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 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	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 12/16/24 and concluded 12/18/24.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the	F 578		1/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/09/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, resident, family, and staff interview, the facility failed to ensure all forms of communication related to code level status accurately reflected the residents' wishes for 2 of 18 sampled residents (Resident #30 and #48) and 1 supplemental resident (#14) reviewed for advance directives. Failure to ensure the medical record and other forms of communication accurately reflected the resident's code status limited the facility's ability to communicate to direct care staff and emergency personnel the resident's choice in the event of a medical emergency. Findings Include: Review of the facility policy titled "CPR [cardiopulmonary resuscitation]/AED [automated external defibrillator]/Code Level" occurred on 12/18/24. This policy, revised May 2021, stated, ". . . Uniform Code Levels (Code 1 and Code 2) and cardiac arrests will be discussed with all new residents and/or responsible party upon admission, hospital return, and annually with completion of the MDS [minimum data set]. Their wishes will be obtained, the Uniform Code Level Form will be completed, and documentation will	F 578	1. Resident #14□s care plan was reviewed and updated to reflect Code Level 2. Resident #30 and Resident #48□s Code Level was reviewed, and the face sheet, physician order summary, EMAR, and care plan were updated to reflect Code Level 2 per the residents' wishes. 2. All residents in the facility have the potential to be affected. 3. All nurses and social work employees were provided education on 1/8/2025 on Eventide□s CPR/AED/Code Level Policy, specifically regarding the expectation that all forms of communication related to Code Level status (face sheet, physician order summary, EMAR and care plan) accurately reflects the resident□s wishes. 4. All current residents have been audited to ensure that all forms of communication related to code level status (face sheet, physician order summary, EMAR and care plan) accurately reflects the resident□s wishes in the medical record. Audits will be conducted on all residents	

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F 578	Continued From page 2 be made in the resident's chart. A provider's order must be received . . . This is to ensure that a resident's wishes regarding CPR are followed in a time of crisis . . . " - Review of Resident #14's medical record occurred on all days of survey. "The Uniform Code Level Directives for Cardiopulmonary Resuscitation," signed by the resident on 04/18/24, indicated Code Level 2. The form identified code level 2 as "No intervention will be made in the event of a cardiac or respiratory arrest including defibrillation, chest compression, artificial respiration, or chemical resuscitation. Other conditions will be treated as medically appropriate" The face sheet, physician order summary, and electronic medication administration record (EMAR) identified a code level 2. The care plan identified a code level 1 "All available reasonable technology is used in the event of cardiac or respiratory arrest." During an interview on 12/18/24 at 2:15 p.m., an administrative staff member (#1) confirmed the care plan failed to identify Resident #14's current code status. - Review of Resident #30's medical record occurred on all days of survey. "The Uniform Code Level Directives for Cardiopulmonary Resuscitation," signed by the resident's representative on 05/12/23, indicated Code Level 2. The face sheet, physician order summary, and EMAR failed to identify a code status. The care plan identified a code level 1. During an interview on 12/17/24 at 3:30 p.m., an administrative nurse (#2) confirmed the resident's	F 578	to ensure that all forms of communication related to Code Level status accurately reflect the resident□s wishes. The DON or designee will complete audits on resident code levels. The Director of Nursing or designee will audit weekly for three months, monthly for three months, and quarterly for six months. The facility will complete additional audits as recommended by the QA Committee. 5. Date for completion of corrective action: 1/13/2025	

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F 578	Continued From page 3 face sheet, physician order summary EMAR, and care plan failed to identify Resident #30's current code status. - Review of Resident #48's medical record occurred on all days of survey. "The Uniform Code Level Directives for Cardiopulmonary Resuscitation," signed by the resident's significant other on 11/30/23, indicated Code Level 2. The face sheet, physician order summary, EMAR, and care plan indicated a code level 1. During an interview on 12/17/24 at 5:15 p.m., Resident #48 and her significant other verified the code level 2 as accurate.	F 578		
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 1.19.1), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 18 sampled residents (Resident #29). Failure to accurately code 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:	F 641	1. Resident #29□s Significant Change MDS Assessment (ARD 11/1/2024) was modified to reflect the fracture diagnosis in I4000 and to remove the coding of a fall in J1800. The modified MDS was accepted on 12/30/2024. Resident #29□s Discharge Return Anticipated MDS (ARD 10/25/2024) was modified to correct the coding of a fall in J1800, and the modifications were accepted on 12/30/2024. 2. All residents have the potential to be affected.	1/13/25

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F 641	Continued From page 4 SECTION I: Active Diagnosis The Long-Term Care Facility RAI 3.0 User's Manual, revised October 2024, pages I-8, I-10, and I-12, states, ". . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring . . . during the 7-day look-back period . . . Musculoskeletal . . . I4000, other fracture . . . Specific documentation may be found in progress notes, most recent history and physical, transfer notes, hospital discharge summary, etc. . . ." Review of Resident #29's medical record occurred on all days of survey and identified the following progress notes: * 10/25/2024 at 2:33 a.m.: "Fall. Time of fall: 0125 [1:25 a.m.] . . . . Resident self-transferring and fell. . . . Small laceration on bridge of nose and nose is red and swollen. . . ." * 10/27/2024 at 1:23 p.m. ". . . Hospital Return. . . Resident admitted from: [hospital] . . . Reason for admission: Recent fall and nasal fracture. . . ." A significant change MDS, dated 11/01/24, identified staff failed to code Resident #29's nasal fracture in I4000. During an interview on 12/18/24 at 3:09 p.m., a nurse (#3) confirmed staff failed to code the nasal fracture on the significant change MDS. SECTION J: HEALTH CONDITIONS The Long-Term Care Facility RAI 3.0 User's	F 641	3. MDS Coordinator involved in coding error was provided one on one education and demonstrated understanding of RAI 3.0 Manual on 12/18/24. Education was provided to all nurses involved in the MDS Assessment Process on 1/8/2025 to ensure MDS coding of sections I4000-Active Diagnosis and Section J1800-Health Conditions reflects guidelines from the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User□s Manual (Version 1.19.1). 4. MDS Audits have been completed on all current residents for J1800 and I4000 in the last year to ensure the accuracy of the coding. The DON or designee will complete audits on accurate MDS coding of falls and medical diagnoses. The Director of Nursing or designee will audit weekly for one month, monthly for three months, and quarterly for one year. The results of the audits will be reported to the QA committee, and the facility will complete additional audits as recommended by the QA Committee. 5. Date for completion of corrective action: 1/13/2025	

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F 641	Continued From page 5 Manual, revised October 2024, page J-34 states, ". . . J1800: Any Falls Since Admission/Entry or Reentry or Prior Assessment . . . whichever is more recent. . . . If this is not the first assessment/entry or reentry (A0310E = 0), the review period is from the day after the ARD [assessment reference date] of the last MDS assessment to the ARD of the current assessment. . . . DEFINITION PRIOR ASSESSMENT: Most recent MDS assessment that reported on falls. . . . Code 0, no: if the resident has not had any fall since the last assessment. . . ." Review of Resident #29's medical record occurred on all days of survey. A discharge return anticipated MDS, dated 10/25/24, identified staff coded the resident's fall on item J1800. A significant change MDS, dated 11/01/24, identified staff coded a fall on item J1800 since the last MDS. The medical record did not identify a fall between 10/25/24 and 11/01/24. The facility miscoded Resident #29's significant change MDS for J1800 as the medical record lacked evidence of a fall occurring after the date of the prior assessment on 10/25/24. During an interview on 12/17/24 at 5:18 p.m., a nurse (#3) confirmed staff miscoded the significant change MDS for falls.	F 641		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 761		1/13/25

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F 761	Continued From page 6 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure safe and secure storage of medications and controlled substances (narcotics) in 1 of 1 unit (Transitional Care Unit (TCU)) observed. Failure to secure medications and controlled substances may result in unauthorized access to medications. Findings include: The facility failed to provide a policy on storage of medications and controlled substances. - Observation on 12/18/24 at 1:37 p.m., of the	F 761	1. On 12/18/2024, the Certified Medication Aide (MA) (#5) was immediately educated regarding the safe and secure storage of medications and controlled substances, including the necessity of always storing narcotic medications in a double-locked container. 2. All residents have the potential to be impacted. 3. All medication storage areas were assessed and found to be in working condition. On 1/8/2025, all certified	

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F 761	Continued From page 7 TCU medication cart with a medication aide (MA) (#5) showed narcotic medication cards within the cart not stored in a locked box. The MA stated, "When I walk away, I lock the cart and put the keys in my pocket. I do not lock these in a lock box [referencing narcotic cards]." - Observation on 12/18/24 at 1:49 p.m., showed the TCU medication storage room door and the narcotic storage cupboard door unlocked and ajar with non-nursing personnel present. A staff nurse (#4) was unaware of why both doors were unlocked and ajar. During an interview on 12/18/24 at 2:05 p.m., an administrative nurse (#2) confirmed she expected staff to lock the medication storage room door and narcotic cupboard doors, and store narcotics in the lock box in the medication cart.	F 761	medication aides and nurses were educated regarding medication storage expectations. 4. All medication storage areas were audited to ensure the safe and secure storage of medications and controlled substances. DON or designee will complete audits on safe and secure storage of medications. The Director of Nursing or designee will audit weekly for three months, monthly for three months, and quarterly for six months. The facility will complete additional audits as recommended by the QA Committee. 5. Date for completion of corrective action: 1/13/2025	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and	F 880		1/13/25

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F 880	Continued From page 8 controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

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F 880	Continued From page 9 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 5 of 16 sampled residents (Resident #8, #9, #17, #32, and #36) and 2 supplemental residents (#7 and #46) observed during cares/dressing change. Failure to practice infection control standards related to hand hygiene, enhanced barrier precautions (EBP), during a dressing change, and disinfection of equipment has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene Policy" occurred on 12/18/24. This policy, revised January 2024, stated, ". . . Hand hygiene will be done a.) Before and After resident contact (before you leave the room) . . ." Review of the facility policy titled "Transmission-Based Precautions" occurred on 12/18/24. This policy, revised January 2024, stated, ". . . Enhanced barrier precaution - These	F 880	1. All residents including residents #8, #9, #17, #32, #36, #7, and #46 in the facility were monitored for signs and symptoms of infection. 2. All residents have the potential to be impacted. 3. On 1/8/25, all staff were provided with education regarding proper infection control standards related to hand hygiene, enhanced barrier precautions, dressing change completion, and disinfection of equipment in correlation with Eventide□s Hand Hygiene, Transmission-Based Precautions, and Dressing Changes/Bandages Policies. 4. The DON or designee will complete audits on hand hygiene, enhanced barrier precautions during a dressing change, and equipment disinfection. The Director of Nursing or designee will audit weekly for one month, monthly for three months, and quarterly for one year. The results of	

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F 880	Continued From page 10 are used to limit or prevent the spread of resistant organisms during high-contact resident care activities. . . . In addition to standard precautions gown and gloves must be worn during high-contact resident care activities such as: . . . Transferring in the resident's room . . ." Review of the facility policy titled "Dressing Changes/Bandages" occurred on 12/18/24. This policy, revised March of 2022, stated, ". . . Clean area where supplies will be placed with germicidal wipes . . ." - Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, ". . . Enhanced Barrier Precautions for indwelling catheter. . . ." Observation on all days of survey showed an EBP sign outside of Resident #8's room. Observation on 12/17/24 at 9:50 a.m. showed Resident #8 seated in a wheelchair and the certified nurse aide (CNA) (#8) transferred the resident into bed. The CNA failed to don gloves and a gown before transferring Resident #8. - Review of Resident #36's medical record occurred on all days of survey. The current care plan stated, ". . . Enhanced Barrier Precautions in place. . . ." Observation on all days of survey showed an EBP sign outside of Resident #36's room. Observation on 12/17/24 at 9:58 a.m. showed a CNA (#9) and a nurse (#10) failed to don gloves or a gown and entered Resident #36's room to	F 880	the audits will be reported to the QA committee, and the facility will complete additional audits as recommended. 5. Date for completion of corrective action: 1/13/2025	

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F 880	Continued From page 11	F 880		

perform a transfer. The CNA and nurse used a full body mechanical lift to transfer the resident from the wheelchair to the bed.

- Review of Resident #32's medical record occurred on all days of survey. The current care plan stated, ". . . Enhanced Barrier Precautions due to ulcers to feet. . . ."

Observation on all days of survey showed an EBP sign outside of Resident #32's room.

Observation on 12/17/24 at 10:31 a.m. showed a CNA (#11) donned gloves and a gown to assist Resident #32 onto the toilet. A second CNA (#9) entered the room to assist with the transfer and failed to don gloves and a gown. After the transfer, the CNA (#9) failed to perform hand hygiene before exiting the room.

During an interview on 12/17/24 at 10:55 a.m., an administrative nurse (#2) stated she expected staff to wear appropriate personal protective equipment when transferring residents in an EBP room and expected staff to complete hand hygiene before leaving a resident's room after assisting with a transfer.

- Observation on 12/16/24 at 1:40 p.m. showed two CNAs (#5 and #13) entered Resident #17's room with a full body mechanical lift and transferred the resident from the wheelchair to the bed. While performing cares, CNA (#5) failed to perform hand hygiene between glove changes and failed to perform hand hygiene or disinfect the lift when exiting the room.

- Observation on 12/16/24 at 1:54 p.m. showed

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 12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHEYENNE CROSSINGS CARE CENTER/TCU	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 880	Continued From page 12	F 880		

two CNAs (#5 and #13) entered Resident #7's room with the full body mechanical lift the CNAs failed to disinfect during the observation and transferred Resident #7. The CNAs failed to perform hand hygiene upon entering Resident #7's room, assisted with personal cares and failed to perform hand hygiene in between glove changes, before exiting the room, and failed to disinfect the mechanical lift when exiting the room.

- Observation on 12/17/24 at 10:56 a.m. showed two CNAs (#6 and #7) assisted Resident #9 to the bathroom using the full body mechanical lift. After assisting the resident, the CNA (#7) exited the resident's room without disinfecting the lift.

During an interview on 12/17/24 at 11:20 a.m., a CNA (#7) stated, "It is our policy to sanitize between residents. I did forget to wipe the lift down."

- Observation on 12/17/24 at 1:46 p.m. showed a CNA (#14) entered Resident #46's room to perform personal cares. The CNA failed to perform hand hygiene between gloves changes with cares and failed to perform hand hygiene before exiting the room.

- Observation on 12/18/24 at 12:10 p.m. showed a licensed nurse (#12) entered Resident #36's room to perform a dressing change. The nurse failed to clean the bedside table with a germicidal wipe and placed the dressing supplies directly on the resident's bedside table.

During an interview on 12/18/24 at 10:30 a.m., an administrative nurse (#2) confirmed staff are

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	355124	A. BUILDING _____ B. WING _____	C 12/18/2024

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(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 880	Continued From page 13 expected to complete hand hygiene during resident cares and sanitize equipment after each use.	F 880		