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 _____	08/22/2019

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 The standard Medicare/Medicaid recertification survey started on August 19, 2019 and concluded August 22, 2019.	F 000		
F 623 SS=D	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		9/26/19

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

Electronically Signed | 09/16/2019

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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: Based on record review and staff interview, the facility failed to notify the resident and/or family member, and the Office of the State Long-Term Care Ombudsman, in writing, of a transfer outside of the facility, including the destination and reason for the transfer, and the resident's right to appeal the action for 2 of 3 sampled residents (Residents #42, and #43) transferred to the hospital. Failure to provide a notice of transfer does not allow the resident and/or family member the right to make an informed choice regarding the resident's rights. Findings include:	F 623	1. Resident #42 and #43 representatives were notified of the transfer and provided with the written notice. 2. All residents who have a transfer or discharge have the potential to be affected. 3. Nursing and Social Work staff will be educated on the requirements for completion and documentation of the Notice of Transfer or Discharge. Staff education will occur on September 19, 2019. 4. QA monitoring will be implemented	

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F 623	Continued From page 3 - Review of Resident #42's medical record occurred on all days of survey. The progress notes identified the facility transferred the resident to the Emergency Room (ER) on 05/12/19, and admitted the resident to the hospital until 05/21/19. The record lacked evidence the facility provided the resident and/or family member a written notice of transfer. - Review of Resident #43's medical record occurred on 08/21/19. The progress notes identified the facility transferred the resident to the hospital on 04/09/19. The record lacked evidence the facility provided the resident and/or family member a written notice of transfer. During an interview on 08/21/19 at 5:45 p.m., a social services staff member (#1) stated staff could not locate transfer notices for residents #42 and #43's, hospitalization on 05/12/19 and 04/09/19 in their medical records.	F 623	following completion of mandatory education. QA will be initiated on September 20, 2019. The Director of Social Services or Designee will audit completion of the Notice of Transfer or Discharge for all residents with a transfer or discharge for one month, five residents with a transfer or discharge for three months, and five residents per quarter for a year with additional audits as recommended by the QA committee. Results will be reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Social Services and DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: September 26, 2019	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, resident interview and staff	F 684	1. Resident #32's medical record was updated with indication of the bruise and	9/26/19

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F 684	Continued From page 4 interview, the facility failed to provide the necessary care and services to prevent the development of bruises for 1 of 10 sampled residents requiring extensive assist with cares (Resident #32) and at risk of developing abrasions and or bruises. Failure to assess the cause and reassess/monitor current skin issues and treatments has the potential for further skin breakdown and resident discomfort. Findings include: Review of the facility policy titled "Skin Assessment" occurred on 08/21/19. This policy, revised July 2015, stated, ". . . to inspect and assess all areas of the resident's skin to identify current and potential problems . . . Tissue Tolerance is the ability of the skin and its surrounding structure to endure the effects of pressure without adverse effects . . . Appropriate skin assessments will be completed by the nurse. . . . All assessments will be documented in the medical record with problems included in the care plans . . . Bruises/skin Tears . . . the nurse must: provide appropriate treatment . . . if the cause is unknown, notify the designated personnel immediately regarding appropriate vulnerable adult reporting, investigate to determine the cause . . . in the progress notes document the presence of the bruise/skin tear and description/measurements, cause/possible cause, and who was notified . . . place on the eTAR [electronic treatment record] to monitor weekly until resolved. . . ." Review of Resident #32's medical record occurred on all days of survey. Current medications include, ". . . "Aspirin Tablet 81 MG	F 684	investigation related to the cause of the bruise was completed. Nursing staff involved with resident #32's care during the timeframe the bruise occurred were interviewed and educated on safe patient handling on August 26 and August 27, 2019. 2. All residents that require staff assistance have the potential to be affected. 3. The facility will educate all staff on safe patient handling and appropriate notification of and observation for changes in skin integrity including bruising. Education will be provided on September 19, 2019. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on September 20, 2019. The DON or designee will be responsible for monitoring the knowledge of the staff on the appropriate notification of skin integrity changes and any applicable documentation required 3 times per week for three months and three times per quarter for one year. Results will be 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: September 26, 2019	

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F 684	Continued From page 5	F 684		

(milligrams) give 81 mg by mouth one time a day". A quarterly Minimum Data Set (MDS) dated 07/08/19 identified the resident as needing staff physical assist, support of two plus persons for dressing and bed mobility, and has a Brief Interview for Mental Status (BIMS) score of 14. (BIMS score of 13 to 15 reflects intact cognition)

Observation on 08/19/19 at 11:55 a.m. showed a bruise to Resident #32's right hand approximately the size of a quarter, located between the base of his thumb and pointer finger knuckle. When asked about the bruise Resident #32 stated, "It just happened this morning, she holds my hand there (pointing to the area of the bruise) when she puts my shirt on. There was one (a bruise) on the other side too." Resident #32 is weepy and teary eyed when he speaks about the bruise.

Nurses' notes and wound assessments stated the following:
* 08/10/19, ". . . skin check performed. No new areas of concern. . . ."
* 06/01/19, ". . . small bruise to left wrist. . . ."
* 05/11/19, ". . . continues to have bruise to L wrist. . . ."
* 05/15/19, ". . . [Resident #32] reports that when staff were trying to assist him to a seated position this morning, they were holding his wrist and he is concerned about developing a bruise from this as the location is right next to a current bruise . . . thinks they didn't realize how tight their hold on his wrist was. . . ."

Resident #32's care plan identified, ". . . Date Initiated: 04/13/17 Potential for skin breakdown r/t [related to] mobility secondary to Parkinson's disease and osteoarthritis . . . Monitor for

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F 684	Continued From page 6 changes in skin integrity when providing cares and provide appropriate follow up if areas of concern are noted." The medical record failed to show documentation of the current bruise on Resident #32's right hand. During an interview on 08/22/19 at 11:08 a.m., an administrative nurse (#4) agreed there was an undocumented bruise on Resident #32's right hand.	F 684		
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 facility policy and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #50) receiving continuous oxygen. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels. Findings include: Review of the facility policy titled "Oxygen Use	F 695	1. Staff will be educated on the use of supplemental oxygen for resident #50. On August 20, 2019 education was provided to staff who were working on August 19, 2019 during observation of oxygen tank not being turned on. 2. All residents who use supplemental oxygen have the potential to be affected. 3. The facility will educate all staff on the use of supplemental oxygen. Staff education will be provided on September 19, 2019.	9/26/19

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F 695	Continued From page 7 and Storage" occurred on 08/21/19. This policy, revised August 2018, stated, ". . . Oxygen will be administered per practitioner orders . . . Turn on the flowmeter and adjust the rate as needed . . . Assess the resident at frequent intervals. . . ." Review of Residents #50's medical record occurred on all days of survey. A physician's order stated, ". . . oxygen 2 L [liters] . . . continuous. . . ." Observation on 08/19/19 at 12:22 p.m. showed Resident #50 seated in his wheelchair (WC) in the dining room wearing oxygen via nasal cannula, the portable oxygen tank was set to zero L. Per the surveyors request a staff nurse (#5) checked Resident #50's oxygen tank, agreed it was set at zero, retrieved a new tank, and set it to 2 L. During an interview on 08/22/19 08:40 a.m., an administrative nurse (#4) agreed Resident #50's oxygen should have been set on 2 L continuously.	F 695	4. QA monitoring will be implemented following the completion of mandatory education. QA will be initiated on September 20, 2019. The DON or designee will be responsible for monitoring the use of supplemental oxygen as ordered three times per week for three months and three times per quarter for one year with additional audits as recommended by the QA committee. Results will be 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: September 26, 2019	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		9/26/19

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F 812	Continued From page 8 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, review of dish machine temperature log, review of the Food and Drug Administration (FDA) Food Code 2013, and staff interview, the facility failed to store, prepare, and serve food under sanitary conditions for 1 of 2 dish machines (Long Term Care). Failure to ensure proper sanitation of dishes and utensils may result in foodborne illness to residents, staff, and visitors. Findings include: The FDA Food Code 2013, pages 145-146, stated, ". . . Sanitization of equipment and utensils . . . Hot water mechanical operations . . . achieving utensil surface temperature of 71 degrees Celsius [C] (160 degrees Fahrenheit [F]) as measured by an irreversible registering temperature indicator. . . ." Observation on 08/21/19 at 9:43 a.m., showed a dishwasher in use in the Long Term Care (LTC) kitchen. A hotplate thermometer, placed in the dishwasher, showed a maximum temperature of 151 degrees F on two consecutive cycles. The "Dish Machine Temperatures" log indicated,	F 812	1. Utensil surface temperatures of dishwasher will be maintained above 160F. 2. All residents have the potential to be affected. 3. Review of equipment took place on August 21, 2019. Education on operation of the dishwasher and infection control practices related to proper dishwashing temperature occurred on August 21, 2019. Education will be provided to all staff who operate the dishwasher on September 19, 2019. 4. QA monitoring will be implemented following mandatory staff education. QA will be initiated on September 20, 2019. The Director of Nutrition and Culinary Services or Designee will audit dishwashing temperature three times per week for three months and then three times per quarter for one year with additional audits as recommended by the QA committee. Results will be reported to the Executive director. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition and Culinary Services and DON will	

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F 812	Continued From page 9 ". . . Plate temperature should be at least 160 degrees. . . ." A culinary staff member (#2), who washed the breakfast dishes, identified the booster on the dishwasher was not working properly and had notified maintenance. The culinary staff member (#2) continued to operate the dishwasher knowing the proper plate temperatures were not reached. During an interview on the morning of 08/21/19, a culinary staff supervisor (#3) stated she expected dietary staff to check the dishwasher temperatures daily, notify the supervisor if the plate temperatures are below 160 degrees and take the dishes to an alternate dishwasher to clean them.	F 812	submit reports of the monitoring results to the QA committee at each scheduled meeting. 5. Date of Correction: September 26, 2019	