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 _____	07/15/2021

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 07/12/21 and concluded 07/15/21.	F 000		
F 641 SS=D	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 record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.17), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 18 sampled residents (Resident #12). Failure to accurately complete 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: The Long-Term Care Facility RAI User's Manual, revised October 2019, page H-2 states, ". . . 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. H0100C, ostomy (including urostomy, ileostomy, and colostomy). H0100D, intermittent catheterization. H0100Z, none of the above. . . ."	F 641	1. Resident #12 MDS was modified on 7/14/2021 and the modification was accepted on 7/15/2021. Review of all additional current residents with urinary appliances last MDS was conducted and no additional coding errors were found. 2. All residents who have urinary appliance have the potential to be affected. 3. Nursing staff will be educated on proper coding of urostomy vs. other types of catheters. Staff education was provided on July 20th and 21st, 2021. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on July 26, 2021. The Director of Nursing or Designee will audit completion of section H0100 of five residents for one month, three residents for three months, and three 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 Nursing and DON will submit a report of the	7/26/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2021

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F 641	Continued From page 1 - Review of Resident #12's medical record occurred on all days of survey. Diagnosis included neurogenic bladder. The care planned identified a urostomy in place. The Quarterly MDS, dated 05/07/21, identified facility incorrectly coded an indwelling catheter and external catheter, and failed to code the urostomy. During an interview on 07/14/21 at 2:22 p.m., an administrative nurse (#1) confirmed facility staff coded Section H of the quarterly MDS incorrectly for Resident #12's urostomy.	F 641	monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: August 2, 2021	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility incident investigation, staff interview, and review of operator's manual, the facility failed to provide appropriate and sufficient supervision to prevent accidents for 2 of 2 closed records (Resident #60 and #61) reviewed with Hoyer (full body mechanical lift) transfers. Failure to safely utilize a mechanical lift has the potential for injury for Resident #60 and resulted in a fall with serious injury for Resident #61, and placed all residents requiring this type of transfer at risk for accidents and/or injury. This citation is considered past non-compliance based on review of the	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 2 corrective action the facility implemented immediately following the second incident. Findings include: Review of the Operators Manual for the Volara (Hoyer mechanical lift) occurred on 07/15/21. This operator's manual, dated March 2019, stated, " . . . Lifts are designed to "transfer" a resident, not "transport" them. . . . Raise until there is tension on the straps and then double-check to make sure the loops are nested in the bottom of the hooks. If the base is in the narrow position, adjust it to the widest position once you are clear from the bed and always before turning the lift. . . . Use only the lift handle bars to move the lift. Pulling or pushing on the person or the beam will cause the lift to be unstable. . . ." - Review of Resident #60's medical record occurred on July 14-15, 2021. Diagnoses included liver cancer, hepatic failure, and myositis. The admission Minimum Data Set (MDS) dated 01/15/21, identified total dependance with assist of two for transfers. The care plan identified, ". . . Self-care deficit related to weakness . . . potential for falls related to inability to transfer independently. . . . Transfers: total assist of 2 with hoyer. . . ." Review of Resident #60's nurses notes identified the following: * 01/11/2021 at 3:11 p.m.: "Time of fall: 1415. Description of event: Resident was being transferred with assist of 2 via hoyer lift from the bathroom to his bed. While turning hoyer to bed hoyer began to tip sideways hitting the floor. . . .	F 689		

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F 689	Continued From page 3 ROM (range of motion) in all extremities upper and lower no new bruising to back or arms, assessed head no bumps or bruises noted. . . . denies pain at this time. . . . Change to assist of 3 with all transfers. . . ." Review of the facility Investigation identified staff transferred Resident #60 with assist of two staff (physical therapist #2 and certified nurse assistant #3) and the Hoyer lift from the bathroom to the bed. The legs of the lift were in the narrow position due to coming through the doorway of the bathroom. The two-facility staff (#2 and #3) began to turn the lift towards the bed and the lift started to tip. Staff stated they were unable to stop the lift from tipping over with the resident in the sling. - Review of Resident #61's medical record occurred on July 14-15, 2021. Diagnoses included a broken internal right hip prosthesis, pain in right hip, and presence of right artificial hip joint. The quarterly MDS, dated 02/19/21, identified total dependence with assist of two for transfers. The care plan identified, ". . . Self-care deficit related to R) [right] hip hardware malfunction, heart failure and recent CABG [coronary artery bypass grafting]. . . . potential for falls related to decreased mobility. . . . Transfers: Assist of 2 [sic] with hoyer. . . ." Review of Resident #61's nurses notes identified the following: * 02/18/2021 at 12:09 p.m., "Time of fall: 10:45 a.m. Description of event: CNA [certified nursing assistant] notified nurses that resident had fallen on the floor. When this writer entered room resident was sitting on his bottom with his back	F 689		

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F 689	Continued From page 4	F 689		

against the bed and his legs lying flat on the floor. Resident was sitting on the hoyer sling and the lift was on hisright [sic] side tipped over and leaning over his head. The part of the lift that hooks to the sling was resting on the bed. The aids that were present were unhooking him from the sling when I walked in. The legs of the hoyer were closed and the sling being used was a ceiling lift sling. Upon assessment staff noted a superficial laceration on the top of his head on the left side which was bleeding. Resident stated the top of the hoyer hit him in the head when he fell. Resident also stated he broke his fall with his left hand and was complaining of 3/10 aching pain in his L [left] shoulder."

Review of the facility investigation identified staff transferred Resident #61 with assist of two staff (CNA #8 and CNA #9) and the Hoyer lift, using the incorrect sling (ceiling sling), and transporting Resident #61 from the bathroom to the bed. The CNA (#8) moved the lift and the other CNA (#9) stood nearby assisting when the Hoyer started to tip. The legs of the lift were in the narrow position and staff were unable to stop the lift from tipping over with the resident in the sling.

Resident #61 remained an assist of two staff with the Hoyer lift. CNAs (#8 and #9) received education on keeping the legs of the lift in the widest position and using the appropriate sling on 02/18/21. CNAs (#8 and #9) completed Hoyer sling application and lift use competency on 02/23/21. CNAs (#8 and #9) received a coaching and improvement plan on 02/23/21 regarding the importance of keeping the legs of the lift in the widest position. All nursing staff received Hoyer lift education and completed competency during

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F 689	Continued From page 5 the staff meeting on 03/04/21. During an interview on 07/15/21 at 10:00 a.m., an adminstrative nurse (#1) confirmed that Resident #60 and #61's falls were a result of improper use of the Hoyer lift and stated, "we educated the staff [PT #3 and CNA #2] after the first fall, after the second fall with the hoyer we educated both CNAs [#8 and #9], and identified there was a problem. We then provided training to all staff that use any of the lifts and they completed the Hoyer competency." Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented the corrective action for the residents affected by the deficient practice by: *Completing an investigation with interviews of staff who assisted with the transfers on 01/11/21 and 02/18/21. *Determining the investigations showed staff failed to follow the operators manual for the Volara Hoyer mechanical lift for both incidents resulting in falls, and resident with serious injury. *Inspecting the Hoyer lift and sling involved immediately following the incident and finding the equipment to be in good working condition. *Providing 1 on 1 education immediately after the incident from 1/11/21 and 02/18/21 with involved staff regarding proper use of Hoyer lift and sling with competency and return demonstration to the DON. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: *Providing education to all nursing staff on proper	F 689		

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F 689	Continued From page 6 Hoyer lift transfers on 03/04/21. *Auditing Hoyer lift transfers starting on 01/11/21. The facility completed audits weekly for 7 months. The survey team determined a deficient practice existed on 01/11/21 and 02/18/21. The facility implemented corrective action on 01/11/21 and 02/18/21 and completed all nursing staff education on 03/04/21.	F 689		
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: THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 08/22/19. Based on record review, review of facility policy, and resident, family, and staff interviews, the facility failed to provide the necessary care and services for 2 of 3 sampled residents (Resident #24 and #48) with applying the continuous positive airway pressure (CPAP) mask accurately. Failure to provide oxygen as ordered has the potential for residents to experience complications related to inadequate oxygen saturation levels.	F 695	1. Staff will be educated on the use of CPAP machines and masks for resident #24 and resident #48. On July 15th, 2021 education was provided to the night nurses that apply CPAP machines on proper use and technique. 2. All residents who use a CPAP have the potential to be affected. 3. The facility will educate all staff on the use of CPAPs. Staff education was provided on July 20th and 21st, 2021. 4. QA monitoring will be implemented following the completion of mandatory education. QA will be initiated on July 26,	7/26/21

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F 695	Continued From page 7 Findings include: Review of the facility policy titled "CPAP, BIPAP [bilevel positive airway pressure]/Trilogy [brand name ventilator], and AutoPAP [automatic titrating positive airway pressure]" occurred on 07/14/21. This policy revised July 2018, stated, "To provide appropriate respiratory/nursing care to residents on CPAP . . ." - Review of Resident #24's medical record occurred on all days of survey and showed medical diagnoses of shortness of breath and obstructive sleep apnea (OSA). Resident #24's current care plan stated, ". . . has altered respiratory status/difficulty breathing. Has dyspnea [difficulty or labored breathing] at times. . . . CPAP as ordered . . ." Review of the physician's order written on 02/22/21, stated "CPAP at NOC [at bedtime] for OSA." Review of social services note on 5/20/2021, stated "[family member] did express concerns about resident's CPAP not being put on at night . . . Grievance filed and given to resident care manager . . ." During an interview on 07/12/21 at 1:10 p.m., Resident #24 stated, "she has difficulty wearing her CPAP at NOC because not all staff know how to apply the mask correctly and it blows all over my face or they do not put it on at all." During an interview on 07/14/21 at 2:00 p.m., an administrative nurse #1 confirmed staff applied the CPAP mask incorrectly and stated, "I	F 695	2021. The DON or designee will be responsible for monitoring the use of CPAPs three times per week for one month, once a 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: August 2, 2021	

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F 695	Continued From page 8 provided a reference sheet to three staff who work nights, and they were shown how to apply the [CPAP] mask and I have not been told of any complaints since." During a phone interview on 07/15/21 at 9:10 a.m., family member #1 stated, "staff are not placing the CPAP on correctly or not at all, one [staff] did not want to wake her [Resident #24] up so she did not place the CPAP [mask] on her for the night, I talked to them in May during [Resident #24's] care conference and they are still putting it on wrong." - Review of Resident #48's medical record occurred on all days of survey. Current physician's order stated, "CPAP at bedtime." Resident #48's current care plan stated, "has impaired respiratory function including diagnoses of dyspnea, obstructive sleep apnea, history of pneumonia, and . . . acute respiratory failure with hypoxia. . . . uses oxygen and a CPAP" During an interview on 07/13/21 at 11:28 a.m., Resident #48 stated staff "do not know how to use the CPAP machine." States they over-fill the water in the machine and they don't know what settings to use, states "too much oxygen and it blasts in my nose."	F 695		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review	F 756		7/26/21

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F 756	Continued From page 9 of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the consulting licensed pharmacist failed to complete resident's medication regimen reviews (MRRs) at least	F 756	1. Consultant pharmacist was provided education on the requirement for each resident□s drug regimen to be reviewed once per month and irregularities are to	

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F 756	Continued From page 10 once a month, and report irregularities to the attending physician, the facility's medical director, and director of nursing for 11 of 18 sampled residents (#6, #11, #12, #20, #24, #29, #33, #45, #46, #53, and #56). Failure of the pharmacist to complete MRRs, identify and report all drug irregularities may result in the prolonged and unnecessary use of medications and adverse consequences. Findings include: Review of the facility policy titled "Medication Regimen Review (MRR)" occurred on 07/15/21. This policy, revised September 2017, stated, ". . . The pharmacist will review the residents medication regimen monthly . . . to identify irregularities and to identify clinically significant risks and/or adverse consequences. . . . irregularities identified will be documented . . . report the irregularity to the Director of Nursing . . . and they will contact the attending physician. . . ." Review of Residents #6, #11, #12, #20, #24, #29, #33, #45, #46, #53, and #56's medical records from January 2020 - June 2021 (18 months), identified the licensed pharmacist failed to complete the following: *Resident #6 - 10 of 18 required MRRs. *Resident #11 - 7 of 12 required MRRs. *Resident #12 - 9 of 18 required MRRs. *Resident #20 - 10 of 18 required MRRs. *Resident #24 - 10 of 18 required MRRs. *Resident #29 - 12 of 18 required MRRs. *Resident #33 - 6 of 8 required MRRs. *Resident #45 - 8 of 16 required MRRs. *Resident #46 - 3 of 6 required MRRs.	F 756	be reported to the DON or designee. Review must be documented in the electronic health record. Drug Regimen Reviews were completed on July 23, 2021 for all residents including the residents affected #6, #11, #12, #20, #24, #29, #33, #45, #46, #53, and #56. 2. All residents that take medications have the potential to be affected. 3. Education was provided to the consultant pharmacist on July 15th, 2021. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on July 26, 2021. The DON or designee will be responsible for monitoring the completion of required documentation each month for all residents for six months and once per quarter for all residents for six months. 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: August 2, 2021	

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F 756	Continued From page 11 *Resident #53 - 11 of 18 required MRRs. *Resident #56 - 11 of 18 required MRRs. During an interview on 07/12/21 at 2:45 p.m., an administrative nurse (#1) confirmed the licensed pharmacist failed to complete monthly MRRs.	F 756		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility menus,	F 803	1. Staff will be educated on proper	7/26/21

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 _____	07/15/2021

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

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F 803	Continued From page 12 and staff interview, the facility failed to serve food according to prepared menus during 4 of 5 meal observations (Evening meal on Transitional Care Unit (TCU) 07/12/21, Evening meals on TCU and Long Term Care (LTC) Unit on 07/13/21, Noon meal on TCU 07/14/21). Failure to serve food according to facility's menus placed residents at risk for inadequate nutrition and unplanned weight loss/gain. Findings include: - Observation of TCU evening meal tray line occurred on 07/12/21 and showed a dietary staff member (#5) used a gloved hand to place a handful of lettuce salad on residents' plates. Review of the menu identified the correct portion size as 1 cup. - Observation of LTC Unit evening meal tray line occurred on 07/13/21 and showed a dietary staff member (#5) served creamed chipped beef for residents on a regular diet with a 2-ounce spoodle (portion spoon/ladle). Review of the menu identified the correct portion size for a regular diet as 6 ounces. - Observation of TCU evening meal tray line occurred on 07/13/21 and showed a dietary staff member (#6) served creamed chipped beef for residents on a regular diet with a 3-ounce spoodle. Review of the menu identified the correct portion size for a regular diet as 6 ounces. - Observation of TCU noon meal tray line occurred on 07/14/21 and showed a dietary staff member (#7) served residents on a regular diet the following:	F 803	portion sizes and ensuring the residents are provided the correct portion sizes to meet their nutritional needs 2. All residents have the potential to be affected. 3. Education was provided to all staff on utilizing the menu to properly select the appropriate portion size to meet residents' nutritional needs occurred on July 20th and 21st, 2021. 4. QA monitoring will be implemented following mandatory staff education. QA will be initiated on July 26th, 2021. The Director of Nutrition and Culinary Services or Designee will audit proper portion sizes three times per week for one month, once a 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 Director of Nutrition and Culinary Services and DON will submit reports of the monitoring results to the QA committee at each scheduled meeting. 5. Date of Correction: August 2, 2021	

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 _____	07/15/2021

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

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F 803	Continued From page 13 (Sloppy Joe (Beef Barbeque) - 4-ounce spoodle (menu identified 2 ounces) *Tater Tots - handful of Tater Tots in gloved hand (menu identified 4 ounces) *Carrots - large, slotted spoon with no size measurement (menu identified 4 ounces) *Fruit Salad - 3-ounce spoodle (menu identified 1/2 cup) *Cheddar mashed potatoes - heaping portion using a small spoon with no size measurement (menu identified 1/2 cup) *Pureed Chicken - heaping portion using a small spoon with no size measurement (menu identified #10 scoop) During an interview on 07/15/21 at 10:37 a.m., an administrative dietary staff member (#4) confirmed staff should follow the menu for correct serving sizes.	F 803		