STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 complaint investigation, conducted September 17-18, 2014, the sample included (6) six current residents for review.	F 000	F 241 1. Resident #2, #3, & #4, the facility will provide dignity to all residents. 2. All Residents of the facility have the potential to be affected. 3. Facility staff re-educated to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Re-education will be completed prior to Date of Correction. 4. Date of Correction: November 2, 2014 5. The Director of Nursing or designee will be responsible to monitor resident dignity and respect. QA monitoring started on 10/6/14. After date of correction the DON or designee will monitor daily for two weeks, weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to provide care for 3 of 6 sampled residents (Resident #2, #3, and #4) in a manner and environment that maintained or enhanced each resident's dignity. Failure to knock on doors/request permission prior to entering resident rooms (Resident #2, #3, and #4), ensure privacy while providing cares (Resident #2), and/or treat residents respectfully while providing cares (Resident #4) does not promote resident dignity or enhance quality of life. Findings include: Review of the facility policy titled "Standards of Care" occurred on 09/18/14. This policy, dated May 2013, stated, ". . . DIGNITY: 1. . . . curtain . . . to be closed with cares, 2. Knock at the door when entering the resident's room . . ." - During observation on 09/17/14 at 3:13 p.m., a managerial dietary staff member (#6) knocked and immediately entered Resident #3's room as a	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tonya W. Pankratz | TITLE: Executive Director | (X6) DATE: Revised 11/6/14

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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	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

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F 241	Continued From page 1	F 241		

nurse (#4) assessed the pressure ulcer on his buttocks. The managerial dietary staff member (#6) failed to announce herself and/or request Resident #3's permission prior to entering his room.

- During observation on 09/17/14 at 3:35 p.m., a certified medication assistant (CMA) (#7) entered Resident #2's room as he lay in bed, pulled back the privacy curtain, scanned the room, turned, and exited the room to prepare Resident #2's medications. The CMA (#7) failed to announce himself and/or request Resident #2's permission prior to entering his room.

- During observation on 09/17/14 at 3:40 p.m., Resident #2 lay in bed with the window blind/curtain open. Observation showed a walkway directly outside his bedroom window. The nurse (#4) pulled the sheet down in order to treat the pressure ulcer on Resident #2's buttocks; exposing him as he was unclothed under the sheet. The nurse (#4) failed to close the curtains to Resident #2's room prior to beginning treatment.

- During observation on 09/17/14 between 5:00 and 5:30 p.m., two certified nursing assistants (CNAs) (#2 and #3) transferred Resident #4 from the bed to a wheelchair using a Hoyer (full body) lift. During the transfer, Resident #4 stated "one side at a time." The CNA (#2) responded in a condescending tone of voice "just one side at a time." Upon seating Resident #4 into the wheelchair, Resident #4 released flatus (gas) during positioning. The CNA (#2) laughed in a loud manner, and the other CNA (#3) did the same in a more discreet manner.

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F 241	Continued From page 2 - During observation on 09/18/14 at 8:48 a.m., an unidentified nurse entered Resident #2's room as he lay in the dark watching tv, pulled back the privacy curtain, spoke with him, and exited the room. The unidentified nurse failed to announce herself and/or request Resident #2's permission prior to entering his room. - During observation on 09/18/14 at 9:45 a.m., two CNAs (#8 and #9) knocked and immediately entered Resident #4's room to transfer him to bed. The two CNAs (#8 and #9) failed to announce themselves and/or request Resident #4's permission prior to entering his room. During an interview on 09/18/14 at 4:00 p.m., an administrative staff member (#1) confirmed he would expect facility staff to knock/wait for a response prior to entering resident's room, shut window blinds/curtains prior to providing cares to a resident, and speak respectfully to/in front of residents.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	F 280		

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F 280	Continued From page 3 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the residents' current status for 1 of 6 sampled residents (Resident #2). Failure to revise the care plans limited staff's ability to communicate care needs and ensure continuity of care for Resident #2. Findings include: Review of Resident #2's medical record occurred on all days of survey. Diagnoses included tobacco use. The facility failed to provide a copy of Resident #2's smoking assessment upon request. Both the physician's orders and his current care plan failed to address his tobacco use. The progress notes, dated 08/19/14, 09/01/14, and 09/03/14, identified Resident #2 smoked "off the property" and was inconsistent in signing out. During an interview on 09/18/14 at 9:45 a.m., two managerial nurses (#16 and #17) reported Resident #2 smokes off campus as the facility does not have a designated smoking area. They also reported Resident #2 is responsible for his	F 280	F 280 1. Resident #2 was assessed and care plan was updated to reflect the residents' current status. 2. All residents who have a change of condition have a potential to be affected. Care plans will be reviewed and updated as needed. 3. CNA's and Nurses re-educated to update care plans to reflect current status of residents to communicate the care needs of the residents. Re-education will be completed prior to Date of Correction. 4. Date of Correction: November 2, 2014. 5. The Director of Nursing or designee will be responsible to monitor resident care plans. QA monitoring implemented and started on 10/6/14. After date of correction the DON or designee will monitor daily for two weeks, weekly for one month, monthly for three months, then random audits as needed. Results will be immediately reported to the Executive Director. 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 280	Continued From page 4 own cigarettes/lighter and stores them in his room. During an interview on 09/18/14 at 10:35 a.m., Resident #2 reported he "smokes in the park two blocks away," and disposes of his cigarettes by "putting them out in a pop can and throwing them in a garbage [can]." During an interview on 09/18/14 at 12:00 p.m., an administrative staff member (#1) reported the facility does not have a smoking assessment as residents are not allowed to smoke on site. The administrative staff member (#1) also reported Resident #2 "keeps his cigarettes/lighter locked in his bedside stand," and staff "encourage him to sign out [before he leaves the facility]." The facility failed to ensure Resident #2's care plan reflected the necessary individualized interventions to ensure he was safe to leave the facility to smoke unsupervised and failed to indicate how Resident #2 would contact the facility should a mishap occur (ie: falling out of his wheelchair, getting his wheelchair stuck in the snow, etc.)	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 5 This REQUIREMENT is not met as evidenced by: SAFETY OFF CAMPUS 1. Based on observation, record review, and staff interview, the facility failed to ensure 1 of 1 sampled resident (Resident #2) who utilized his wheelchair to leave the facility campus to smoke could do so safely. Failure to complete an assessment to determine whether Resident #2 was safe to leave the campus unsupervised to smoke and failure to identify how he would acquire assistance from staff (if needed) once he's left the facility may result in an avoidable accident with/without injury. Findings include: The facility failed to provide a copy of a smoking policy upon request. Review of Resident #2's medical record occurred on all days of survey. Diagnoses included schizophrenia, obesity, paraplegia, and tobacco use. The quarterly Minimum Data Set (MDS), dated 08/21/14, identified Resident #2 as cognitively intact and independent with locomotion on/off the unit even with his lower extremity impairment. The facility failed to provide a copy of Resident #2's smoking assessment upon request. Both the physician's orders and his current care plan failed to address his tobacco use. The progress notes identified the following: * 08/19/14, "Spoke with [Resident #2] this morning about when he goes outside to smoke he needs to make sure he is going off the	F 323	F 323 1. Resident #2 assessed for safety to remain free of accident hazards. 2. Residents who are independent and sign out of the facility have the potential to be affected and have been assessed. 3. Assessed Resident #2 capabilities to determine safety prior to date of correction. Resident #2 Care Plan was updated prior to date of correction to identify how Resident #2 would obtain assistance if needed when out of the facility. CNA's and Nurses staff re-education on safety assessments of residents with the ability to leave the facility to be free of accidents. Re-education will be completed prior to Date of Correction. 4. Date of Correction: November 2, 2014. 5. The Director of Nursing or designee will be responsible to monitor resident safety assessments of the residents who leave the facility. QA monitoring implemented started on 10/6/14. After date of correction the DON or designee will monitor daily for two weeks, weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. 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 323	Continued From page 6	F 323		

property and also to make sure that he is signing out at the nurses station when he goes to smoke because he is going off the property. . . ."
* 09/01/14, "Resident [#2] up all night and outside in w/c [wheelchair] smking [sic]. . . ."
* 09/03/14, "tried many times to find him [Resident #2] so that his tx [treatment] to buttocks could be done and he was out and about outside and did not sign out . . ."

During an interview on 09/18/14 at 9:45 a.m., when asked questions regarding Resident #2's smoking habits, two managerial nurses (#16 and #17) reported he has to go off campus as the facility does not have a designated smoking area.

During an interview on 09/18/14 at 10:35 a.m., when asked questions regarding his smoking habits, Resident #2 reported he "smokes in the park two blocks away [from the facility].

During an interview on 09/18/14 at 10:45 a.m., when asked questions regarding Resident #2's smoking habits, a managerial nurse (#18) reported Resident #2 "smokes a handful of times during the day, [in the] winter too."

During an interview on 09/18/14 at 12:00 p.m., an administrative staff member (#1) reported residents are not allowed to smoke on site as the facility has been smoke free for approximately two years. He stated, "[Resident #2] can't smoke on site, but he has his rights, to smoke if he wants to. We can't stop him from doing what he wants off site." The administrative staff member (#1) explained the facility does not have a smoking policy or smoking assessment secondary to being smoke free. When asked questions specific to Resident #2's smoking

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	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 323	Continued From page 7 habits, the administrative staff member (#1) reported seeing "[Resident #2] in the street, just off the sidewalk." Observation on 09/18/14 at 1:30 and 4:15 p.m., showed Resident #2 sitting at the end of the facility driveway behind a parked van in his wheelchair; approximately three-to-four feet from the curb. He was holding a soda. Further observation showed no recreation areas, picnic areas, or garbage cans near the facility. The facility failed to ensure Resident #2 received the care and services necessary to attain the highest degree of safety possible while smoking off campus. They failed to: * Assess Resident #2's capabilities and deficits to determine whether supervision was required, * Ensure Resident #2 returned to the facility in a timely manner and/or identify/care plan how Resident #2 would acquire assistance from staff (if needed) once he'd left the facility.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 441	Continued From page 8 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: HAND HYGIENE AND DISPOSAL OF SHARPS 1. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control standards regarding 1 of 1 insulin injection and 2 of 2 accuchecks (blood glucose monitoring) and regarding hazardous waste disposal during 1 of 2 observations. Failure to perform hand hygiene, dispose of blood glucose strips and used lancets properly may result in needle stick injuries and exposure to bloodborne pathogens.	F 441	F 441 1. Resident #2, #3, & #4, reassessed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection. 2. In the absence of appropriate hand-washing and disposal of sharps all residents have the potential to be affected. 3. CNA's and Nursing staff re-educated on infection control. This education included: hand hygiene before and after direct resident contact, before and after any invasive procedures, before and after entering isolation precaution settings, before and after dressing changes to the residents, before and after assisting a resident with toileting, after handling soiled or used dressings and catheters, and after removing gloves. Re-educated to dispose of biohazard materials in biohazard containers. Re-education provided to identify isolation procedures. Re-education will be completed prior to Date of Correction. 4. Date of Correction: November 2,2014 5. The Director of Nursing or designee will be responsible to monitor infection control, isolation procedures, and disposal of biohazard materials. QA monitoring implemented and started on 10/6/14. After date of correction the DON or designee will monitor daily for two weeks, weekly for one month, monthly for three months, and then random audits as needed. Results will be immediately reported to the Executive Director. The DON or designee will submit a report of the monitoring results to the QA Committee at each scheduled meeting.	

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	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 441	Continued From page 9 Findings include: Review of the facility policy titled "Transmission Based Precautions" occurred on 09/18/14. This policy, dated August 2013, stated, "Hand Hygiene - refers to washing of hands with soap and water with an anti-microbial soap or thoroughly applying an alcohol-based hand rub (ABHR). This is the primary means to prevent the transmission of infection. . . . examples of when hand hygiene should be done: . . . Before and after performing any invasive procedure (e.g. fingerstick blood sampling . . . injections, etc) . . . Equipment Cleaning/Disinfecting Guidelines . . . Critical Items - these include all items [sic] enter sterile tissue or vascular system . . . Will be disposed of in an approved manner for medical waste. . . ." Review of the facility policy and procedure "Needles & Syringes - Use and Disposal" occurred on the afternoon of 09/18/14. The policy stated, "The Safety Needle System will be used when giving injections. Contaminated needles/sharps will . . . be properly disposed of according to procedure. PURPOSE: To prevent contaminated needle stick injury to staff person. To ensure proper disposal of contaminated needles/sharps. PROCEDURE: 1. When using any needles/sharps, take the sharps container with you into working area, carefully place contaminated needle/sharp into the container. . . ." On 09/17/14 at 5:00 p.m., a nurse (#4) performed a puncture to Resident #4's finger with a gloved hand to obtain a blood sample for an accucheck. Upon completion, the nurse removed her glove and enclosed the glucose strip and alcohol wipe inside the glove. The nurse disposed of the glove	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 441	Continued From page 10	F 441		

and contents into the garbage can in the resident's room. The nurse left the resident's room without performing hand hygiene, walked to the medication cart, cleaned the accucheck device with a sanitizing wipe (PDI), and then walked to a sink nearby to wash her hands with soap and water.

On 09/17/14 at 5:30 p.m., a nurse (#5) stood at a medication or treatment cart with an accucheck device. The device contained a glucose strip with a blood sample on it. A lancet sat on top of the cart. With a gloved hand, the nurse removed the strip and enclosed it within the glove, picked up the lancet and disposed both into the regular garbage.

On 09/17/14 at 5:40 p.m., a nurse (#5) administered an insulin injection to Resident #7 with a gloved hand. Upon completion, the nurse removed her glove and exited the room without performing hand hygiene. The nurse returned the Flex Pen to the medication cart and then used an alcohol based hand rub at the location of the medication cart.

On the afternoon of 09/18/14, an administrative staff member (#1) agreed sharps should not be disposed of into the regular garbage.

THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 12/19/13.

PERSONAL CARES

2. Based on observation, review of facility policy, and staff interview, the facility failed to follow infection control practices for 3 of 6 sampled residents (Resident #2, #3, and #4) observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 441	Continued From page 11	F 441		

receiving personal cares. Failure to follow infection control practices for these residents placed facility staff, residents, and visitors at risk for potential infections.

Findings include:

Review of the facility policy titled "Transmission Based Precautions" occurred on 09/18/14. This policy, dated August 2013, stated the following:
* ". . . * Isolation - refers to the practice used to reduce the spread of an infectious agent and/or minimize the transmission of an infection. . . .
* Contact Precautions - measures that are intended to prevent transmission of infectious agents/micro-organisms that are spread by direct or indirect contact with the resident or the resident's environment. . . .
* Hand Hygiene - refers to washing of hands with soap and water with an anti-microbial soap or thoroughly applying an alcohol-based hand rub (ABHR). This is the primary means to prevent the transmission of infection. . . . The following are examples of when hand hygiene should be done: Before and after direct resident contact . . . Before and after changing a dressing, before and after assisting a resident with toileting . . . After handling soiled or used . . . dressings . . . catheters . . . After removing gloves . . ."

- During the initial tour on 09/17/14 at 11:30 a.m., observation showed five residents' rooms on Wings 1, 2, 4, and 5 with no visible signage on either the doors to the residents' rooms or on the carts containing personal protective equipment (PPE) sitting directly outside their rooms.

- During an interview with a certified nursing assistant (CNA) (#10) on 09/17/14 at 2:30 p.m.,

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	355078	A. BUILDING _____ B. WING _____	C 09/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

(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 441	Continued From page 12	F 441		

when asked what type of precautions were necessary when working with Resident #3 (a resident on Wing 2 with an PPE cart outside his room), the CNA (#10) stated, "[Resident #3] has "c-diff [C. Difficile]." She reported staff are required to "glove and gown if providing cares." She further reported staff are to "glove if not providing cares."

- During an interview on 09/17/14 at 2:35 p.m., when asked what type of precautions were necessary when working with Resident #3, a second CNA (#11) pulled a red folder (containing several handouts on the various types of precautions) out of the PPE cart and stated, "It shows everything. Does that help you? You could ask the nurse."

- During an interview on 09/17/14 at 2:40 p.m., when asked what type of precautions were necessary when working with Resident #3, a nurse (#12) pulled the red folder out of the PPE cart and stated, "The one that's out is to be used." She was unable to locate a handout that was "out", and stated, "There isn't one." When asked how a staff person and/or visitor would know what type of precautions were necessary prior to entering Resident #3's room, she stated, "We don't post [the precautions on the door] anymore. I'll ask someone." She then proceeded to ask the CNA (#10) for direction.

- During observation on 09/17/14 at 2:42 p.m., two CNAs (#10 and #13) masked, gloved and put on a gown prior to entering Resident #3's room. The CNA #10 previously reported gloves and a gown were required when providing cares. She did not report needing to wear a mask. Resident #3 lay in bed as the two CNA's rolled him onto his

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F 441	Continued From page 13	F 441		

side, removed his soiled brief, provided pericares, and placed a new brief. The CNA (#10) removed her gloves, wiped her forehead, re-gloved, and removed the bag from the waste basket. After placing a new bag in the basket, she wiped the bedside table with a sani-wipe, removed her mask, gloves, and gown, and washed her hands in the bathroom. She then opened the bathroom door, re-gloved, removed the gloves, and left the resident's room. The CNA failed to wash her hands after toileting the resident on one occasion and/or removing her gloves on three occasions, and failed to sanitize her hands prior to exiting his room on one occasion. While exiting the resident's room, a sign was observed on the outside of the door to Resident #3's room which read, "Please see nurse before entering."

- During an interview on 09/17/14 at 2:55 p.m., the nurse (#12) approached the surveyor and stated, "They told me it [signage] should be on there [the door to the resident's room]. They went and got one right away."

- During observation on 09/17/14 at 3:13 p.m., Resident #3 lay in bed as the CNA (#14) rolled him onto his side and removed his brief. A nurse (#4) gloved and assessed his pressure ulcer. The nurse (#4) then removed her gloves and exited the resident's room. One of the CNAs (#14) removed her gloves, washed her hands, re-gloved, and told Resident #3 she was going to empty his catheter. The CNA (#14) opened an alcohol wipe packet, placed the wipe on top of the packet, and laid them both on the floor before emptying the catheter bag. The nurse (#4) re-entered Resident #3's room with an ointment, gloved, administered the ointment, removed her gloves and exited the room. The CNA failed to

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EVENTIDE JAMESTOWN	1300 2ND PL NE JAMESTOWN, ND 58401

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F 441	Continued From page 14	F 441		

place the alcohol wipe on a clean surface while emptying the resident's catheter, and the nurse failed to wash her hands before/after providing ulcer cares and prior to exiting the resident's room.

- During an interview on 09/17/14 at 3:25 p.m., after pointing out the signage on two residents' rooms on the 500 Wing, the nurse (#4) approached the surveyor and stated, "They put those signs up within the last hour."

- During observation on 09/17/14 at 3:35 p.m., a certified medication assistant (CMA) (#7) entered Resident #2's room as he lay in bed, pulled back the privacy curtain, located Resident #2, and exited the room. Within minutes, the CMA (#7) returned with Resident #2's medications, administered them, and exited the room. The CMA failed to sanitize his hands prior to exiting the resident's room on two occasions.

- During observation on 09/17/14 at 3:40 p.m., Resident #2 lay in bed as the nurse (#4) gloved and assessed his pressure ulcer. She removed her gloves and exited the resident's room. The nurse (#4) re-entered Resident #2's room, gloved, sanitized the top of the table, removed her gloves, and exited the room "to ask a question." The nurse (#4) re-entered Resident #2's room, gloved, covered his ulcer with a dressing, and then covered him with the sheet. She then picked up the area, removed her gloves, and exited the room. She stated, "He's on contact precautions, not isolation precautions." The nurse failed to wash her hands before/after providing ulcer cares and after removing her gloves, and failed to sanitize her hands prior to exiting the resident's room.

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F 441	Continued From page 15 - During observation on 09/18/14 at 8:48 a.m., an unidentified nurse entered Resident #2's room as he lay in the dark watching television, pulled back the privacy curtain, spoke with him, and exited the room. The unidentified nurse then walked to the medication cart in the hall, picked up another resident's medications, and walked into the dining room to administer them. The unidentified nurse failed to sanitize her hands prior to exiting the resident's room and administering another resident's medications. - During observation on 09/18/14 at 9:45 a.m., two CNAs (#8 and #9) transferred Resident #4 into bed using a mechanical lift, raised the head of the bed, removed his shoes, placed pillows under his legs, and exited the room. The two CNAs (#8 and #9) failed to sanitize their hands prior to exiting the resident's room. During an interview on 09/18/14 at 4:00 p.m., an administrative staff member (#1) confirmed he would expect facility staff to wash their hands before/ after changing a dressing or providing perineal care, after handling soiled dressings, and after removing their gloves. He also confirmed isolation room should be clearly identified.	F 441		