STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355124	A. BUILDING _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT SHEYENNE CROSSINGS	**125 13TH AVENUE WEST WEST FARGO, ND 58078**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced onsite complaint survey was completed on April 23-24, 2018. The sample included three (3) sampled residents and four (4) closed records for focused review.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility's policy, and staff interview, the facility failed to ensure staff implemented the facility's abuse/neglect policy during the provision of services for 1 of 1 resident (Resident #3) who experienced a significant medication error prior to discharge. Failure to implement the facility's policy placed Resident #3 and other residents at risk for possible neglect/additional medication errors. Findings include: Review of the policy titled, "Vulnerable Adult - North Dakota" occurred on 04/24/18. This policy, revised 09/01/16, stated, ". . . Neglect - Failure to	F 607	F607 □ Develop/Implement Abuse/Neglect Policies 1. Resident #3 no longer lives in the facility. Residents who experience a reportable medication error will have the incident thoroughly investigated and steps taken to see that other residents with the potential to be affected are not put at risk and are kept safe according to policy. 2. All residents who experience a significant reportable medication error have the potential to be affected. 3. Education will be completed for vulnerable adult abuse/neglect policies. Facility will review all reportable events and investigate thoroughly making certain	5/29/18

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

Electronically Signed | 05/15/2018

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F 607	Continued From page 1 provide . . . services necessary to avoid physical harm . . . An internal investigation will be made by the DON [Director of Nursing] or designee. . . . Alleged employee: will not participate in direct resident care until internal investigation is completed and the DON or her designee is able to make a decision deeming the employee able to return. . . ." The "Vulnerable Adult Report," dated 11/08/17, identified, "[Registered Nurse (RN)] self reported that she gave oral liquid Benadryl [an antihistamine] via resident's PICC [Peripherally Inserted Central Catheter] line (a catheter inserted into a large vein in the arm that carries blood to the heart)] on 2 occasions on 11/02/17. When [RN] realized she had given the medication the wrong route, she contacted the On-Call Provider, Poison Control, Pharmacy . . . and On-Call Manager. The Poison Control Center recommended that Provider send to ER [Emergency Room] and he was admitted to Observation Unit. Nurse received update from hospital on resident on 11/03/17 and resident was doing well, had some lethargy and no significant changes in labs. PICC line was removed. Education provided to nurse on "Medication Rights." Pharmacy label did not have oral indicated on pharmacy label, but it was indicated on bottle directions - discussed the importance of reading all labels. . . ." Throughout the survey, the team interacted with the newly hired Administrator (#2) and interim Director of Nursing (#1). They began working at the facility one week prior to the complaint survey and approximately five and a half months after the incident under investigation.	F 607	that steps are taken to ensure all residents are safe and prevent further abuse/neglect during the investigation period. All management staff will be educated on the Vulnerable Adult policy to be certain that residents are kept safe and protected during all investigations and appropriate monitoring and evaluation occurs by May 22, 2018. 4. The DON or designee will be responsible to monitor and investigate all vulnerable adult reports. QA monitoring will be implemented May 23, 2018. The DON or designee will monitor all vulnerable adult reports for a month, monthly for three months and then audits will be completed at least quarterly for one year and additional audits as recommended 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 present a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: May 29, 2018	

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F 607	Continued From page 2 During an interview on 04/24/18 at 8:30 a.m., when asked questions pertaining to the medication error, the administrative nurse (#1) explained she had stepped into her current role approximately one week prior, and "would have to do some research." Approximately two hours later, the administrative nurse (#1) provided a copy of the "Vulnerable Adult" report pertaining to the incident. When asked if the nurse involved in the incident was removed from her duties, the administrative nurse (#1) reported she had attempted to go through the previous DON's files, and wasn't able to locate any additional information showing that was done. The facility was unable to provide evidence a thorough investigation of the medication error had occurred and that other residents were protected during the investigation as per the facility's policy.	F 607		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		5/29/18

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F 610	Continued From page 3 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to thoroughly investigate an allegation and prevent further neglect from occurring while the investigation was in progress for 1 of 1 resident (Resident #3) who experienced a significant medication error prior to discharge. Failure to thoroughly investigate a significant medication error which required Resident #3 to be hospitalized for four days. By not thoroughly investigating this incident the facility placed other residents at risk for possible neglect/additional medication errors. Findings include: The facility was unable to provide evidence a thorough investigation of the medication error had been completed and further potential neglect was prevented while the investigation was being conducted. Refer to F607.	F 610	F610 □ Investigate/Prevent/Correct Alleged Violation 1. Resident #3 no longer lives in the facility. Residents who experience a significant reportable medication error will have the incident thoroughly investigated and steps are taken to see that other residents with the potential to be affected are not put at risk and are kept safe. 2. All residents who experience a significant reportable medication error have the potential to be affected. 3. Education will be completed for vulnerable adult abuse/neglect policies. Facility will review all reportable events and investigate thoroughly making certain that steps are taken to ensure all residents are safe and prevent further abuse/neglect during the investigation period. All management staff will be educated on the Vulnerable Adult policy to be certain that residents are kept safe and protected during all investigations and appropriate monitoring and evaluation occurs by May 22, 2018. 4. The DON or designee will be responsible to investigate and monitor all vulnerable adult reports. QA monitoring will be implemented May 23, 2018. The DON or designee will monitor all vulnerable adult reports for a month, monthly for three months and then audits	

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F 610	Continued From page 4	F 610	will be completed at least quarterly for one year and additional audits as recommended by the 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 present a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: May 29, 2018	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		5/29/18

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F 657	Continued From page 5 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to develop a comprehensive care plan for 2 of 4 closed records (Resident #3 and #4) reviewed. Failure to develop a care plan that includes the care and services to be provided to the resident may negatively impact the resident's continuity of care and quality of life. Findings include: Review of the facility policy titled "Care Plans" occurred on 04/24/18. This policy, revised September 2017, stated, ". . . The comprehensive care plan will be completed by the 14th day after admission and will be reviewed and updated monthly and as needed. Pertinent information from care plan will be added to the . . . CNA (Certified Nurse Aide) care plan for continuity of care. . . ." - Review of Resident #3's medical record occurred on April 23-24, 2018. A significant Minimum Data Set (MDS), dated 11/02/17, identified short term memory deficits, moderately impaired reasoning skills, and IV (intravenous) medications. The physician's orders, dated October 1-December 11, 2017, identified Resident #4 received the following medications via his Peripherally Inserted Central Catheter (PICC) line (a catheter inserted into a large vein in the arm that carries blood to the heart):	F 657	F657 □ Care Plan Timing and Revision 1. Residents #3 and #4 no longer reside in the facility. All resident□s care plans were reviewed and updated to reflect person centered care, for timeliness and accuracy of care provided. 2. All residents have the potential to be affected. 3. Care Plans are initiated on admission using an interdisciplinary process to develop. Care plans are reviewed and revised as needed for each resident with every change of condition and MDS assessment by a nurse or nurse leader. Nursing will ensure the care plan accurately reflects the resident□s current condition through assessment and by communicating all changes in condition to staff providing care. Education will be completed for staff completing care plans by May 22, 2018. 4. The DON or designee will be responsible to monitor the Care Plan process to accurately reflect person centered care. QA monitoring was implemented on May 23, 2018. The DON or designee will monitor ten care plans weekly for a month, thirty care plans monthly for three months, and then audits will be completed at least quarterly for one year and additional audits as recommended by the QA committee	

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F 657	Continued From page 6 * Benadryl (an antihistamine) 50 milligrams (mg) every 6 hours * Morphine Sulfate Solution (a pain reliever) 2 mg/milliliters (ml) 0.5 ml every hour as needed * Vacomycin HCl (an antibiotic) 1.5 gm (grams) every 48 hours Resident #3's care plan failed to identify the resident received medications through a PICC line, and failed to identify the interventions necessary to care for the site (aseptic techniques, type/frequency of dressing changes, signs/symptoms of skin irritation and/or displacement) and the catheter (changing the catheter cap, flushing the tube, which arm to use for a blood pressure, and/or whether the arm could be immersed in water.) During an interview on 04/24/18 at 8:30 a.m., an administrative nurse (#1) confirmed Resident #3's care plan failed to identify the resident received medications through a PICC line, and failed to identify the interventions necessary to care for the site and the catheter. - Review of Resident #4's medical record occurred on April 23-24, 2018. A significant MDS, dated 07/04/18, identified Resident #4 as cognitively intact and requiring IV antibiotics. The physician order's, dated June 29-July 21, 2017, identified Resident #4 received 2 mg Nafcillin Sodium Solution Reconstituted (an antibiotic) intravenously every 4 hours, flushed per . . . protocol with 300 units Heparin (an anticoagulant) after each dose of antibiotic every 4 hours for IV, and PICC dressing change once a week, and measure circumference of arm and line every Monday.	F 657	recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting. 5. Date of Correction: May 29, 2018	

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F 657	Continued From page 7 Resident #4's care plan failed to identify the resident received medications through a PICC line, and failed to identify the interventions necessary to care for the site and the catheter. During an interview on the morning of 04/23/18, an administrative nurse (#1) confirmed Resident #4's care plan failed to identify received medications through a PICC line and discharge plans. Refer to F760	F 657		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, record review, review of professional reference, review of facility policy, and staff interview, the facility failed to ensure 1 of 1 resident (Resident #3) remained free of a significant medication error prior to discharge. Failure of staff to administer only parenteral (non-oral) medications through Resident #3's Peripherally Inserted Central Catheter (PICC) line (a catheter inserted into a large vein in the arm that carries blood to the heart) resulted in a significant medication error which required Resident #3 to be hospitalized for four days. Findings include: Berman, Snyder, Kozier, and Erb, "Fundamentals	F 760	F760 □ Residents are Free of Significant Med Errors 1. Resident #3 no longer resides in the facility and all residents receiving PICC line medications have the potential to be affected. 2. All residents who have a PICC line and receive IV medications have the potential to be affected. Facility will complete appropriate monitoring. 3. Education will be completed for medication administration through a PICC Line for all nurses, including the 6 rights of medication administration and reading labels thoroughly prior to administration, with monitoring and evaluation by May 22,2018	5/29/18

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F 760	Continued From page 8 of Nursing Concepts, Process, and Practice", 10th Edition, Copyright 2016 by Pearson Education, Inc., New Jersey, pages 758-759, 771-772, and 1341, stated, ". . . In oral administration, the drug is swallowed. . . . The parenteral route is defined as . . . by needle . . . Intravenous (IV) - into a vein. . . . sterile equipment and sterile drug solution are essential for all parenteral therapy. . . . When administering a drug, regardless of the route of administration, the nurse must . . . Read the MAR (Medication Administration Record) carefully . . . Then administer the medication in the prescribed dosage, by the route ordered, at the correct time. . . peripherally inserted central venous catheter (PICC) . . . SITE CARE Use strict aseptic technique . . . The frequency of dressing changes is dependent on the dressing material . . . Assess the site for redness, swelling, tenderness, or drainage . . . assess for possible displacement . . . Change the catheter cap as indicated by agency protocol . . . Flush the catheter before and after each dose of medication . . . Do not allow anyone to take a blood pressure on the arm in which the PICC line is inserted . . . the arm should not be immersed in water. . . ." Review of the facility policy titled "Medication - Errors [and] Drug Reactions" occurred on 04/24/18. This policy, revised November 2017, stated, ". . . A Significant Medication Error is defined as an error which . . . jeopardizes the resident's health or safety . . . If the medication error is significant, the following steps will occur: A nurse will document the basic facts in the progress notes. A nurse will notify the practitioner and the Resident Care Manager/Clinical Coordinator/Director of Nursing. . . . Take	F 760	4. The DON or designee will be responsible to monitor IV medication error process to accurately reflect care provided. QA monitoring was implemented on May 23, 2018. The DON or designee will monitor twenty administrations weekly for a month, thirty monthly for three months, and then audits will be completed at least quarterly for one year and additional audits as recommended by the QA committee recommendations. Results will be immediately reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA Committee at each scheduled meeting 5. Date of Correction: May 29, 2018	

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F 760	Continued From page 9 whatever steps are necessary to prevent reoccurrence of the error. . . . The Director of Nursing will monitor medication errors for trends and will provide a report to the Quality Assurance Committee and consult with the Executive Director as needed. . . . The Director of Nursing will determine which medication errors need to be reported to the . . . North Dakota Department of Health [NDDOH]. . . ." Information provided by the complainant indicated facility staff failed to ensure Resident #3 received only injectable medications through his PICC line. Review of Resident #3's medical record occurred on all days of survey. Medical diagnoses included atrial fibrillation (periodic irregular heart rhythm), hypertension (high blood pressure), acute kidney failure, shortness of breath, and fatigue. The record identified orders for chewable and/or liquid (oral) and IV forms of Benadryl (an antihistamine). The physician's orders, dated October 1-December 11, 2017, identified the following: * ". . . Diphenhydramine HCl Liquid (generic name for Benadryl) Give 50 mg [milligrams] by mouth every 6 hours for itching. . . ." * ". . . Benadryl 50 mg IV q [every] 6 h [hours] per PICC - OK to give chewable if no RN [registered nurse] available, every 6 hours for itching. Discontinue the Liquid Benadryl when the IV Benadryl is delivered. . . ." A "Medication Error Report," dated 11/02/17, identified, ". . . Oral Benadryl 50 mg given through PICC line. . . . Wrong Route . . . Call	F 760		

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F 760	Continued From page 10	F 760		

Poison Control - recommend to sent to ER [Emergency Room] . . . Sent to ER to be evaluated for contamination. . . ." The "Vulnerable Adult Report" also identified, ". . . RN . . . self reported that she gave oral liquid Benadryl via resident's PICC line on 2 occasions . . . When . . . RN realized she had given the medication the wrong route, she contacted the On-Call Provider, Poison Control, Pharmacy . . . and Medical Pharmacy, and On-Call Manager. The Poison Control Center recommended that Provider send to ER and he was admitted to Observation Unit. . . ."

A progress note, dated 11/02/17 at 7:00 p.m., identified, "Order obtained to send resident [#3] to ER to run labs for possible PICC line contamination. . . ."

The "Hospitalist Admission Note," dated 11/02/17 at 8:19 p.m., identified, ". . . [Resident #3] presents from nursing home with increased somnolence [sleepy/drowsy] after oral Benadryl was administered through his PICC line twice today. Aside from fatigue patient denies any acute complaints. . . . The [patient] was recently discharged about 1 week ago. He had a PICC line at time of discharge in order to make comfort measure medications easier. . . ."

A progress note, dated 11/06/17 at 4:24 p.m., identified, "Resident [#3] readmitted from [Hospital] . . ."

The follow-up section of the "Medication Error Report," dated 11/02/17, identified, ". . . [Registered Nurse] involved in conversation/investigation. Discussed the

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importance of medication error [and] that we are glad she self-reported. Remove DCed [discontinued] meds [medications] from med-drawer, write clear orders, read full bottle label. Discussed medication rights. Reported to NDDOH. . . ." The follow-up section of the "Vulnerable Adult Report" also identified, ". . . Nurse received update from hospital on resident on 11/03/17 and resident was doing well, had some lethargy and no significant changes in labs. PICC line was removed. Education provided to nurse on 'Medication Rights.' Pharmacy label did not have oral indicated on pharmacy label, but it was indicated on bottle directions - discussed the importance of reading all labels. . . ."

Throughout the survey, the team interacted with the newly hired Administrator (#2) and interim Director of Nursing (#1). They began working at the facility one week prior to the complaint survey and approximately five and a half months after the incident under investigation.

During an interview on 04/24/18 at 8:30 a.m., when asked questions pertaining to the medication error, an administrative nurse (#1) explained she had stepped into her current role approximately one week prior, and "would have to do some research." Approximately two hours later, the administrative nurse (#1) provided a copy of the "Medication Error" report and "Vulnerable Adult" report pertaining to the incident. She (#1) then reported contacting Pharmacy, and they "verified the route was not on the label." The administrative staff member (#1) confirmed the nurse received additional education on "Medication Rights." Evidence provided by the facility on the "Medication Error"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355124	A. BUILDING _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE AT SHEYENNE CROSSINGS	**125 13TH AVENUE WEST WEST FARGO, ND 58078**

(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 760	Continued From page 12 report identified the nurse was provided education on the importance of medication rights. She (#1) also provided copies of the nurse's employment records, showing the facility held a Skills Fair on 11/28/16 and 05/24/17. Nursing staff, including the nurse involved in the incident, received training on catheter cares (including reverse demonstration) during each fair. When asked if the rest of the nursing staff also received additional education or if the facility completed monitoring on this issue, the administrative nurse (#1) reported she had attempted to go through the previous DON's files, and wasn't able locate any additional education or monitoring documentation. She (#1) then added she had located/reviewed all of the incident reports dated November 2, 2017-April 24, 2018, and reported, "This was the only medication error involving a PICC line." The nurse failed to administer Resident #3's medications via the route ordered resulting in a four day hospitalization.	F 760		