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 _____	10/20/2022

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 10/17/22 and concluded on 10/20/22.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, staff and resident interview, the facility failed to ensure the interdisciplinary team assessed the appropriateness to self-administer medications (SAM) for 1 of 2 sampled residents (Resident #38) with medications observed in the resident's room. Failure to determine whether SAM is a safe practice has the potential to limit a resident's right to SAM or result in a medication error and/or harm to a resident. Findings include: Review of the facility policy titled "Medication-Self-Administration of Meds [Medications]" occurred on 10/19/22. This policy, revised December 2021, stated, ". . . Ask the resident if they would like to self-administer medication . . . If the resident wishes to do this complete the Self-Administration of Medication Assessment . . ." Observation on the afternoon of 10/17/22, showed two nasal spray medications on Resident #38's bedside table. The resident reported he	F 554	1. Resident #38 self-administration of medications assessment was completed. Review of all additional current resident's self-administering medications was conducted and no additional missing documentation was found. 2. All residents who self-administer medications have the potential to be affected. 3. Nursing staff will be educated on properly conducting self-administration of medications assessments per facility policy. Staff education was provided on November 3, 2022. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on November 9, 2021. The Director of Nursing or Designee will audit completion self-administration of medications assessments 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	11/22/22

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

Electronically Signed | 11/09/2022

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F 554	Continued From page 1 uses the nasal sprays in the morning and at bedtime. Review of Resident #38's medical record occurred on all days of survey. A physician's order dated 02/17/22 stated, " . . . Resident may do own nasal spray - Please observe he is doing correctly . . ." The record lacked a SAM assessment indicating Resident #38 can safely self-administer medications. During an interview on 10/18/22 at 11:30 a.m., an administrative nurse (#1) confirmed staff failed to complete the SAM assessment for Resident #38.	F 554	reported to the Executive Director. If concerns are identified, immediate corrective action will be implemented. The Director of Nursing will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: November 22, 2022	
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		11/22/22

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F 585	Continued From page 2 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	F 585		

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F 585	Continued From page 3 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, and review of resident council meeting minutes the facility failed to resolve grievances related to dietary concerns for 7 of 20 confidential residents (Residents A, B, C, D, E, F, and G) interviewed	F 585	1. Staff will be educated on the proper actions to be taken to resolve resident grievances. Staff education will be provided in follow up to the concern noted of cold food and plan made to resolve	

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F 585	Continued From page 4 on the Transitional Care Unit (TCU). Failure to resolve the resident's concerns in a timely manner resulted in continued dissatisfaction regarding cold food. Findings include: During the afternoons of 10/17/22 and 10/19/22, Residents A, B, C, D, E, F, and G reported food is cold when served. Each resident indicated they had reported this to staff and the food is still cold when served. During the supper meal on 10/19/22 at 6:00 p.m., four residents at one table reported the roast beef and mashed potatoes were cold when delivered. Review of the Resident Council Minutes, dated 06/23/22 and 08/16/22, identified food is sometimes cold when delivered, food wait times are "some days good and some days bad," and the resident's "feel there is at times an issue with the delivery of meals." Observation on 10/19/22 of the evening meal served on the TCU showed the following: * First meal plated at 5:50 p.m. and the last plated meal delivered at 6:36 p.m. * After plating the hot foods the staff member put a plate on a serving tray and failed to cover the food immediately. * On two separate occasions the dietary staff member (#4) left plated foods uncovered during the time he/she retrieved more plate covers. * At times, the resident meal trays sat on the counter for several minutes before delivered.	F 585	cold food. 2. All residents have the potential to be affected. 3. The facility will educate all staff on resident grievances and the meal serving process. Education was provided on November 3, 2022. 4. QA monitoring will be implemented following the completion of mandatory education. QA will be initiated on November 9, 2022. The Director of Nutrition and Culinary Services or Designee will be responsible for monitoring the meal service process and temperatures of food served 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. The Executive Director will oversee the grievance process including timely follow up and resolution of grievances. If concerns are identified, immediate corrective action will be implemented. The Director of Nutrition and Culinary Services will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of correction: November 22, 2022	

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F 585	Continued From page 5 During an interview on 10/20/22 at 8:39 a.m., a dietary manager (#2) stated she expected all meals to be served within a "30 minute or so area" and agreed the issue of cold foods may be related to the meal service/tray delivery process.	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, review of professional literature, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sample residents (Resident #52 and #63) reviewed with fluid restrictions. Failure to accurately transcribe Resident #52's fluid restriction order onto the Medication Administration Record (MAR) and to enter Resident #63's fluid restriction order onto the MAR when received placed the residents at risk for exacerbation of current diagnoses and/or decline in health status. Findings include: Review of the facility policy titled "Fluid Restriction" occurred on 10/20/22. This policy, dated October 2019, stated, ". . . The policy of Eventide is to monitor fluid intake on residents who have provider orders for fluid restrictions. . . . Fluids will be recorded by the following process: Nurse/TMA [medication aide] will record all fluid provided with medications and between meals on	F 658	1. Staff will be educated on proper management of fluid restrictions. Resident #52 and #63 orders were corrected. Review of all additional current resident's with fluid restrictions orders was conducted and no additional missing documentation was found. 2. All residents with fluid restrictions have the potential to be affected. 3. Education was provided to staff on November 3, 2022. 4. QA monitoring will be implemented following completion of mandatory education. QA will be initiated on November 9, 2022. The Director of Nutrition and Culinary Services 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,	11/22/22

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F 658	Continued From page 6 the MAR. . . ." Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 62, stated, ". . . Carrying Out a Physician's Order. Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. . . . If the order is neither ambiguous nor apparently erroneous, the nurse is responsible for carrying it out. . . ." - Review of Resident #52's medical record occurred on all days of survey. Diagnoses included congestive heart failure (CHF) (fluid build up in the heart). Resident #52's medical record identified a 6-day hospital stay in September 2022 for respiratory failure (difficulty to breath) with hypoxia (poor oxygenation to body tissues). The physician's discharge orders stated, ". . . Limit fluid intake to about 1500 mL [milliliters] per day [24 hours]. . . ." Review of Resident #52's MAR for September 19 through October 18, 2022 stated, "1500 ml Fluid Restriction every shift [eight hours] for Fluid Overload . . ." - Review of Resident #363's medical record occurred on all days of survey. Diagnoses included CHF. A physician's order, dated 10/02/22, stated, ". . . 1500 mL fluid restriction . . ." Review of Resident #363's October 02-18, 2022 MAR lacked an order for fluid restrictions.	F 658	immediate corrective action will be implemented. The Director of Nutrition and Culinary Services will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Date of Correction: November 22, 2022	

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F 658	Continued From page 7 During an interview the morning of 10/19/22, an administrative staff member (#1) and a dietary manager (#2) confirmed Resident #52 and #363's physician orders are 1500 ml per 24 hours, not per shift, the order transcribed to Resident #52's MAR did not match the physician's order, and Resident #363's MAR lacked a fluid restriction order.	F 658		
F 880 SS=D	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 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 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		11/22/22

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F 880	Continued From page 8 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 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	F 880		

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F 880	Continued From page 9 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and review of professional literature, the facility failed to follow standards of infection control for 2 of 14 sampled residents (Residents #1 and #6) observed during cares. Failure to follow infection control standards has the potential for transmission of communicable diseases and infections to residents, staff, and visitors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 744, stated, ". . . clean penis . . . from center outward and wash down . . . Use a clean area of the washcloth or a new washcloth when washing a new area. . . prevents cross-contamination. . . Wash and dry . . . posterior [groin] folds . . . tends to be more soiled than the penis because of its proximity to the rectum . . . This follows the principle of cleaning from the least contamination to that of the greatest. . . ." Review of the facility policy titled "Gloves-Guidelines for Wearing" occurred on 10/20/22. This policy, revised May 2022, stated, ". . . Gloves are disposable, and should be changed between residents and between dirty to clean procedures on same resident. . . . Always perform hand hygiene before and after gloving." Review of the facility policy titled "Hand Hygiene" occurred on 10/20/22. This policy, revised May	F 880	1. Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of §483.80 for the affected resident(s)/neighborhood(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring patient care staff have adequate knowledge of proper perineal cares to correctly clean the resident's genitals and anal area, in accordance with best practices. (2) Ensuring patient care staff perform hand hygiene or handwashing when donning/doffing gloves, moving between tasks, residents, and after touching potentially contaminated surfaces, in accordance with CDC guidelines. The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: (1) Educate nursing staff on proper perineal cares to prevent infections and skin breakdown. To verify these staff understand proper perineal care, the staff will perform a successful perineal care observed by the DON or designee. (2) Educate nursing staff on correctly completing hand hygiene after changing	

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F 880	Continued From page 10 2022, stated, ". . . Hand hygiene will be done" a. Before and after resident contact (before you leave the room) b. Before every clean procedure c. After dirty procedure . . ." - Observation on 10/18/22 at 8:11 a.m. showed a certified nurse aid (CNA) (#5) provided frontal perineal cares to Resident #6 while seated on the toilet. The CNA (#5) donned gloves and used a washcloth to cleanse the resident's groin. Without rinsing/folding the washcloth or obtaining a new washcloth, the CNA wiped the penis tip. The CNA removed her gloves, and without hand hygiene, applied new gloves and shaved the resident's face. The CNA (#5) then assisted Resident #1 to stand, cleansed bowel with disposable wipes, completed the back perineal cares, and removed her gloves. Without performing hand hygiene, the CNA (#5) donned new gloves, pulled up the resident's brief and pants, transferred him into his wheelchair, and moved the wheelchair to the sink. The CNA (#5) set Resident #1 up to brush his teeth and applied toothpaste on his toothbrush. The CNA (#5) then removed her gloves, and without performing hand hygiene, exited the resident's room. - Observation on 10/18/22 at 9:07 a.m. showed a CNA (#5) provided perineal cares to Resident #1 while in bed. The CNA (#5) used a washcloth the cleanse the resident's groin, and without rinsing/folding the washcloth or obtaining a new washcloth, wiped the penis tip.	F 880	tasks, moving between residents, changing gloves, and touching potentially contaminated surfaces. To verify these staff understand hand hygiene and handwashing, the staff will perform a successful return demonstration by identifying the need and following the correct procedure for performing hand hygiene and handwashing. 2. Identification of Others The IP and DON, in conjunction with the applicable interdisciplinary team (IDT) members, will review current nursing facility guidelines for perineal cares and hand hygiene from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 11/22/2022, the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure proper perineal cares for residents requiring assistance with toileting. b. Failure to complete hand washing or hand hygiene in accordance with CDC guidelines. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloa	

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F 880	Continued From page 11	F 880	ds/GuidanceforRCA.pdf (2) The DON, SDC, IP or suitable designee will ensure the following: a. Educate nursing staff on the importance of and techniques for performing perineal cares. b. All staff will receive education keeping hands clean between tasks, contacts with potentially contaminated surfaces and between residents. This education will include the CDC's lesson on clean hands available at https://youtu.be/xmYMUly7qiE. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of nursing staff to ensure perineal care is performed appropriately on residents requiring toileting. (2) Observations of all staff types to ensure performance of proper handwashing and hand hygiene, when	

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 _____	10/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 12	F 880	indicated, in the course of their routine duties. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 11/22/22	