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 _____	06/28/2018

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 The standard Medicare/Medicaid recertification survey started on 06/25/2018 and concluded on 06/28/18.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		8/2/18

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

Electronically Signed | 07/20/2018

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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F 623	Continued From page 1 (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the	F 623		

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F 623	Continued From page 2 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY CONDUCTED ON 05/11/17. Based on record review and staff interview, the facility failed to provide the Office of the State Long Term Care (LTC) Ombudsman a written notice of transfer, including the destination, the reason for transfer, and the resident's right to appeal the action for 4 of 4 residents (Resident #6, # 63, #67, and #93) transferred to the hospital. Failure to provide a notice of transfer or discharge does not allow the Ombudsman to keep informed of all transfers/discharges.	F 623	F-0623 Notice Requirements Before Transfer/Discharge 1.) Facility has sent notice of transfer or discharge to the Ombudsman including the destination, and the reason for transfer for residents #6, #63, #67, and #93. 2.) All residents who are transferred or discharged have the potential to be affected. 3.) Social services and nursing staff has been educated July 23rd, 2018 on the requirement to notify Office of the State Long Term Care Ombudsman a written	

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F 623	Continued From page 3 Findings include: - Review of Resident #6's medical record occurred on all days of survey. Progress notes identified Resident #6 was hospitalized from March 5-9, 2018 and June 1-4, 2018. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for these hospitalizations. - Review of Resident #63's medical record occurred on all days of survey. Progress notes identified Resident #63 was hospitalized from April 28-30, 2018. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for this hospitalization. - Review of Resident #67's medical record occurred on all days of survey. Progress notes identified Resident #67 was hospitalized from April 26-28, 2018. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for this hospitalization. - Review of Resident #93's medical record occurred on 06/28/18. Progress notes identified Resident #93 was hospitalized May 23, 2018. The record lacked evidence the facility provided the State LTC Ombudsman written notice of transfer for this hospitalization. During an interview on 06/28/18 at 11:41 a.m., an administrative staff member (#7) stated she sends the notice of transfer forms every Friday to the State LTC Ombudsman. The document is scanned into the computer system and is not re-scanned with the date sent to ombudsman.	F 623	notice of transfer, including the destination, the reason for transfer, and the resident□s right to appeal the action. 4.) Social services and or designees will be responsible to monitor that all transfers and discharges are sent to the Office of the State Long Term Care Ombudsman, dated and recorded in documentation. QA monitoring was implemented July 23rd, 2018. Social Services or designees will monitor all transfers and Discharges for a month, weekly for one month, monthly for three months, and then quarterly audits per QA committee recommendations. Results will be immediately reported to the Executive Director. Social Services or designees will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5.) Date of Correction: August 2nd, 2018.	

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F 623	Continued From page 4 The facility failed to provided evidence the State LTC Ombudsman received written notice of transfers for these hospitalizations.	F 623		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, the facility failed to complete a significant change in status assessment (SCSA) for 1 of 5 sampled residents (Resident #67) admitted to hospice. Failure to determine the need for and complete a SCSA limited the facility's ability to accurately assess the resident's status, and identify and implement appropriate care approaches. Findings include: The Long-Term Care Facility RAI 3.0 User's Manual (Version 1.15), dated October 2017, page 2-23 stated, ". . . A SCSA is required to be performed when a terminally ill resident enrolls in	F 637	F-0637 Comprehensive Assessment After Significant Change 1.) Facility has reassessed resident #67 and completed a significant change in status assessment. 2.) All residents who have a significant change have the potential to be affected. The facility will ensure staff will complete a significant change in status assessment and MDS coded accordingly as indicated in the long-term care facility RAI 3.0 user□s manual. 3.) Staff completing the MDS will be educated on completing the significant change in status assessment per the long-term care facility RAI 3.0 user□s manual and were sent to training July	8/2/18

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F 637	Continued From page 5 a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD [assessment reference date] must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). . . ." Review of Resident #67's medical record occurred on all days of survey. A physician's order stated, "admitted to [name of hospice agency] 05/16/18." The care plan stated, ". . . [Resident's name] was admitted to [name of hospice agency] service on 05/16/18. Hospice will assist to provide support to [Resident's name] and her family . . ." During an interview on 06/27/18 at 12:45 p.m., an administrative nurse (#8) confirmed Resident #67 should have had a SCSA completed for the start of hospice.	F 637	17th through July 18th, 2018. 4.) The DON or designee will be responsible to monitor the appropriate completion of the significant change in status assessment. QA monitoring was implemented on 7/23/2018. The DON or designee will monitor weekly for a month, monthly for three months, and then quarterly audits 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/designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: August 2nd, 2018	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observations, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.15), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 6 of 20 sampled residents (Resident #16, #63, #72, #73, #142, and #293). Failure to accurately complete Section H	F 641	F-0641 Accuracy of Assessments 1.) Residents #16, #63, #72, #73, #142, #293 MDS Assessments were modified to reflect the correct assessments. MDS sections H0100B, H0300, J1400, N0410C, N0410E and P0200E have been audited for accuracy. 2.) All residents have the potential to be	8/2/18

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F 641	Continued From page 6 (Bladder and Bowel), Section J (Health Conditions), Section N (Medications), and Section P (Restraints and Alarms) of the MDS does not allow each resident's assessment to reflect their current status/needs, and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION H: BLADDER AND BOWEL The Long-Term Care Facility RAI Manual, page H2 - H9, stated, ". . . Coding Instructions: Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days. H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube). H0100B, external catheter . . . H0300: Urinary Continence Code 0, always continent: if throughout the 7-day look-back period the resident has been continent of urine, without any episodes of incontinence. Code 1, occasionally incontinent: if during the 7-day look-back period the resident was incontinent less than 7 episodes. This includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime. . . ." Observation on 06/26/18 at 8:58 a.m. showed Resident #73 with an indwelling catheter connected to a leg drainage bag. Review of Resident #73's medical record occurred on all days of survey. Diagnoses included obstruction and retention of urine. A	F 641	affected. 3.) All staff who complete the MDS Assessments have been educated on proper coding of the MDS July 17th through July 18th via MDS training through Pathway Health. 4.) The Director of Nursing or designee will be responsible to monitor the MDS Assessment Process to accurately reflect the condition of the resident. QA Monitoring was implemented 7/23/2018. The DON or designee will monitor MDS sections H0100B, H0300, J1400, N0410C, N0410E and P0200E weekly for a month, monthly for three months and quarterly audits 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: August 2nd, 2018.	

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F 641	Continued From page 7	F 641		

physician's order dated 04/28/18, indicated an indwelling catheter. The Medicare 30 day MDS, dated 05/25/18, showed a check next to H0100A, indwelling catheter and H0100B, external catheter. Section H0300 showed a "1," indicating occasionally incontinent of urine.

During an interview on 06/27/18 at 3:50 p.m., an administrative nurse (#8) confirmed she coded section H0100B and H0300 incorrectly

SECTION J: HEALTH CONDITIONS

The Long-Term Care Facility RAI Manual, page J24, stated, ". . . J1400 Coding Instructions: Code 0, no: if the medical record does not contain physician documentation that the resident is terminally ill and the resident is not receiving hospice services. 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."

- Review of Resident #293's medical record occurred on all days of survey. The medical record showed Resident #293 started on hospice services on 05/22/18. A "Physicians Certification of Terminal Illness" form, signed and dated 05/23/18, indicated Resident #293's terminal diagnosis. The significant change in status MDS, dated 05/29/18, showed a "no" in section J1400.

During an interview on 06/27/18 at 12:45 p.m., an administrative nurse (#8) confirmed she should have coded "yes" for section J1400.

- Review of Resident #142's medical record

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F 641	Continued From page 8 occurred on all days of survey. The medical record showed Resident #142 started receiving hospice services on 05/31/18. A "Hospice Initial Certification" form, dated 05/31/18 and signed by the physician, identified a 6 month terminal diagnosis. An admission MDS, dated 06/07/18, showed a "no" in section J1400. SECTION N: MEDICATIONS The Long-Term Care Facility RAI Manual, pages N-4 to N-7, stated," . . . Indicate the number of days the resident received the following medications by pharmacological classification, not how it is used, during the last seven days . . . . Enter "0" if medication was not received by the resident during the last 7 days . . . . N0410C, Antidepressant: Record the number of days an antidepressant medication was received by the resident at any time during the 7-day look-back period . . . N0410E, Anticoagulant (e.g., warfarin, heparin, or low- molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel here. . . ." - Review of Resident #16's medical record occurred on all days of survey. Diagnoses included depression. The March 2018 Medication Administration Record (MAR) showed Resident #16 received sertraline HCL (an antidepressant) 50 mg (milligrams) every day in March. The quarterly MDS, dated 03/21/2018, showed a "0" in section N0410C: Antidepressant.	F 641		

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F 641	Continued From page 9 - Review of Resident #72's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance and anxiety disorder. The May 2018 MAR showed Resident #72 received Zoloft 50 mg every day in May. The quarterly MDS, dated 05/23/18, showed a "0" in section N0410C. During an interview the morning of 06/28/18, an administrative nurse (#8) confirmed she should have coded a "7" for medication received in last 7 days in section N0410C. - Review of Resident #73's medical record occurred on all days of survey. Diagnoses included cerebral infarct (stroke). The May 2018 MAR showed Resident #73 received Ticagrelor (antiplatelet medication) daily. The Medicare 30 day MDS, dated 05/25/18, showed a "7" in section N0410E. During an interview on the morning of 06/28/18, an administrative nurse (#8) confirmed she should not have coded Resident #73's MDS a "7" for anticoagulant use in section N0410E. SECTION P: RESTRAINTS AND ALARMS The Long-Term Care Facility RAI Manual, pages P-9 to P-10, stated, ". . . After determining whether or not an item listed in P0200 was used during the 7-day look-back period . . . Code 0, not used: if the device was not used during the 7-day look-back period . . . Code 1, used less than daily: if the device was used less than daily . . . Code 2, used daily: if the device was used on a daily basis during the look-back period . . .	F 641		

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F 641	Continued From page 10 Wander/elopement alarm includes devices such as bracelets, pins/buttons worn on the resident's clothing, sensors in shoes, or building/unit exit sensors worn by/attached to the resident that activate an alarm and/or alert the staff when the resident nears or exits a specific area or the building. This includes devices that are attached to resident's assistive device (e.g., walker, wheelchair, cane) or other belongings. . . ." Review of Resident #63's medical record occurred on all days of survey. The current physician's order stated, ". . . Test wander guard to make sure functioning correctly . . . Check placement of wander guard to left ankle . . ." The quarterly MDS, dated 05/07/18, showed a "no" in section P0200E (wander/elopement alarm). During the afternoon of 06/26/18, observation showed Resident #63 sitting in the common area with a wander guard to the left ankle. During an interview on 06/28/18 at 11:24 a.m., an administrative nurse (#8) confirmed she coded Resident #63's MDS incorrectly.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 1. MEDICATION ADMINISTRATION Based on observation, review of professional reference, and staff interview, the facility failed to	F 658	F-0658 Services Provided Meet Professional Standards 1.) Medications will be prepared for	8/2/18

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F 658	Continued From page 11 ensure staff followed professional standards of practice for 1 of 5 observations of medication administration. Failure to prepare medications for the resident immediately before administration by "pre-dishing" ahead of time andfailure to document the time controlled medications are dispensed has the potential to increase the risk of medication errors. Findings include: The Geriatric Medication Handbook, 7th ed., American Society of Consultant Pharmacists, page 148 stated, ". . . Medications should be prepared for the resident immediately before administration; medications should never be prepared in advance for multiple residents . . ." Observation on 06/27/18 at 7:51 a.m., showed a Medication Assistant II (MA) (#6) enterd Resident #80's room, the MA (#6) set down three medication cups, one stacked inside the other, each medication cup contained one to two pills. When asked about the pre-dished medications, the MA (#6) stated, "I prepared them earlier and after I give them I write the time on the medication cup. When I am done with my medication pass I enter the time on the narcotic sign out sheet." Observation showed, written on the cups, the first initial of Resident #80, Resident #53 and Resident #72. The MA (#6) identified all three cups contained controlled medications. * At 8:08 a.m., observation showed the MA (#6) had not yet administered the medications to Resident #53 and Resident #72. The MA (#6) placed the two medication cups into a storage container in the locked medication room at the	F 658	residents immediately before administration, one resident at a time, and narcotics/controlled medications will be signed out immediately after being removed from the package. Insulin pens will be primed according to manufacturer□'s instructions. 2.) All residents receiving medications, and those receiving insulin have the potential to be affected. 3.) All licensed nurses have received training on the proper way to prime insulin pens, and all nursing staff have received education on medication administration policy and process 7/23/2018. 4.) The Director of Nursing or designee will be responsible to monitor medication administration passes and priming of insulin pens. QA Monitoring was implemented on 7/23/2018. The DON or designee will monitor weekly for a month, monthly for three months and quarterly audits 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: August 2nd, 2018	

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F 658	Continued From page 12 nurse's station. *At 10:28 a.m., review of the document to sign out controlled medications, showed the medications for Resident #80, Resident #53 and Resident #72 were not documented as dispensed. During an interview on 06/27/18 at 4:25 p.m., an administrative nurse (#1) reported nursing staff should not pre-dish medications and should sign out narcotics/controlled medications immediately when removed from the package. 2. PRIMING INSULIN PEN Based on observation, review of manufacturer's instructions, and staff interview, the facility failed to ensure staff followed professional standards of practice for 1 of 2 observations of insulin administration. Failure to correctly prime an insulin pen may result in the resident not receiving the prescribed dose of insulin. Findings include: The manufacturer's instructions for the NovoLog flex pen, revised March 2017, stated, " . . . Step 4: push the capped needle straight onto the pen and twist the needle on until it is tight. Step 5: Pull off the outer needle cap . . . Priming your NovoLog FlexTouch pen, Step 7: turn the dose selector to select 2 units. Step 8: Hold the pen with the needle pointing up. Tap the top of the pen gently a few times to let any air bubbles rise to the top. Step 9: Hold the pen with the needle pointing up. Press and hold in the dose button until the dose counter shows 0 . . . A drop of insulin should be seen at the needle tip. If you do	F 658		

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F 658	Continued From page 13 not see a drop of insulin, repeat steps 7 to 9, . . ." Observation on 06/27/18 at 9:10 a.m., showed a staff nurse (#4) prepared a NovoLog insulin pen. The staff nurse (#4) held the tip of the insulin pen horizontally and primed the insulin pen with the needle cap in place. During an interview on the morning of 06/28/18, an administrative nurse (#1) confirmed an insulin pen should be primed in the upward position with the needle cap off.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional reference, and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #244) receiving oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Berman and Synder, S., "Kozier & Erb's	F 695	F-0695 Respiratory/tracheostomy Care and Suctioning 1.) Resident #244 was reassessed for oxygen use, and nursing consulted with provider to obtain appropriate order. All residents receiving oxygen have been reassessed. 2.) All residents utilizing oxygen have the potential to be affected. 3.) All nursing staff has been provided education on monitoring oxygen use, in addition to facility oxygen use and storage	8/2/18

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F 695	Continued From page 14 Fundamentals of Nursing Concepts, Process, and Practice," 9th ed., Pearson Education, Inc., New Jersey, page 1397, stated, "OXYGEN THERAPY . . . Like any medication, oxygen is not completely harmless to the client. Clients receive an inadequate amount or an excessive amount of oxygen and both can lead to a decline in the client's condition. An inadequate amount of oxygen (hypoxia) will lead to cell death, and if left untreated can ultimately lead to death. . . ." Review of Resident #244's medical record occurred on all days of survey. The physician's orders, dated 06/20/18 stated, ". . . Oxygen at 2 liters [L]/minute per nasal cannula as needed for dyspnea . . ." The resident's June 2018 eMAR (electronic medication administration record) identified oxygen had not been used since admission. The vital records showed staff checked Resident #244's O2 (oxygen) saturations once since her admission on 06/20/18. During observation on the afternoon of 06/25/18 and the morning of 06/26/18, the resident was lying in bed receiving oxygen at 2L/minute per nasal cannula. During an interview on 06/27/18 at 1:54 p.m., an administrative nurse (#1) stated she was unable to find documentation to support the use of O2 continuously.	F 695	policy on 7/23/2018. 4.) The Director of Nursing or designee will be responsible to monitor compliance with oxygen use and storage policy. QA Monitoring was implemented on 7/23/2018. The DON or designee will monitor weekly for a month, monthly for three months and quarterly audits 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: August 2nd, 2018	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		8/2/18

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F 761	Continued From page 15 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, review of facility policy, and staff interview, the facility failed to label mulit-dose insulin pens and discard outdated medications on 2 of 4 units (1 East and 2 East). Failure to label multi-dose insulin pens with the date opened and discard expired medications increased the risk of residents receiving outdated medications with reduced medication efficacy. Findings include: Review of the facility policy titled "Medication Administration Information" occurred on	F 761	F-0761 Label/store Drugs and Biologicals 1.) Via immediate audits ensured all insulin pens are labeled with the date opened, and disposed of all expired medications. 2.) All residents receiving drugs/biologicals have the potential to be affected. 3.) All nursing staff have received education on medication administration policy and the updated process which ensures that all medications are labeled with open date and disposed of	

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F 761	Continued From page 16 06/27/18. This policy dated October 2016, stated, ". . . Mulit-dose vials must be labeled with the date opened. . . ." - Observation on 2 East on 06/27/18 at 9:10 a.m., showed a staff nurse (#4) administer a scheduled dose of NovoLog insulin with a mulit-dose insulin pen. The insulin pen/pharmacy label did not contain a date when opened. During the observation the nurse (#4) stated the insulin pen should have been dated when it was opened and verified the date was not written on the pen or the pharmacy label. - Observation on 1 East on 06/28/18 at 8:40 a.m., showed a staff nurse (#5) administer a scheduled dose of NovoLog insulin with a mulit-dose insulin pen. The insulin pen/pharmacy label did not contain a date when opened. During the observation the nurse (#5) stated the insulin pen should have been dated when it was opened, and she would write the date on the label since she opened the pen that morning. - Observation of the medication storage areas located in the nurse stations and in resident rooms occurred on 06/27/18 with a Medication Assistant II (MA) (#6). Observation identified the following medications and the expiration date: Nurse station (2 East) medication storage area: * Seven single dose syringes of Prevnar 13 pneumococcal vaccine - May 2018 Resident rooms on 2 East : * Antidiarrheal 2 mg capsules - October 2017 * Tylenol 500 mg tablets - July 2017 * Milk of Magnesia (bottle) - March 2018	F 761	appropriately when expired on 7/23/2018. 4.) The Director of Nursing or designee will be responsible to monitor medication storage areas to ensure all medications are labeled and that there are no expired medications. QA Monitoring was implemented on 7/23/2018. The DON or designee will monitor weekly for a month, monthly for three months and quarterly audits 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: August 2nd, 2018	

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F 761	Continued From page 17 * Lactulose suspension (bottle) - September 2017 * Hemorrhoidal ointment (tube) - December 2017 * Tylenol 325 mg tablets - July 2017 * Antidiarrheal 2 mg capsules - August 2017 * Saline Nasal spray (bottle) - December 2017 * Antacid tablets (bottle) - October 2017 * Antidiarrheal 2 mg capsules - December 2017 During the observation, the MA (#6) agreed the above items needed to be discarded. Failure to correctly label and dispose of medications may increase the risk of residents receiving an inaccurate dose of medication and/or reduced medication efficacy.	F 761		
F 880 SS=D	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. 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	F 880		8/2/18

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F 880	Continued From page 18 under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) 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.	F 880		

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F 880	Continued From page 19 §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 infection control practices for 3 of 14 sampled residents (Resident #35, #192, and #293) observed during personal cares. Failure to follow infection control practices of hand hygiene during toileting/personal cares has the potential to spread infection to other residents, personnel, and visitors. Review of the facility policy titled "Gloves-Guidelines For The Wearing" occurred on 06/27/18. This policy, dated November 2013, stated, ". . . Always wash hands before and after gloving. . . ." Review of the facility policy titled "Hand Hygiene" occurred on 06/27/18. This policy, dated November 2013, stated, ". . . Hand hygiene will be done: . . . b. before every clean procedure, c. after every dirty procedure. . . ." Review of the facility policy titled "Management of Residents with (C-Diff) Clostridium Difficile" occurred on 06/27/18. This policy, dated February 2018, stated, ". . . Exceptional hand washing is a must as hand sanitizers do not work, no other form of hand hygiene is	F 880	F-0880 Infection Prevention and Control 1.) Residents #35, #192 and #293 will be monitored for change in infectious disease process. All staff will follow facility infection prevention practices per hand hygiene policy, gloves-guidelines for the wearing and management of residents with clostridium difficile. 2.) All residents have the potential to be affected. 3.) All direct care staff have received education on hand hygiene policy, gloves-guidelines for the wearing, and management of residents with Clostridium Difficle on 7/23/18. 4.)The Director of Nursing or designee will be responsible to monitor hand hygiene compliance per facility policies. QA Monitoring was implemented on 7/23/2018. The DON or designee will monitor weekly for a month, monthly for three months and quarterly audits 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	

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F 880	Continued From page 20 acceptable. . . ." - Review of Resident #192's medical record occurred on all days of survey. Diagnoses included C-Diff and on isolation precautions. Observation on 06/27/18 at 2:30 p.m. showed a certified nursing assistant (CNA) (#12) applied a gown and gloves and entered Resident #192's room. The resident stated he had a bowel movement (BM) in his brief. Using a gait belt, the CNA (#12) assisted the resident into the bathroom, removed the brief containing BM, and assisted the resident onto the toilet. Without changing gloves or performing hand hygiene, the CNA removed the resident's gait belt and pants, obtained wipes from a cabinet, and opened the door looking for staff assistance. When Resident #192 finished on the toilet, the CNA (#12) applied the gait belt, assisted the resident to stand, and performed perineal care after an other BM. Without changing gloves or performing hand hygiene, the CNA (#12) assisted the resident into bed, adjusted the blankets, moved the bedside table closer to the bed, gave the resident his call light, and obtained the resident's dirty clothes. The CNA (#12) then removed his/her gown and gloves and performed hand hygiene with soap and water. The CNA (#12) failed to remove his/her gloves and perform hand hygiene after removing a brief containing BM, after providing perineal cares and prior to completing other tasks. - Observation on 06/26/18 at 11:40 a.m. showed a CNA (#11) assisted Resident #35 off the toilet and provided perineal care after a BM. The CNA (#11) changed gloves, assisted the resident into	F 880	submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5.) Date of Correction: August 2nd, 2018	

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F 880	Continued From page 21 her wheelchair, and removed the resident's gait belt. Without performing hand hygiene, the CNA (#11) wheeled the resident to the sink, removed his/her gloves and obtained a clean paper towel for the resident. The CNA (#11) collected the garbage in the bathroom and performed hand hygiene. The CNA (#11) failed to perform hand hygiene after providing perineal care and prior to completing other tasks. - Observation on 06/26/18 at 10:09 a.m. showed two CNA's (#9 and #10) donned gloves and performed perineal care for Resident #293 while he was in bed. One CNA (#9) assisted Resident #293 with perineal care, disposed of the soiled brief, removed her gloves, and failed to complete hand hygiene. The CNA's (#9 and #10) applied a clean brief, pulled his pants up, repositioned him on his side, placed pillows behind his back and between his legs. The CNA (#9) held the bed control in her hand and lowered the bed, offered Resident #293 a drink and held the straw with her fingers to place it into the residents' mouth, touched her walkie-talkie to respond to a coworker, and placed the call light and bedside table next to Resident #293. The CNA (#9) then performed hand hygiene. During an interview on 06/27/18 at 3:10 p.m., an administrative nurse (#13) stated she expected staff to remove gloves and perform hand hygiene after removing a brief with BM. After perineal care, once the resident is safe, she expected staff to remove gloves and perform hand hygiene before doing other tasks.	F 880		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2)	F 908		8/2/18

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F 908	Continued From page 22 §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure emergency suction machine, remained in safe operating condition for 1 of 3 units (1 West). Failure to ensure the suction machine remained functional in the event of an emergency situation placed residents at risk for choking and aspiration. Findings include: Observation of the suction machine at the 1 West nurse station occurred on 06/27/18 at 2:12 p.m. with two nursing staff members (#2 and #3). Observation showed a nursing staff member (#2) attempted to connect tubing from the suction machine to the two collection canisters for the suction machine. After two minutes of unsuccessful attempts to connect and operate the suction machine, the nurse (#2) asked for assistance from another nursing staff member (#3). Both nurses (#2 and #3) attempted for a total of eight minutes to operate the suction machine. The nurses (#2 and #3) failed to connect the tubing correctly and the machine did not produce full suction when turned on. The nursing staff member (#3) started to page through the instruction manual and stated she would call maintenance to check the machine. During an interview on 06/27/18 at 3:50 p.m. an administrative nurse (#1) acknowledged the nursing staff members (#2 and #3) had not properly connected the tubing to the suction	F 908	F-0908 Essential Equipment, Safe Operating Condition 1.) All emergency suction machines were assembled and checked to ensure machines were in safe operating condition 6/29/2018 by contracted maintenance. 2.) All residents utilizing suction machine have the potential to be affected. 3.) All nurses and maintenance have received education on the assembly of the suction machine to ensure the machine is in safe operating condition 7/23/2018. 4.) Nursing and Maintenance or designees will be responsible to monitor that suction machines are in safe operating condition and nurse competency on proper assemble and use of machine per facility policy. The DON or designee will monitor weekly for a month, monthly for three months and quarterly audits per QA committee recommendations beginning the week of 7/23/2018. 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: August 2nd, 2018	

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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 908	Continued From page 23 machine and stated, "all nursing staff complete suction machine training upon hire and at the annual skills review."	F 908		