

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Eventide Fargo		STREET ADDRESS, CITY, STATE, ZIP CODE 3225 51st St S Fargo, ND 58104	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46963</p> <p>Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 20 sampled residents (Resident #58 and #85). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents.</p> <p>Findings include:</p> <p>SECTION N: MEDICATIONS</p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages N-6 to N-8 stated, . N0415: High-Risk Drug Classes: Use and Indication . Coding Instructions . N0415G1. Diuretic: Check if a diuretic medication was taken by the resident at any time during the 7-day look-back period . N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin .) was taken by the resident at any time during the 7-day observation period .</p> <p>- Review of Resident #58's medical record occurred on all days of survey. A physician's order, dated 05/30/24, stated Aspirin Oral Capsule 81 MG [milligram] . give 81 mg by mouth one time a day . The quarterly MDS, dated [DATE], showed staff failed to identify Resident #58 received an antiplatelet medication.</p> <p>- Review of Resident #85's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed N0415G1 coded as the resident received a diuretic medication within the 7-day look back period. The resident's medical record lacked documentation Resident #85 received a diuretic during the look back period.</p> <p>During an interview on 08/28/24 at 2:07 p.m., an administrative staff member (#1) agreed staff failed to code the MDS correctly for Resident #58 and #85.</p>

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
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>37620</p> <p>Based on observation, review of facility policy, review of profession reference, and staff interview, the facility failed to follow professional standards of practice for 2 of 2 sampled residents (#28 and #51) and 1 supplemental resident (#47) observed for insulin preparations and administrations. Failure to clean the end of the insulin pens prior to placing on a new needle, and failure to prime the insulin pens correctly may result in infections and/or the residents receiving an inaccurate dose of insulin.</p> <p>Findings include:</p> <p>Review of professional reference, How to Use an Insulin Pen found at https://www.learningabout diabetes, stated, . take the cover off the pen. use alcohol to clean the end of the pen where the needle twist on . peel back the cover on the needle. Screw the needle onto the pen.</p> <p>Review of the facility policy Insulin-Subcutaneous occurred on 08/29/24. This policy, revised May 2022, stated, . Prime the insulin pen by turning the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear.</p> <p>Observation on 08/26/24 at 5:00 p.m. showed a nurse (#2) prepared Resident #28's Humalog insulin pen for administration. The nurse (#2) removed the cap from the insulin pen and without cleaning the end of the pen with alcohol, applied a new needle.</p> <p>Observation on 08/26/24 at 5:15 p.m. showed a nurse (#2) prepared Resident #51's Aspart insulin pen for administration. The nurse (#2) removed the cap from the insulin pen and without cleaning the end of the pen with alcohol, applied a new needle.</p> <p>Observation on 08/27/24 at 8:00 a.m. showed a nurse (#3) prepared Resident #47's Novolog and Levemir insulin pens for administration. The nurse (#3) removed the caps from the insulin pens and without cleaning the end of the pens with alcohol, applied new needles. The nurse (#3) dialed each insulin pen to 2 units and primed both with the pens in a horizontal position.</p> <p>During an interview on 08/28/24 at 10:08 a.m., an administrative nurse (#4) stated she expected staff to clean the end of the insulin pen with alcohol prior to placement of a new needle and to prime insulin pens vertical as per policy.</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>28611</p> <p>Based on record review, review of the hospice contract, and staff interview, the facility failed to ensure residents' records contained the hospice election form, most recent hospice plan of care, and/or certification of terminal illness for 2 of 5 sampled residents (Resident #4 and #83) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice.</p> <p>Findings include:</p> <p>The hospice contract for (hospice agency name), signed 01/30/20, stated, . The designated interdisciplinary team member is responsible for . obtaining the following information from Hospice: (A) the most recent Hospice plan of care specific to each resident; (B) Hospice election form; (C) physician certification and recertification of the terminal illness specific to each resident .</p> <p>- Review of Resident #4's medical record occurred on all days of survey. A nurse's note, dated 05/31/24, stated, . Resident plans to remain in LTC [long-term care] with [name of organization] hospice services. [Resident's daughter] signed all necessary documents and writer answered all questions. Resident #4's medical record failed to contain the hospice election form and certification of terminal illness. Resident #4 elected hospice services on 03/13/24 (prior to admission).</p> <p>- Review of Resident #83's medical record occurred on all days of survey. A nurse's note, dated 07/25/24, stated, . [Resident #83] is [name of hospice] for CHF [congestive heart failure] and HTN [hypertension] . Resident #83's medical record failed to contain the hospice election form, plan of care, and certification of terminal illness. Resident #83 elected hospice services on 04/12/24 (prior to admission).</p> <p>During an interview on the afternoon of 08/28/24, an administrative nurse (#1) confirmed Resident #4 and #83's medical records lacked all required hospice information.</p> <p>46259</p>		