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 02/23/2017

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 For the unannounced complaint survey conducted February 21-23, 2017, the sample included five (5) residents for focused review.	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, review of resident counsel minutes, observation, record review, review of professional reference, and resident and staff interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #1) received reasonable accommodation of needs regarding room trays. Failure to pass trays in a timely manner and/or assist residents with their meals limited the quality of their dining experience. Findings include: Information submitted by the complainant identified the facility failed to ensure staff passed room trays in a timely manner and/or failed to ensure staff provided meal assistance at the times the trays were requested. Review of the "Resident Counsil [sic] Meeting	F 246	Tag F-246 1.) Corrective Action: Identified resident #1 will be accommodated for special needs and preferences. All other residents with special needs and preferences will be accommodated including those with medication/food interactions. The ordering and delivering procedure has been updated and changes were implemented to the dining structure, and placement of amenities to provide a more timely service. 2.) How and who are identified as being affected by practice: All residents who voice preferences have the potential to be affected. 3.) Measures to Ensure Compliance: Nursing and Dietary management/designees will provide education and training on the updated	3/30/17

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

Electronically Signed | 03/10/2017

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 02/23/2017

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 246	Continued From page 1 Minutes" identified the following: * 11/16/16, ". . . Long wait times for meals. . . . Residents concerned that others are not getting the help that they need during meal times. Always seem to be short staffed and people have to wait a long time. . . ." * 01/18/17, ". . . Long wait times for food. . . ." Wolters Kluwer's "Nursing 2017 Drug Handbook," 37th ed., Lippincott, Williams, and Wilkins, Philidelphia, pages 863-866, states, ". . . Carbidopa-Levodopa/Sinemet (Parkinson's medication) . . . Give drug with food to decrease GI [gastro-intestinal] upset . . ." Review of Resident #1's medical record occurred on all days of survey. Diagnoses included multiple sclerosis (MS), Parkinson's disease, fatigue, weakness, and dysphagia. A significant change Minimum Data Set (MDS), dated 12/20/16, identified extensive assistance of one person required for eating. The current care plan stated, ". . . Potential for changes in nutritional status r/t [related to] acute weakness/dehydration related to MS . . . Parkinson's . . . dysphagia . . . Staff will assist with set-up at meal times and assist with feeding. . . ." Review of Resident #1's current physician's orders identified the following medications: * Ranitidine for gastroesophageal reflux disease (GERD), * Antacid for GI distress, * Tums for heartburn/belching. Observation showed the following:	F 246	meal tray delivery and meal service procedures. Education to staff will be completed by March 30, 2017. 4.) Monitoring Performance: Audits will be performed Nursing and Dietary Management: 3 times/week for 4 weeks, 2 times/week for 8 weeks, and 1 time/week for 12 weeks and PRN thereafter. Audits will be discussed at monthly QA meetings by Nursing/Dietary Management for review and recommendations starting April 2017 and every month thereafter for the next 6 months and as needed after that point. 5.) Timeline of Corrective Action to be Completed: Corrective action and education will be completed by March 30, 2017.	

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 02/23/2017

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 246	Continued From page 2 * 02/21/17 at 5:35 p.m., observation showed a certified nursing assistant (CNA) (#1) delivered Resident #1's tray and placed it on the counter in her room. The CNA (#1) then assisted Resident #1 into the bathroom, removed her gloves, washed her hands, exited the bathroom, and placed Resident #1's main entree into the microwave to be reheated. As she began preparing Resident #1's room tray, she stated, "[Resident #1's tray is] usually the last tray, [because] we need to feed her." The CNA (#1) then re-entered the bathroom, provided Resident #1's toileting cares, removed her gloves, assisted Resident #1 back into bed, and washed her hands. At 6:00 p.m., the CNA (#1) began assisting Resident #1 with her meal. * 02/22/17 at 7:37 a.m., A nurse (#4) administered Resident #1's 7:30 a.m. medications. Resident #1 stated, "Can I get my breakfast tray earlier? I'm hungry. I want breakfast now." The nurse replied, "[There is] no schedule. You can have [breakfast] whenever you want." As she left the room, the nurse implied she would inform staff of Resident #1's request. After she exited the room, Resident #1 stated, "I'm supposed to eat a half hour after [my] Sinemet." * 02/22/17 at 8:34 a.m., A certified nursing assistant (CNA) (#5) delivered a glass of milk to Resident #1's room and then took her breakfast order. * 02/22/17 at 8:52 a.m., the CNA (#5) delivered Resident #1's breakfast tray to her room (1 hour and 15 minutes after she requested her breakfast tray), and assisted her with the meal. During an interview on the afternoon of 02/23/17, administrative staff members (#2 and #3). offered	F 246		

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 02/23/2017

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 246	Continued From page 3 no additional information regarding delivering room trays and providing meal assistance. Failure to pass trays in a timely manner (1 hour and 15 minutes after Resident #1 requested her breakfast tray), and/or assist Resident #1 with her meals limited the quality of her dining experience. This failure may also result in Resident #1's experiencing unnecessary stomach upset following medication administration.	F 246		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of facility policy, and staff interview, the facility failed to provide treatment and services to prevent skin breakdown and minimize the potential for the	F 314	Tag F-314 1) Corrective Action: Identified residents #3 and #4 will be evaluated for turning and repositioning, and pressure relief interventions to prevent new	3/30/17

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 02/23/2017

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 314	Continued From page 4 development of pressure ulcers for 2 of 5 sampled residents (Resident #3 and #4) at risk for pressure ulcers who required assistance with repositioning. Failure to consistently reposition residents and implement interventions for pressure relief may result in the development of pressure ulcers. Findings include: Information submitted by the complainant identified the facility failed to reposition residents in a timely manner. Review of the facility policy titled "Skin Assessment" occurred on 02/23/17. This policy, revised July 2015, stated, ". . . If the resident is able to reposition themselves in the bed instruct he/she to do so hourly. If not staff must reposition the resident hourly. . . . After the tissue tolerance has been assessed the nurse uses this information to ensure an appropriate individualized plan of care (turning/repositioning). . . ." - Review of Resident #4's medical record occurred on all days of survey. Diagnoses included osteoarthritis, history of femur and vertebra fractures, and ulcer to the buttocks. An admission Minimum Data Set (MDS), dated 01/13/17, identified extensive assistance of two or more staff members for bed mobility/transfers, and incontinence. The current care plan stated, ". . . Potential for skin breakdown related to impaired mobility. . . . Assist resident to turn and reposition every 1 hour and prn [as needed], off-loading pressure	F 314	development of pressure injuries and the reoccurrence of healed pressure injuries will be implemented. Care plans updated and communicated to staff, along with concurrent documentation to ensure compliance. Scheduling of turning and repositioning tasks in Point of Care was corrected to reflect the plan of care. 2) How and who are identified as being affected by practice: All residents at risk for skin breakdown have the potential to be affected. 3) Measures to Ensure Compliance: All residents at risk for skin breakdown will be evaluated for the need of turning and repositioning. An individualized plan of care will be implemented. All nursing staff will receive additional education on facility Skin Assessment policy and Standards of Care for the treatment and prevention of pressure injuries by March 30, 2017. Licensed nurses will be re-educated on how to correctly schedule tasks based off of the care plan in Point of Care. 4) Monitoring Performance: Audits will be performed by the Nurse Management team/designee as follows: 3 times/week for 4 weeks, 8 times/month for 2 months and prn thereafter. DON or designee will review audits for discussion and further recommendations at monthly QA meetings starting April 2017, and lasting 6 months in duration and as needed thereafter. 5) Timeline of Corrective Action to be Completed: Corrective action and education will be completed by March 30,	

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 02/23/2017

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 314	Continued From page 5 for at least one minute. . . . Assist of two for bed mobility. . . ." The "Turn and Reposition" log, dated February 9-22, 2017, identified the following: * 2 of 14 days: staff repositioned Resident #4 two times during the day/evening shifts (16 hour period), * 9 of 14 days: staff repositioned Resident #4 one time during the day/evening shifts, * 3 of 14 days: staff failed to reposition Resident #4 throughout the day/evening shifts. (The resident did refuse to be repositioned on one occasion.) The facility failed to reposition Resident #4 "every 1 hour off-loading pressure for at least one minute" as care-planned. - Review of Resident #3's medical record occurred on all days of survey. Diagnoses included cognitive impairments, multiple sclerosis (MS), and history of humerous fracture. A quarterly MDS, dated 12/17/16, identified severely impaired cognition, extensive assistance of two or more staff members for bed mobility/transfers, incontinence, and at risk of developing pressure ulcers. The current care plan stated, ". . . Potential for skin breakdown related to MS, decreased mobility, incontinent B & B [bowel and bladder]. . . . Assist resident to turn and reposition every 2 hours and prn, off-loading pressure for at least one minute. . . . Assist of one for bed mobility. . . ." The "Turn and Reposition" log, dated February 9-22, 2017, identified the following:	F 314	2017.	

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 02/23/2017

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 314	Continued From page 6 * 1 of 14 days: staff repositioned Resident #3 four times during the day/evening shifts, * 7 of 14 days: staff repositioned Resident #3 three times during the day/evening shifts, * 4 of 14 days: staff repositioned Resident #3 two times during the day/evening shifts, * 2 of 14 days: staff repositioned Resident #3 one time during the day/evening shifts. The facility failed to reposition Resident #3 "every 2 hours off-loading pressure for at least one minute" as care-planned. During an interview on the afternoon of 02/23/17, an administrative staff member (#3) stated, "[the] CNAs are not charting at the time of cares." She later added, "[The staff] documented once per shift; days, evenings . . . pms." The facility failed to reposition residents with pressure ulcers and/or at risk for skin breakdown every 1-2 hours as care-planned.	F 314		
F 364 SS=D	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, review of resident counsel minutes, observation, resident and staff interviews, and	F 364	Tag F-364 1.) Corrective Action: Identified resident #1 eating in her room will receive	3/30/17

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 02/23/2017

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 364	Continued From page 7 testing of food temperatures, the facility failed to provide meals to 1 of 1 resident (Resident #1) eating in her room at temperatures which enhanced the palatability of the food. Failure to ensure the palatability of food served to residents resulted in resident dissatisfaction. Findings include: Information submitted by the complainant identified the facility failed to ensure the palatability of food served to residents. Review of the "Resident Counsil [sic] Meeting Minutes" identified the following: * 11/16/16, ". . . Food (especially soup) very cold. . . ." * 01/18/17, ". . . Food temperatures are a problem. . . ." - On 02/21/17 at 5:35 p.m., observation showed a certified nursing assistant (CNA) (#1) delivered Resident #1's tray and placed it on the counter in her room. The CNA (#1) then assisted Resident #1 into the bathroom, removed her gloves, washed her hands, exited the bathroom, and placed Resident #1's main entree into the microwave to be reheated. As she began preparing Resident #1's room tray, she stated, "[Resident #1's tray is] usually the last tray, [because] we need to feed her. The food cools off." The CNA (#1) then re-entered the bathroom, provided Resident #1's toileting cares, removed her gloves, assisted Resident #1 back into bed, and washed her hands. At 6:00 p.m., the CNA (#1) began assisting Resident #1 with her meal. During an interview on 02/22/17 at 7:37 a.m.,	F 364	food at palatable temperatures to enhance satisfaction through an updated meal delivery process, meal times and structure, and amenity set up to ensure that meals are delivered at temperatures which enhance the palatability of the food. 2.) How and who are identified as being affected by practice: All residents who receive oral intake have the potential to be affected. 3.) Measures to Ensure Compliance: All dietary/nursing staff involved in the serving process will be educated on the updated serving procedure and meal structure timing by dietary/nursing leadership or designees by March 30, 2017. 4.) Monitoring Performance: Auditing will be performed by Nursing/Dietary Management or designee 3 times/week for 4 weeks, 2 times/week for 8 weeks, and 1 time/week for 12weeks and PRN thereafter. Results of audits will be discussed at QA Committee meetings by Dietary and Nursing Management for review and recommendations starting April 2017 and 6 months thereafter and as needed from there. 5.) Timeline of Corrective Action to be Completed: Corrective action and education will be completed by March 30th.	

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 02/23/2017

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 364	Continued From page 8 when asked about room tray food temperatures, Resident #1 (identified as interviewable by the facility) stated, "It works to have a microwave. [The food is] often cold." - During a random interview on 02/22/17 at 7:55 a.m., when asked about room tray food temperatures, Resident #2 (identified as interviewable by the facility) stated, "[It] should be hot. [It's] cold when served." - During a random interview on 02/22/17 at 8:11 a.m., when asked about room tray food temperatures, Resident #4 (identified as interviewable by the facility) stated, "[It's] not always hot when it gets here." A sample tray was ordered during the noon meal on 02/22/17. At 12:45 p.m., the surveyor took the temperatures of the main entree items using a food thermometer. The green beans were cold and the mashed potatoes were warm. During an interview on the afternoon of 02/23/17, administrative staff members (#2 and #3) offered no additional information regarding food temperatures. The facility failed to provide meals to residents eating in their rooms at temperatures which enhanced the palatability of the food.	F 364		
F9999	FINAL OBSERVATIONS The complaint issues regarding resident preferences, medications, insufficient amount of food, weight loss, oral cares, bathing, grooming, application of appliances, transfers, appointments, supervision, and personal	F9999		

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 02/23/2017

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
F9999	Continued From page 9 property, could not be substantiated.	F9999		