STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355127	A. BUILDING _____ B. WING _____	C 11/07/2023

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
F 000	INITIAL COMMENTS An unannounced onsite investigation survey regarding a facility reported incident was completed on November 8, 2023. During the investigation the facility was found noncompliant with regulatory requirements.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility investigation, and review of facility policy, the facility failed to ensure adequate supervision and assistance for 1 of 2 sampled residents (Resident #3) who required staff supervision while toileting. Failure to provide supervision in the bathroom resulted in an avoidable fall and fracture. Findings include: Review of the facility policy titled "Standards of Care" occurred on 11/08/23. This policy, last revised October 2016, stated, ". . . Each staff member providing direct nursing care will have in their possession throughout their shift the written plan of care for each resident and will perform specific cares as directed according to this form. . . ."	F 689	Education will be provided to the staff involved at the time of the incident regarding facility Standards of Care policy, specifically following care plan regarding adequate supervision with toileting. Resident #3's care plan was reviewed and updated to include more specific instructions regarding supervision with toileting. All residents requiring supervision with toileting for safety have the potential to be affected. Education will be provided to all nursing staff regarding facility Standards of Care policy, specifically following care plan regarding adequate supervision with toileting. All care plans were reviewed and updated for resident's who have the potential to be affected to include more	12/1/23

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

Electronically Signed | 11/28/2023

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F 689	Continued From page 1 Review of Resident #3's medical record occurred on 11/08/23. Resident #3's care plan at the time of the fall stated, "Do not leave alone on toilet." Nursing progress notes identified the following: *10/02/23 at 5:52 p.m., ". . . According to [Resident #3] she was trying to reposition herself on the toilet and fell forward on her face. Staff ran in to help her and found her lying in a pool of blood with her face stuck to the wall. Staff were able to remove her from the wall, called the ambulance, and cleaned her up. A large laceration was noted to the left side of her head. [Resident #3] was transferred to [hospital name] ER [emergency room] for further evaluation d/t [due to] the head injury. . ." *10/02/23 at 6:47 p.m., ". . . Time of fall: 1600 [4:00 p.m.] Description of event: Staff called that [Resident #3] was on the floor face down in her bathroom in a pool of blood. Writer ran in there and found resident bleeding profusely. Was the fall witnessed?: no Did the resident hit their head?: yes . . ." *10/02/23 at 6:52 p.m., "Fall Update . . . Staff called for assistance in [Resident #3]'s bathroom at 1600 stating that she had fallen. Writer entered the bathroom to find [Resident #3] face down on the bathroom floor to the right of the toilet with her head pushed into the wall, her L [left] arm under her body, and her R [right] arm tucked back to her R side. There was a large amount of blood noted on the floor under [Resident #3]'s face. Staff were directed to call the ambulance. . . . Writer asked [Resident #3] what she was doing prior to falling off the toilet, and she said she was leaning forward to reposition her buttocks on the toilet. She said as she leaned forward she 'toppled over' onto the floor. . . ."	F 689	specific guidelines for those who require supervision with toileting. Nursing staff will be provided education by December 1st, 2023. The Director of Nursing or designee will be responsible to monitor compliance with providing adequate supervision for resident's who are care planned to have supervision while toileting. QA Monitoring was implemented on 11/30/23. The DON or designee will monitor weekly for a month, monthly for three months and random audits 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.	

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F 689	Continued From page 2 *10/02/23 at 10:21 p.m., ". . .Update from [hospital name] ER: Resident will be admitted to hospital with dx [diagnosis] of C2 [cervical axis] vertebra fx [fracture] and laceration to forehead. . . ." Review of the facility's investigation of the incident identified the following: ". . . [Resident #3] is . . . assist of 2 to transfer on and off of toilet with hoyer lift [full body lift] for toileting. . . . [Resident #3] had an unwitnessed fall on 10/2/23 at 1600. C.N.As [certified nurse aides] [(CNA (#4) and CNA (#5)] assisted [Resident #3] onto the toilet per [Resident #3]'s request using hoyer lift. . . . [Resident #3] asked to sit on the toilet for a bit. CNA (#4) stepped out of the bathroom to provide [Resident #3] privacy, per [Resident #3]'s preference, keeping the door ajar and remained in [Resident #3]'s room ready to assist her when she was done using the toilet. [Resident #3] reports she had leaned forward to reposition her buttocks on the toilet and toppled over onto the floor. Staff heard the sound of [Resident #3] falling from just outside her bathroom door and rushed to her. C.N.A [CNA (#4)] found [Resident #3] on the floor face down on her stomach. The right side of her head was against the wall, her left arm under her body, and her right arm tucked back to her right side. . . ." On 11/08/23 at 4:13 p.m., an administrative staff member (#1) confirmed facility staff unhooked Resident #3's sling from the full body lift after positioning her on the toilet. The facility failed to ensure Resident #3 received adequate supervision to attain the highest degree of safety possible while toileting which resulted in	F 689		

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F 689	Continued From page 3 a fall with a fracture.	F 689		