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	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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46963 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 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.

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.

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