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 05/02/2024

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 An unannounced onsite investigation survey regarding a complaint was completed on May 2, 2024. During the complaint investigation the facility was found compliant with regulatory requirements related to complaint allegations.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to provide adequate supervision and assistive devices for 1 of 2 sampled residents (Resident #1) observed during a transfer. Failure to use a gait belt during transfers placed the resident at risk for accidents, falls, or injuries. Findings include: Review of the facility policy titled "Standards of Care" occurred on 05/02/24. This policy, revised January 2024, stated, ". . . A gait belt will be used for all assisted transfers and ambulation . . ." Review of Resident #1's medical record occurred on 05/02/24. Diagnoses included history of falling and symptoms and signs involving cognitive functions and awareness. The current care plan	F 689	1. Certified Nurse Aide (CNA) #1 was provided with immediate re-education on 5/2/24 regarding the necessity of using a gait belt with all assisted transfers and ambulation as outlined in Eventide's Standards of Care Policy. 2. All residents in the facility who require assistance with transfers and ambulation have potential to be impacted by the same deficient practice. 3. Re-education will be provided to all nursing staff on the importance of following Eventide's Standards of Care Policy including use of a gait belt with all assisted transfers and ambulation. Re-education will be provided on 5/22/2024.	5/24/24

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

Electronically Signed | 05/15/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 1 stated, "Ambulation, Transfers and Toileting: assist x [times] 1 FWW [front wheeled walker]." Observation on 05/02/24 at 11:47 a.m., showed a certified nurse aide (CNA) (#1) assisted Resident #1 from the resident's bed to the wheelchair and again from the wheelchair to the toilet without utilizing a gait belt. During an interview on 05/02/24 at 12:50 p.m., an administrative nurse (#2) stated she expected staff to use the gait belt during all assisted transfers.	F 689	4. The QA Team at Eventide at Sheyenne Crossings will complete audits to monitor the facility's performance and ensure solutions are effective. The Director of Nursing or designee will audit proper use of gait belts during resident assisted transfers and ambulation 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.	