DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
355124	A. BUILDING Shevenne Crs B. WING Care Center	March 21st, 2011

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Sheyenne Crossing Care Center	125 13th Ave West, West Fargo North Dakota, 58078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K130	The facility failed to adequately protect the gas meter, regulators and as required by NFPA 54.		1. How the corrective action will be accomplished: Eventide has contracted with Horizon contractors to install 2(two) steel and concrete reinforced bollards to protect the gas meter piping and regulator assembly. 2. How the facility will identify other portions of the facility having the potential to be affect by the same deficient practice: This is the only location of the facility that has a natural gas meter installed in such a manner that protection is warranted against equipment damage. 3. What measures will be put in place or what systemic changes made to ensure that the deficient practice will not occur: Changes, as outlined above in number one, will be implemented. 4. How the facility will monitor its corrective action to ensure that the deficient practices being corrected and will not recur: Periodic visual inspections will be conducted to observe impact to the bollard assemblies and if they affect the integrity of the protective system. . 5. Date(s) when the corrective action(s) will be completed: a. A verbal contract was awarded to Horizon contracting on March 29th, 2011 with a completion date of 14 working days after award to be completed no later than April 12th, 2011. b. Photographic images of the completed work will be submitted to Monte Engel at the North Dakota Department of Health.. c. Copies of Invoices and for labor and materials involved to complete this project will be submitted to the Monte Engel at the North Dakota Department of Health upon completion.	April 12th,2011

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Admin	3/30/2011