F0641		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: This REQUIREMENT is NOT MET as evidenced by: Based on record review, policy and procedure review, professional reference review, and staff interview, the facility failed to provide the care and services for 1 of 1 sampled resident (Resident #5) on hemodialysis with a Permacath (a type of vascular access for dialysis). Failure to assess the hemodialysis vascular access site may result in complications and adverse effects, such as clotting and possible loss of the access site. Findings include: Review of the facility policy titled “Hemodialysis Access Sites” occurred on 09/18/25. This policy, revised April 2022, stated, “. . . The facility is responsible to . . . Provide ongoing monitoring and care of the resident's vascular access . . . Central	F0698	1.) Resident #5’s hemodialysis central venous access site is being assessed according to facility policy and procedure. 2.) All residents receiving hemodialysis have the potential to be affected. 3.) Education will be provided to all licensed nurses on the facility's Hemodialysis Access Sites policy and procedure by October 10th, 2025. 4.) The DON or designee will monitor for compliance that all residents with hemodialysis access sites are being assessed according to facility policy weekly for a month, monthly for three months, and quarterly as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: October 10th, 2025	10/10/2025

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F0698 SS = D	Continued from page 3 Venous Access . . . Assess site BID [two times per day]. Observe for redness, warmth, drainage. Report problems immediately to physician/practitioner/dialysis center . . ." Review of the "Core Curriculum for the Dialysis Technician - A Compressive Review of Dialysis," Fifth Edition, page 121 and 127 stated, ". . . Vascular access makes chronic hemodialysis (HD) possible . . . An access is an HD patient's lifeline. Each access must be cared for as if it is the last one a patient can have. . . access failure means loss of the HD life-line. The access must be repaired or replaced - if the patient has a site left. Access problems can cause hospital stays, surgery illness, limb loss, and death. . ." Review of Resident #5's medical record occurred on all days of survey and included a diagnosis of End Stage Renal Disease (ESRD). The current care plan stated, ". . . Monitor CMS [circulation, motion, sensation] of extremity with access site per facility policy. Update provider/dialysis center if concerns are noted . . . Resident receives dialysis (M/W/F) [Monday/Wednesday/Friday] . . ." Review of Resident #5's nurses' notes identified the following: *06/23/25 at 3:29 p.m., ". . . No longer using fistula [a surgical connection between an artery and a vein to make it possible for hemodialysis]. Utilizing port to R [right] upper chest. Dressing in place. No obvious bruising, bleeding, redness, or drainage. . . . " *07/28/25 at 12:55 p.m., ". . . returned from Dialysis early. Per report from [Resident #5], she has a clot to her dialysis cath and will need to have it replaced. . . ." *08/20/25 at 6:44 p.m., ". . . Resident had dialysis today, her Perma Cath. blew during dialysis. . . . " *08/21/25 at 9:31 p.m., ". . . Perma cath replacement. . . . " During an interview on 09/17/25 at 2:36 p.m., a nurse manager (#5) confirmed the medical record lacked documentation of assessment of Resident #5's vascular access site twice a day.	F0698		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	1.) Resident #22 and #55 oral medication and insulin are labeled according to accepted pharmacy standards and in accordance with the facility's Medications:	10/10/2025

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F0761 SS = D	Continued from page 4 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, review of facility pharmacy guidelines, and staff interview, the facility failed to ensure accurate labeling of medications for 2 supplemental residents (Resident #22 and #55) observed during medication administration. Failure to obtain new medication labels from the pharmacy for oral medications and insulin or affix a label noting change in the directions, may result in residents receiving an incorrect dose of medications. Findings include: Review of the facility policy titled "Medications: Administration and Storage" occurred on 9/18/25. This policy revised March 2025, stated, ". . . Medications will be administered according to the following directives . . . to provide safe and effective drug therapy for the residents . . . Medications will be labeled according to accepted pharmacy standards . . . Multi dose vials must be labeled when opened . . ." Review of the facility's contracted pharmacy guidelines	F0761	Continued from page 4 Administration and Storage Policy. 2.) All residents have the potential to be affected. 3.) Education will be provided to all licensed nurses and CMAlls on the facility's Medications - Administration and Storage Policy and Procedure by October 10th, 2025. 4.) The DON or designee will monitor for compliance with following facility Medications: Administration and Storage Policy when there are changes to oral medication or insulin orders weekly for a month, monthly for three months, and quarterly as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: October 10th, 2025	

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F0761 SS = D	Continued from page 5 regarding label changes for existing medication orders occurred on 9/18/25. This guideline states, ". . . To meet all federal and state labeling requirements . . . upon receiving a medication direction change [the facility], will place a 'refer to MAR' sticker on the existing medication and follow the MAR [medication administration record] directions when administering the medication to the resident. Pharmacy will supply a new and correct label . . ." -Observation on 9/17/25 at 8:12 a.m. showed a nurse (#10) removed a medication container from the medication cart for Resident #22. The container label identified "Norvasc 5mg [milligram], [heart medication] take 2 tablets daily . . . ". Review of Resident #22's current physician orders and MAR identified a dosage change on 06/11/25 from 2 tablets a day to 1 tablet a day. The container lacked a refer to MAR sticker. The nurse (#10) confirmed the label affixed to the container as incorrect, and staff failed to order a new label. -Observation on 9/17/25 at 4:38 p.m. showed a nurse (#11) removed a Novolog insulin pen from the medication cart for Resident #55. The insulin pen label included the resident's name and directions for administration which stated, "Give Novolog flex pen 10 units SQ [subcutaneous] TID [three times a day] before meals. . ." Review of Resident #55's physician orders and MAR stated, "Give Novolog, 8 units SQ TID before meals." The insulin pen lacked a refer to MAR sticker over the label. The nurse (#11) confirmed the label affixed to the insulin pen as incorrect and staff failed to order a new label. During an interview on 9/17/25 at 4:10 p.m., an administrative nurse (#1) confirmed she expected staff to follow facility policy and ensure medications have a refer to MAR sticker or a correct dose label on them.	F0761		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	1.) Resident #45 was removed from EBP on 9/16/2025. Staff are providing care to Residents #45, #3, and #13 in accordance with the facility's Hand Hygiene policy and procedures. Resident #3's wheelchair cushion was cleaned, and a new cover was placed. Staff are providing care to Resident #17 in accordance with the facility's Blood and Body Fluid Clean-Up and Hand Hygiene policy and procedures. Resident #17's catheter bag was replaced and is not leaking. 2.) All residents have the potential to be affected. 3.) Education will be provided to all nursing staff on the facilities' Transmission-Based Precautions, Blood	10/10/2025

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F0880 SS = E	Continued from page 6 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 6 and Body Fluid Clean-Up, and Hand Hygiene policies and procedures by October 10th, 2025. 4.) The DON or designee will monitor compliance with adherence to facility Blood and Body Fluid Clean-up, Hand Hygiene, and Transmission-Based Precautions policies and procedures weekly for a month, monthly for three months, and quarterly as needed per QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: October 10th, 2025	

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F0880 SS = E	Continued from page 7 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 12 sampled residents (Resident #3, #13, #17, and #45) observed during cares. Failure to practice infection control standards related to bodily fluid spills, hand hygiene, and enhanced barrier precautions (EBP) has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Blood and Body Fluid Clean-up" occurred on 09/18/25. This policy, revised July 2025, stated, ". . . requires that all body fluids. . . be cleaned and disinfected with an appropriate disinfectant. Resident Care Staff is responsible for this. . . . To maintain a safe environment to prevent cross-contamination. . . ." Review of the policy/procedure titled "Transmission-Based Precautions" occurred on 09/18/25. This policy, revised December 2024, stated, "provide staff with guidance to reduce or prevent the indirect transmission of infectious diseases through personal contact, surfaces, and equipment used for the residents . . . to prevent transmission of infection using the least restrictive approach possible that adequately protects the resident's and others . . . Enhanced barrier precautions. . . used to limit or prevent the spread of resistant organisms during high-contact resident care activities . . . put on gown and gloves before all high-risk activities . . . in addition to standard precautions, gown and gloves must be worn during high-contact resident care activities such as . . . transferring in room, providing hygiene, changing briefs, and assisting with toileting . . ." Review of Resident #45's medical record occurred on all	F0880		

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F0880 SS = E	Continued from page 8 days of survey and identified EBP related to sutures. - Observations of Resident #45 showed the following: *9/15/24 at 4:15 p.m., a certified nurse aide (CNA) (#7) entered the room to provide incontinent cares. After providing incontinent cares, the CNA (#7) applied a clean brief and pulled up the resident's pants. The CNA (#7) then removed the soiled gloves, her gloves, applied new gloves, cleaned bowel movement (BM) and urine on the toilet, and removed the soiled gloves. Without performing hand hygiene, the CNA (#7) removed the gait belt from the resident's waist and transported him/her to the dining room. *9/16/25 at 7:27 a.m., CNA (#8) provided perineal cares in the resident's bathroom. The CNA (#8) failed to wear a gown or gloves during perineal cares. During an interview on 9/16/25 at 8:01 a.m., a nurse (#9) confirmed staff are expected to perform hand hygiene before and after glove changes and wear a gown and gloves during personal cares with residents on enhanced barrier precautions. - Observation on 09/15/25 at 3:06 p.m. showed two CNAs (#2 and #3) transferred Resident #3 from her wheelchair to bed with a full-body mechanical lift and removed her wet pants and brief. The wheelchair cushion was visibly soiled with urine. One CNA (#2) provided perineal care and handed the soiled wipes to the other CNA (#3) to discard in the trash. Both CNAs removed the soiled gloves and without performing hand hygiene, pulled up the resident's clean pants and placed the lift sling under the resident before completing hand hygiene. During an interview on 09/16/25 at 3:00 p.m., an administrative nurse (#5) stated she expected staff to ensure all cushions have covers and are clean. - Review of Resident #17's medical record occurred on all days of survey. The current care plan stated, ". . . has a . . . catheter in place . . ." A progress note, dated 10/09/24 at 5:07 p.m., stated, ". . . Family voiced concerns of catheter bag often leaking. . . ." Observation on 09/16/25 at 7:54 a.m. showed an EBP sign outside of Resident #17's door. A CNA (#2) applied a gown and gloves and entered the resident's room. Resident #17 rested in bed with the catheter drainage bag hung on the side of bed and a dark, dried substance	F0880		

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EVENTIDE FARGO	3225 51ST ST S , FARGO, North Dakota, 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
F0880 SS = E	Continued from page 9 on the floor under the catheter bag. The CNA (#2) emptied the catheter bag into a container and a small amount of urine spilled on the floor. The CNA (#2) emptied the container into the toilet. The CNA removed the soiled gloves, performed hand hygiene, applied new gloves and transferred Resident #17 from bed to the toilet with the sit to stand lift. The CNA removed the resident's soiled brief, removed the soiled gloves, and without performing hand hygiene, removed the sit to stand lift and sling. The CNA (#2) then performed hand hygiene, applied new gloves, and performed morning cares. The CNA removed the soiled gloves, and without performing hand hygiene, brought the sit to stand lift back to the bathroom, applied new gloves, stood the resident up, performed perineal care, removed the soiled gloves. Without performing hand hygiene and applying new gloves, adjusted the resident's pants, transferred the resident to the wheelchair, placed the catheter bag under the wheelchair, made the bed, gathered the linen and garbage, applied new gloves and sanitized the lift. The CNA (#2) then removed the gown and gloves, performed hand hygiene and exited the room. The CNA (#2) failed to clean the spilled urine from the floor, and failed to perform hand hygiene after removing soiled gloves, before touching other surfaces, and before applying clean gloves. - Review of Resident #13's medical record occurred on all days of survey. The current care plan stated, ". . . catheter in place . . ." Observation on 09/16/25 at 4:07 p.m. showed an EBP sign on the wall outside of Resident #13's door. A CNA (#12) applied a gown and gloves, entered the resident's room, emptied the catheter bag, removed her gloves, and without performing hand hygiene, applied a new pair of gloves to dress Resident #13. The CNA (#12) failed to perform hand hygiene after removing gloves and before applying clean gloves. During an interview on 09/17/25 at 2:50 p.m., an administrative nurse (#6) confirmed she expected staff to perform hand hygiene after removing gloves, before applying clean gloves, and to clean the floor after a urine spill.	F0880		