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 _____	03/20/2014

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 For the standard Medicare/Medicaid recertification survey started on March 17, 2014 and completed on March 20, 2014, the sample included four (4) residents for complete review, nine (9) residents for focused review, and two (2) closed records for review. The sample included one (1) additional resident to verify specific concerns during the survey.	F 000	**F 000** The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiency stated. The following plan of correction was written and implemented to remain in compliance with all federal and state regulations. The alleged deficiency has bee corrected by the date indicated.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, and staff interview, the facility failed to complete significant change in status assessments (SCSA) for 1 of 13 sampled residents (Resident #4) within 14 days after a significant change occurred in the resident's physical or mental condition. Failure to	F 274	**F 274:** 1. A Significant Change MDS has been completed on Resident #4 to accurately reflect current status. 2. All residents have the potential to be affected. 3. All residents' MDS for the past three months will be evaluated compared to current condition to identify if significant change MDS needs to be completed. Education completed with staff members completing MDS regarding when significant change MDSs need to be completed. 4. Date of Correction: 24 April, 2014	4/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maren K Leman — TITLE: Administrator — (X6) DATE: 4/11/14

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.

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 _____	03/20/2014

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 274	Continued From page 1 complete a SCSA in response to the resident's decline limited the facility's ability to accurately assess each resident's status, and identify and implement appropriate care plan approaches. Findings include: The Centers for Medicare and Medicaid Services (CMS) "Long-Term Care Facility RAI User's Manual," Version 3.0, October 2013, pages 2-20 and 2-23 states, ". . . A 'significant change' is a decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention . . . (for declines only); 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and /or revision of the care plan. . . . A SCSA is also appropriate if there is a consistent pattern of changes, with either two or more areas of decline or two or more areas of improvement. This may include two changes within a particular domain (e.g. [example given], two areas of ADL [activities of daily living] decline or improvement). . . ." - Review of Resident #4's medical record occurred on March 17-20, 2014. Diagnoses included fall with a fracture (01/23/14) and dementia. Resident #4's admission Minimum Data Set (MDS), dated 11/25/13, identified no depression or behavioral symptoms, supervision for locomotion on/off the unit and eating, and no weight loss. The quarterly MDS, dated 02/04/14, indicated a decline in these areas with moderately severe depression, physical and verbal behaviors, extensive assist for locomotion on/off the unit and eating, and weight loss.	F 274	5. The Director of Nursing or designee will be responsible to monitor if significant change MDSs have been completed as appropriate. QA monitoring was implemented. The DON or designee will monitor 6 sample MDSs , monthly for three months, and then random audits as needed. Results will be reported to the Executive Director and corrective measures taken. Results will be brought to the QA Committee for review and recommendation at each scheduled meeting.	

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 _____	03/20/2014

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 274	Continued From page 2 The record lacked evidence staff completed a SCSA following Resident #4's decline in more than two areas of functional status. During an interview, on 03/20/14 at 11:00 a.m., a nurse manager (#3) agreed staff should have completed a significant change MDS on 02/04/14 instead of the quarterly five-day medicare MDS.	F 274		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	**F 278:** 1. MDS corrections will be completed as needed for residents 2, 3, 8, 13, and 7. 2. All residents have the potential to be affected. 3. All residents' MDS for the past year will be evaluated for accuracy in the areas of antipsychotic medications and falls and corrections completed as necessary. Education completed with staff members completing the MDS regarding accuracy of assessments. 4. Date of Correction: 24 April, 2014 5. The Director of Nursing or designee will be responsible to monitor if MDS assessments have been completed accurately as appropriate. QA monitoring was implemented. The DON or designee will monitor 6 sample MDSs, monthly for three months, and then random audits as needed. Results will be reported to the Executive Director and corrective measures taken. Results will be brought to the QA Committee for review and recommendation at each scheduled meeting.	4/24/14

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 _____	03/20/2014

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 278	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), and staff interview, the facility failed to complete Minimum Data Set (MDS) assessments which accurately reflected the resident's status for 5 of 13 sampled residents (Residents #2, #3, #7, #8, and #13) with coding related to falls, falls with injury, falls with fracture and use of antipsychotic medication. Failure to accurately code the MDSs for these residents limited the facility's ability to develop and implement individualized care plans consistent with their needs and functional status and may affect the level of care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual (Version 3.0), May 2013 and October 2013, pages J-31-J-32, stated "J1900: Number of Falls Since . . . Prior Assessment . . . Coding instructions . . . Determine the number of falls that occurred since . . . prior assessment . . . and code the level of fall-related injury for each. . . . Coding Instructions for J1900A, No injury . . . Coding instructions for J1900B, Injury (Except Major) [which includes lacerations] . . . Coding instructions for J1900C, Major Injury [which includes fractures] . . ." The Long-Term Care facility RAI User's Manual, (Version 3.0), May 2013 and October 2013, pages N-4 - N-5, stated "N0410: Medications Received . . . Coding Instructions N0410A,	F 278		

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 _____	03/20/2014

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 278	Continued From page 4 Antipsychotic: Record the number of days an antipsychotic medication was received by the resident at any time during the 7-day look-back period . . ." - Review of Resident #2's medical record occurred on March 17-20, 2014. Current medications listed for Resident #2 included seroquel, an antipsychotic. The medical record identified the physician initiated the seroquel on 02/05/13. An annual MDS, dated 03/31/13, failed to identify the antipsychotic medication in Section N410A. - Review of Resident #3's medical record occurred on March 17-20, 2014. The facility roster/sample matrix identified Resident #3 as having falls. The medical record identified Resident #3 fell on 05/10/13 and sustained a 3.5 centimeter laceration. The resident received 6 staples to repair the laceration in the emergency room. The quarterly MDS, dated 07/12/13, failed to identify in section J1900B the fall with injury, that occurred on 05/10/13. During interview on 03/20/14 at 11:50 a.m., an administrative nursing staff member (#1) confirmed the inaccuracy of Resident #2 and #3's MDSs related to fall with injury and antipsychotic medications. - Review of Resident #8's medical record occurred on March 17-20, 2014. Progress notes identified a fall without injury which occurred on 07/06/13. A quarterly MDS, dated 07/12/13, failed to identify the fall in section J1800 and J1900A. During an interview the afternoon of 03/19/14, a supervisory nursing staff member (#3) stated she	F 278		

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 _____	03/20/2014

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 278	Continued From page 5 failed to capture the fall on the 07/12/13 MDS as staff did not create a fall assessment within the progress notes when the fall occurred. - Review of Resident #13's medical record occurred on March 19-20, 2014. Progress notes identified the resident experienced a fall with minor injury on 11/02/13 which included an abrasion to the bridge of his nose and redness to the buttock region. Progress notes also identified a fall with no injury which occurred on 11/20/13. A quarterly MDS, dated 01/02/14, failed to identify the fall with minor injury in section J1900B. During an interview the morning of 03/20/14, a supervisory nursing staff member (#1) stated she failed to capture the second fall on Resident #13's 01/02/14 MDS. - Review of Resident #7's medical record occurred on March 17-20, 2014. Resident #7's nurse's notes, dated 02/05/14, identified the resident complained of left hip pain after falling in her room. Facility staff sent the resident to the ER for x-rays, which showed a comminuted fracture of the left lateral superior pubic ramus. Review of Resident #7's quarterly MDS, dated 02/13/14, failed to identify the fracture in section J1700C. During an interview at 8:45 a.m. on 03/19/14, a supervisory nursing staff member (#3) stated she should have coded Resident #7's fracture in section J1700C on the quarterly MDS (dated 02/13/14).	F 278		
F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

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 _____	03/20/2014

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 325 SS=G	Continued From page 6 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, review of a professional reference, and staff interview, facility staff failed to implement appropriate interventions to restore/maintain adequate nutritional status for 1 of 1 sampled resident (Resident #8) identified with an avoidable significant weight loss and observed to require assistance with eating. Failure to ensure staff implemented measures to avoid weight loss including providing supplements between meals and ensuring staff provided adequate assistance, consistent with the comprehensive assessment, resulted in Resident #8 experiencing significant and severe weight loss. Findings include: The Centers for Medicare and Medicaid Services (CMS) has outlined the parameters for evaluating significance of unplanned & undesired weight loss:	F 325	**F 325:** 1. Resident 8 will be assessed for nutrition risk and appropriate measures taken including assistance with eating when necessary, timing and preference of supplements, monitoring of supplements, offer fluids with cares, and care plan updated to include calorie needs due to wandering. 2. All residents at nutritional risk. 3. Reassess and address all residents with the following factors: taking a supplement, having significant weight changes with in 30, 90, and 180 days, needing assistance with eating, and wandering behavior. All supplement times will be evaluated to have them provided at alternative times other than meals when possible and include residents' preference for type of supplement and time of administration. Changes will be evaluated to determine if effective in maintaining calorie needs/weight. Education provided with nursing staff on offering fluids with cares and assisting residents with eating as needed. 4. Date of Correction: 24 April, 2014	4/24/14

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 _____	03/20/2014

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 325	Continued From page 7 Interval / Significant Loss / Severe Loss 1 month / 5% / Greater than 5% 3 months / 7.5% / Greater than 7.5% 6 months / 10% / Greater than 10% Review of the facility policy "Weight Changes Assessment/Documentation" occurred on 03/19/14. The policy, dated 07/10/13, stated: "Policy: The policy of Eventide is to monitor and assess all residents who have had a significant weight change to promote optimal nutritional health. Purpose: To prevent any unplanned weight changes. Procedure: . . . Any residents experiencing significant weight gain/loss . . . will be assessed by the dietician. . . . Nutritional supplements or other nutritional interventions will be implemented by dietician as appropriate." - Review of Resident #8's medical record occurred on all days of survey. The facility admitted Resident #8 in August of 2010. Diagnoses included dementia and psychosis, delusional disorder, dysphagia (difficulty swallowing) and depression. The record identified the resident as being on a regular, dysphagia mechanical soft diet and a fluid intake of at least two liters per day. The record identified the resident's daughter signed a diet refusal, denying the resident had any swallowing problems. Review of Resident #8's Minimum Data Set (MDS) assessments included the following: quarterly, dated 01/04/14; quarterly, dated 10/06/13; annual, dated 08/10/13; and quarterly, dated 06/24/13. Each MDS identified the resident with short and long term memory problems, severely impaired in daily decision making, and fluctuating inattention. Each MDS identified Resident #8, at minimum, required verbal cueing	F 325	5. The Director of Nutrition and Culinary Services or designee will be responsible to monitor residents with nutrition risk. QA monitoring was implemented. Residents found to be at nutrition risk will be monitored bi-weekly for one month, monthly for three months, and then randomly as needed. The Director of Nursing or designee will be responsible for auditing of fluids being offered with cares and assisting resident as needed with eating will be completed for 6 sample residents weekly for one month, 6 sample residents monthly for three months and randomly as needed. If concerns are identified, immediate corrective measures will be implemented. Monitoring results will be submitted to the QA Committee for review and recommendation at each scheduled meeting.	

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 _____	03/20/2014

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 325	Continued From page 8 to eat and drink throughout each meal, and assistance of one person on three of the four MDSs reviewed. The most current MDS, dated 01/04/14, identified Resident #8 required staff supervision, cueing, and reminders for meal completion, and one person assistance for eating. Resident #8's current care plan identified the problem of altered nutrition and weight loss due in part to poor meal intake, refusal of meals at times, and diagnosis of dementia. Interventions included "Administer nutritional supplements as recommended (Boost Plus 8 oz [ounces] [a milk like supplement] every day, Boost Breeze [a juice like drink] TID [three times a day], and Magic cup QD [every day] . . . Encourage and assist as needed to consume all food, fluids, and supplements provided. Encourage fluid intake at and between meals. Honor food preferences as requested . . . Offer small portions in attempt to promote nutritional intake . . . Provide a Regular diet and monitor during meals for food consumption. . . ." The care plan identified the problem of Resident #8 wandering throughout the facility. Observation on all days of survey showed Resident #8 would propel herself in her wheelchair from the east to the west wing of the facility. Progress notes included information of her wandering behavior. On 01/03/14, a social services entry stated: ". . . Resident enjoys wheeling around the facility and will stop in the nurse's station on LTC [long term care]. . . ." Review of Resident #8's weight records identified the following: * 03/23/13: 108 pounds (lbs)	F 325		

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 _____	03/20/2014

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 325	Continued From page 9 * 06/15/13: 98.8 lbs; a weight loss of 8.5% over 90 days * 09/14/13: 95 lbs.; a weight loss of 12% over 180 days * 12/21/13: 101 lbs * 01/02/14: 100.8 lbs; Lasix 20 milligrams (mg) ordered daily * 01/17/14: 81.2 lbs; a weight loss of 19.6% (19.8 lbs) over 30 days; 14.3% over 90 days; and a 14.7% over 180 days * 02/19/14: 87.4 lbs.; a weight loss of 5.2% in 30 days * 03/15/14: 88.4 lbs.; a weight loss of 12.5% in 90 days Information obtained from facility staff on the afternoon of 03/17/14 included the schedule for meal service to residents. This included an open breakfast between 7:30 and 9 a.m.; lunch at noon; and supper at 6 p.m. Review of Resident #8's medication administration record (MAR) showed Boost Plus 8 oz scheduled daily at 8 a.m.; Boost Plus Breeze one container (8 oz) three times a day at 8 a.m., 12 noon, and 6 p.m.; and Magic cup (4 oz) every day at 12 noon. The March 2014 MAR showed each supplement administered (given), but no record of the resident's acceptance or amount consumed. Observation and interviews on all days of survey included the following: * 03/17/14 at 3:50 p.m. after providing toileting assistance to Resident #8, two CNAs (#6 and #9) did not offer Resident #8 any fluids including a supplement * 03/18/14 at 7:40 a.m., Resident #8 sat at the breakfast table asleep in her wheelchair. A	F 325		

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 _____	03/20/2014

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 325	Continued From page 10 container of Boost Plus, two pieces of toast, yogurt, and a glass of Boost Plus Breeze sat at her table setting. Resident #8 remained asleep at the dining table at 8:30 a.m. One-half of the Boost Plus Breeze had been consumed. By 9:10 a.m., all the yogurt and Boost Breeze Plus had been consumed. The toast remained. Intake records showed Resident #8 consumed 240 cubic centimeter (cc) of fluid and 76-100% of the meal * 03/18/14 at 9:10 a.m., a CNA (#12) assisted toileting Resident #8 and the resident laid down in bed. No fluids were offered with the cares * 03/18/14 at 12 noon, Resident #8 sat at a table with three other table mates. A glass of Boost Plus Breeze, cup of coffee and a Magic cup sat at her place setting. Resident #8, awake, moved her wheelchair away from the table and a certified nursing assistant (CNA) moved her wheelchair back to the table and locked the brakes on the wheelchair. When Resident #8 received her meal of soup and half of a chicken sandwich, she asked her three tablemates if "anyone around here knows how to handle this soup?" One of the three residents explained to Resident #8 how to eat and Resident #8 said "well I just don't know how to do that," and then Resident #8 stated "I guess I'll just have to go hungry" and "I don't know" and "I don't know how to eat it." Resident #8 then pushed her wheelchair backwards. After more prompting/cueing by a table mate, by 12:30 p.m. Resident #8 ate between 75-90% of the soup. A CNA then delivered a bowl of peaches to Resident #8's place setting and Resident #8 stated regarding her peaches "I don't know how to eat it." During this meal time observation, two CNAs sat in this same dining area feeding other residents at different tables. Observation showed the CNAs within hearing and viewing distance of Resident #8 and her table mates. Intake records	F 325		

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 _____	03/20/2014

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 325	Continued From page 11 identified Resident #8 ate 51-75% of the meal and 200 cc of (unspecified) fluid * 03/18/14 at 5:15 p.m. a CNA (#13) attempted to provide Resident #8 toileting assistance just outside of the resident's bathroom door. The resident refused and the CNA did not attempt nor offer any fluids, nourishment or a supplement * 03/19/14 at 7:40 a.m., Resident #8 sat in her wheelchair at the breakfast table asleep. A glass of a red colored drink (Boost Plus Breeze) and a glass of a white colored drink (Boost Plus) sat on the table in front of her. * 03/19/14 at 8:20 a.m., Resident #8 remained asleep at the breakfast table. The glass of Boost Plus remained untouched; and one half of the Boost Plus Breeze remained in the glass. One-half of a four oz container of yogurt was consumed; and a muffin/breakfast cake sat on a plate, untouched. Intake records showed Resident #8 ate 26-50% of the meal and 120 cc of fluid * 03/19/14 at 9:05 a.m., a CNA (#10) stated she assisted Resident #8 with the yogurt served with breakfast (then observed to be empty) and said Resident #8 took half of her Boost Breeze. The CNA (#10) stated Resident #8 does not like the Boost Plus. The CNA (#10) stated Resident #8 is frequently tired for breakfast as she gets up early in the morning and stays up late. The CNA stated Resident #8 was awake by 6:30 that morning. The CNA (#10) and another CNA (#7) stated no fluids or supplements were offered to Resident #8 between 6:30 a.m. and the breakfast meal * 03/19/14 at 9:25 a.m., a staff nurse (#11) stated nursing staff do not document "every time" how much Resident #8 consumes of the supplements provided during medication pass, but will make a progress note periodically. Review of nursing progress notes between 12/16/13 and 03/18/14	F 325		

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 _____	03/20/2014

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 325	Continued From page 12 lacked information on Resident #8's refusals of supplements offered * 03/19/14 at 9:30 a.m., a CNA (#7) stated more frequently than not Resident #8 is given assistance with meals but she will not always accept it. The CNA stated this morning Resident #8 pulled away from the muffin fed with a fork, yet took the yogurt. The CNA stated staff document fluid intakes after each meal and include amount of supplement taken. The CNA identified being unable to document nourishment intake between meals in the computer system utilized * 03/19/14 at 2:20 p.m., after a CNA (#10) toileted Resident #8, the CNA offered the resident no fluids, nourishment or supplement Review of nutrition progress notes stated the following: * 03/13/14: ". . . Meal intake has historically been poor thus supplements have been offered through out the days as well as snacks. Supplements are not always accepted depending on the day. . . ." * 02/25/14: "Monthly nutrition review. Weight review: 2/25 88.4# [pounds] which is up 6.2# (7.5%) from 1 month ago, down 8.8# (9%) from 3 months ago, and down 7.2# (7.5%) from 6 months ago. Recent weight fluctuations can be attributed to changes in diuretic, refusal of meds [medications] and supplements, and decreased nutritional intake. On average the past week resident has consumed only 39-62% which is pretty stable compared to last month. Supplements currently offered include Boost plus 8 oz QD [every day], Boost Breeze 8 oz TID, and magic cup or ice cream cup QD. Changes in supplements have been made related to resident stating she didn't like them or she was accepting others more than another. Changes in weight and	F 325		

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 _____	03/20/2014

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 325	Continued From page 13 intake maybe unavoidable d/t [due to] natural progression of her disease process. . . ." * 01/16/14: ". . . significant weight loss is noted. Weight is down 9# (9.2%) compared to one month ago. Weight loss attributed to decrease in edema m/b [manifested by] starting Lasix earlier in January. Resident has lost 12.4# since starting diuretic. Nutritional intake has not dramatically changed. Continue[s] to eat poor to fair at meals and varies in supplement acceptance. . . ." The nursing progress notes indicated Lasix, a potent diuretic, started on 01/02/14 and discontinued by 01/17/14. Refer to the review of weights and weight loss prior to and one month following the discontinuation of the Lasix as well as the marked decrease of weight in a 15 day period while Resident #8 received Lasix * 01/13/14: ". . . Supplements continue to be offered to assist in meeting needs d/t oral intake at meals is usually poor. . . ." * 01/07/14: ". . . Resident is a small, picky eater. Staff offer foods that [resident] will typically eat. This past week she has consumed 40-60% of what was offered. This is typically 1-2 items or small portions of a meal. . . . Anticipate with food intake she is minimally meeting her needs to maintain her weight. . . ." * 12/17/13: ". . . Resident will often foot propel herself in her wheel chair to LTC unit and have snack offered to her by staff. Nursing report resident complains of the taste of some of the supplements. . . . Will recommend to start Boost Breeze 1 container TID, Boost Plus 8 oz QD, and Magic Cup 1 container QD. . . ." The note or record lacked information on what types of snacks nursing staff offered and what Resident #8 accepted. Review of CNA charting between January 18 and	F 325		

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 _____	03/20/2014

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 325	Continued From page 14 March 18, 2014 identified Resident #8 received extensive assistance with meals on four occasions and total assistance on four occasions within the two month time period. The remainder of the charting showed Resident #8 received the supervision of one staff member. Observation showed Resident #8 not at an assisted table nor nearby for staff to supervise including prompt or cue Resident #8. Failure to consistently supervise/cue and/or assist Resident #8 during meals, and provide supplements between meals rather than with meals limited knowing how well Resident #8 would consume meals and determine if supplement intake would improve if offered between meals. Review of fluid intake records between March 1 and March 18, 2014, showed Resident #8 received less than 700 cc a day on 15 of 18 days. During interview on the afternoon of 03/18/14, a supervisory nurse (#3) stated Resident #8 received supplements with meals given by the nurse(s). During interview on the morning of 03/19/14, the supervisory nurse (#3) stated monitoring of fluid intake with meals included supplements. Review of the fluid intake records between March 1 and March 19, 2014 did not identify the type of fluid consumed, specifically if Resident #8 consumed any of the supplement. The record showed on 30 of 56 occasions Resident #8 consumed 200 cubic centimeters (cc) or less for the meal. Review of food intake records over the same period of time showed Resident #8 refused five meals and ate between 0 - 25% on 21 of 56 occasions. During interview on the afternoon of 03/19/14, a	F 325		

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 _____	03/20/2014

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 325	Continued From page 15 supervisory nurse (#3) stated staff should give supplements throughout the day, stated staff could develop the MAR to monitor the percentage or quantity of supplements taken when provided, was not aware Resident #8 disliked the Boost Plus and was aware she like the Boost Plus Breeze, stated staff should offer fluids between meals, and stated Resident #8 should receive prompting/cueing during meals. The facility failed to: * ensure Resident #8 received prompting/cueing or assistance to eat and drink during meals * monitor Resident #8's supplement intake as scheduled with med pass * to offer supplements between meals as an intervention developed in the care plan * to offer Resident #8 fluids between meals with personal cares * monitor nourishment intake between meals * consider Resident #8's wandering behavior would increase her caloric needs	F 325		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	**F 441:** 1. Residents 3 and 5 have been reassessed to ensure that catheter cares are appropriately done. Resident 8's hands will be washed when participates in toileting, which could result in soiled hands. 2. All residents that have indwelling catheter or the ability to assist with toileting. 3. All nursing and cna staff re-educated on the proper infection control process. This education included the following: caring for indwelling catheters and hand hygiene for residents when the resident participates in toileting.	4/24/14

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 _____	03/20/2014

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 441	Continued From page 16 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, facility policy review, and staff interview, the facility failed to follow standard infection control practices for 2 of 2 sampled residents (Resident #3 and #5) with an indwelling catheter observed during personal cares, and for 1 of 6 sampled residents (Resident #8) observed during toileting. Failure to follow infection control practices related to management and storage of urinary drainage bags and hand hygiene has the potential to cause or spread infection within the facility. Findings include:	F 441	4. Date of Correction: 24 April 2014 5. The Director of Nursing or designee will be responsible to monitor the care for indwelling catheters and hand hygiene when resident participates in toileting. QA monitoring was implemented. The DON or designee will monitor weekly for one month, monthly for three months, and then random audits as needed. If concerns are identified, immediate corrective measures will be implemented. The DON will submit a report of the monitoring results to the QA Committee for review and recommendations at each scheduled meeting.	

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 _____	03/20/2014

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 441	Continued From page 17 Review of facility policy "Catheters - Indwelling" occurred on 03/19/14. The policy, dated 05/13, stated: ". . . Residents with indwelling catheters generally known as foley catheters will be cared for by staff according to accepted practice. PURPOSE: . . . To maintain a clean and patent catheter drainage system. PROCEDURE: The following steps are to be taken to help prevent urinary tract infection . . . 2. Keep the drainage tubing/catheter junction closed except when changing the leg bag/urinary drainage bag. Use proper aseptic technique when you must disconnect tubing. Use an alcohol wipe to cleanse the junction. . . . 10. When a drainage bag is not in use it is to be placed in the catheter drainage bag cover and kept in the resident bathroom. . . ." - Review of Resident #3's medical record occurred on March 17-20, 2014 and diagnoses included urinary retention and malignant neoplasm of the prostate. The record identified the use of an indwelling urinary catheter. Observation on 03/19/14 at 7:45 a.m. showed a certified nursing assistant (CNA) (#2) changed the urinary drainage bag to a leg bag. With gloved hands the CNA held the end of the urinary tubing under the running water from the faucet, rinsed out the drainage bag, and stored the drainage bag without covering the end of the tubing with the protective cap. - Review of Resident #5's medical record occurred on March 17-20, 2014. Diagnoses included urinary retention and malignant neoplasm of the prostate. The record identified	F 441		

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 _____	03/20/2014

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 441	Continued From page 18 the use of an indwelling urinary catheter. Resident #5's current care plan identified the problem of a risk of infection related to the use of the Foley catheter. Approaches included catheter cares per policy, and "maintain patency of tubes and drains." Observation on 03/18/14 at 8 a.m. showed a CNA (#6) changed the urinary drainage bag to a leg bag. The CNA failed to clean the end of the catheter tubing prior to changing the urinary drainage bag to a leg bag. Prior to storage of the urinary drainage bag into a wash basin container, the CNA stored the drainage bag without covering the end of the tubing with the protective cap. - During interview on the morning of 03/19/14, a CNA (#7) stated that when changing a urinary drainage bag to a leg bag, the CNA clean off the end of the catheter tubing with an alcohol wipe and after removing the bag, the CNA rinses the bag out with water prior to storage. Observation of the catheter bag in the wash basin container showed the catheter bag stored without covering the end of the tubing with the protective cap. During interview on the morning of 03/20/14, an administrative staff (#8) stated staff should cap the tip of the urinary drainage for storage, and the facility has no policy for flushing of drainage bags following use before storage. - During observations of staff assisting Resident #8 with toileting, various direct care staff failed to offer handwashing after toileting. This occurred on 03/17/14 at 7:40 a.m. after toileting and Resident #8 obtained toilet tissue while two CNAs (#6 and #9) obtained supplies for incontinence	F 441		

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 _____	03/20/2014

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 441	Continued From page 19 cares. After the resident wiped, observation showed feces (bowel movement) on the toilet tissue. This also occurred on 03/19/14 at 9:05 a.m. after toileted by two CNAs (#7 and #10). During interview on the afternoon of 03/19/14, a supervisory staff (#3) stated staff are expected to offer handwashing to every resident after toileting.	F 441		