STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 and complaint survey, started on 07/31/17 and completed on 08/03/17, the sample included 5 residents for complete review, 16 residents for focused review, and 3 closed records for review.	F 000		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (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, and staff interview, the facility failed to ensure residents could safely self-administer medications for 2 of 3 sampled residents (Resident #16 and #19) observed with medications in their rooms. Failure to evaluate/re-evaluate a resident's ability to safely self-administer medications placed the resident at risk for improper use, over use, or adverse reactions to the medication. Findings include: Review of the facility policy "Medication -Self-Administration of Medication" occurred on 08/03/17. The policy, dated February 2016, stated, ". . . If a resident responds in the affirmative regarding self-administration, further assessment to determine their ability will take place. This interdisciplinary assessment is reviewed. If the resident wishes to keep the medications at their bedside a physician's order	F 176	1. Resident #16 upon admission on 7/6/17 declined the SAM program, resident continues to decline the SAM program and has deemed to have deferred this right to the facility. Nurse will administer resident's ointment per order. Resident #19 has been assessment for the SAMs program by the multidisciplinary team and due to her moderately impaired cognition is not able to participate in SAM program, the nurse will administer resident's ointment per order. 2. All residents who self administer medications. 3. The facility will ensure that residents self administering medications or medications that are left with residents are assessed to determine their ability and documented, a physician's order is	9/7/17

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

Electronically Signed | 08/21/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 176	Continued From page 1 is required. . . . If there is evidence that the resident cannot safely-administer medication, the interdisciplinary team will re-assess the situation and may withdraw the right to self-administer. The interdisciplinary team will assess self-administration quarterly and as needed. . . . The care plan must reflect self administration and storage arrangements for such medications. . . . For residents who self-administer medications, the following conditions are met for bedside storage to occur: . . . The manner of storage prevents access by other residents. . . . Bedside medication storage is routinely monitored by the Nurse . . ." - Observations on the afternoon of 07/31/17 showed the following: * a cup containing an unidentified ointment on a shelf in Resident #16's bathroom. * a cup containing an unidentified ointment on a shelf in Resident #19's bathroom. - Review of Resident #16's medical record occurred August 2-3, 2017. An admission Minimum Data Set (MDS), dated 07/13/17, identified intact cognition. The medical record lacked evidence Resident #16 had a physician's order and/or had a care-plan to self-administer medications. - Review of Resident #19's medical record occurred August 2-3, 2017. A quarterly MDS, dated 05/19/17, identified moderately impaired cognition. The medical record lacked evidence Resident #19 had a physician's order and/or had a care-plan to self-administer medications. During an interview on 08/02/17 at 4:25 p.m., a	F 176	obtained and care planning to reflect this. All residents who self administer medication will be identified and reviewed for proper assessment and documentation, physician's order and care planning. The current Medication - Self Administration of Medication policy and procedure is being reviewed for any changes in procedure. All staff involved with residents who would like to self administer medications or self administer their medications, will be educated at a meeting on August 24th at 1:30pm regarding the Medication - Self Administration of Medications policy and procedure. 4. Date of Correction: 9/7/17 5. The Quality Assurance Nurse or designee will be responsible to monitor and audit to assure resident's self administering medications have proper assessment and documentation, physician's order and care planning in place. These audits will be conducted, starting August 28th, weekly x4 weeks, monthly x3 months and quarterly for one year. Results will be immediately reported to the DON if concerns are identified, immediate corrective action will be implemented. The QA nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 176	Continued From page 2 certified nursing assistant (#2) stated the ointment found in Resident #16 and 19's bathrooms "were probably icy-hot." During an interview on 08/02/17 at 4:30 p.m., a nurse (#3) stated she could not identify the ointments found in Resident #16 and #19's bathrooms as she had not put the ointment in the cup. During an interview on the morning of 08/03/17, a managerial nurse (#4) confirmed Resident #16 and #19's medical records lacked evidence they had an assessment, a physician's order and/or a care-plan to self-administer medications. She also stated she could not identify the ointments found in Resident #16 and #19's bathrooms as she had not put the ointment in the cup.	F 176		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. 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 1.14), and staff interview, the facility failed to ensure accurate coding of Minimum Data Sets (MDSs) for 1 of 2 sampled residents (Resident #7) coded for hallucinations. Failure to accurately complete Section E (Psychosis) of the MDS does not allow each resident's assessment to reflect their current status/needs, and has the potential to affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI User's Manual, revised October 2016, Chapter 3 page E2, stated, "E0100: Potential Indicators of Psychosis . . . Check . . . if hallucinations were present in	F 278	1. The date of the MDS for resident #7 that was identified in the summary statement was modified for the following specific section hallucinations and submitted to the CMS QIES Assessment Submission and Processing system and to the North Dakota Department of Health. If the corrections affect payment the facility will do billing adjustments accordingly. 2. All residents coded under hallucinations on the MDS have the potential to be affected. 3. All residents in the facility on July 31st, their last MDS was reviewed for accurate coding of E0100. Current procedure related to coding hallucinations on the MDS is being reviewed. All staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. . . ." - Review of Resident #7's medical record occurred on all days of survey. The quarterly MDS, dated 05/09/17, identified psychosis: hallucinations. The medical record lacked evidence Resident #7 experienced hallucinations during the assessment period. During an interview on 08/03/17 at 12:03 p.m., a social service staff member (#1) confirmed Resident #7's medical record lacked evidence of hallucinations during the assessment period.	F 278	completing MDS E0100: Potential Indicators of Psychosis . . . if hallucinations were present in the last 7 days. A hallucination is the perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch. . . ." will be educated at a meeting on August 17, 2017 at 1:00pm regarding deficiency F278. 4. Date of Correction: 9/7/2017 5. The Quality Assurance Nurse or designee will monitor and audit 5 MDS's to assure accuracy of coding section E0100. These audits started the week of August 21st and will be conducted weekly x 4 weeks, monthly x3 months and quarterly for one year. Results will be immediately reported to the DON if concerns are identified, immediate.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that	F 309		9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 309	Continued From page 5 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, review of professional literature, and staff interview, the facility failed to ensure 2 of 4 sampled residents (Resident #6 and #7) diagnosed with dysphagia were positioned properly during meals and/or when providing fluids. Failure to provide proper positioning has the potential to affect the residents' overall swallow safety, and placed them at risk of aspiration. Findings include: Swigert's "The Source for Dysphagia," 3rd ed.,	F 309	1. Resident #7 no longer resides at the facility. For resident #6, no straws was added to resident's plan of care, dietary card as well as "NS" sticker for no straws was added to resident's nameplate outside resident's door. Resident has been educated on using no straws and staff will not be assisting her with straws. 2. All residents can be affected for proper positioning during meals and/or providing fluids. Also, all residents who are identified to have no straws have the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	3534 UNIVERSITY DR S FARGO, ND 58104

(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 309	Continued From page 6 Pro-Ed, Inc., Texas, 2007, pages 9, 10, 125, and educational handouts, identified, ". . . Signs and Symptoms of Dysphagia . . . drooling . . . coughing . . . during a meal or a wet, gurgly vocal quality. . . . Some patients cough and choke when they aspirate, but up to 40-70% of patients may be silent aspirators. That is, they don't cough or even clear their throats when they aspirate [have food/liquids enter their airway]. . . . If a patient is on an antibiotic, it may suppress any possible lung infection secondary to aspiration. Therefore, he may not show signs of early pneumonia simply because he is on antibiotics for something else. . . . During the oral intake of . . . food and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or in a chair. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue. . . ." - Review of Resident #7's medical record occurred on all days of survey. Diagnoses included dementia with behavioral disturbance, respiratory disorder, and oropharyngeal dysphagia. The quarterly Minimum Data Set (MDS), dated 05/09/17, identified severely impaired cognition and extensive assistance of one person required during meals. A progress note, dated 07/25/17, identified, "Speech eval [evaluation] completed . . . Recommendations . . . avoid straws . . . If congestion does not resolve . . . consider a trial of thickened liquids as silent aspiration cannot be ruled out. Continues to have congestion, productive cough, ronchi [rattling lung sounds] noted . . . bilaterally . . . Levaquin [antibiotic] for	F 309	potential to be affected. 3. The facility will ensure residents are in an upright as close to 90 degree as possible during meals and/or providing fluids as well as ensuring resident that are identified as to have no straw are not receiving fluids through straws. The current "Food/Fluid Intake" policy and procedure has been reviewed and revised. All nursing staff will be educated on August 24th at 1:30 by the Speech Therapist on Dysphagia and proper positioning when assisting with food and fluids as well as education on the revised "Food/Fluid Intake" policy. 4. Date of Correction: 09/07/2017 5. The Quality Assurance Nurse or designee will monitor and audit residents during meal times and when receiving offered fluids between meals for proper positioning as well as auditing 5 resident who are identified as not to have straws with their fluids, do not have straws. These audits will be starting August 21st and conduced weekly x4 weeks, monthly x3 months and quarterly for one year. Results will be immediately reported to the DON of concerns are identified, immediate corrective action will be implemented. The QA nurse will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 309	Continued From page 7 Resp. [respiratory] Infection. . . ." Observation showed the following: * On 08/01/17 at 7:50 a.m., Resident #7 sat in his Broda chair (reclining wheelchair) next to an assisted table in the dining room, with his chair reclined to an approximate 60 degree angle. Resident #7 drooled during the meal. The certified nursing assistant (CNA) (#6) failed to raise Resident #7's chair to a 90 degree angle prior to feeding him. * 08/01/17 at 10:10 a.m., three CNAs (#6, #7, and #8) provided cares for Resident #7's. One CNA (#6) offered Resident #7 a drink of water while he sat in his Broda chair, reclined to an approximate 45 degree angle. Resident #7 sipped water from a straw, and showed no immediate signs/symptoms of dysphagia. All three CNAs (#6, #7, and #8) then transferred him into bed utilizing a Hoyer (full body) lift. As soon as one of the staff members reclined the head of his bed, Resident #7 immediately began coughing with a wet, gurgly vocal quality. He could still be heard coughing as the three CNAs (#6, #7, and #8) exited his room. The CNAs (#6, #7 and #8) failed to raise Resident #7's chair to a 90 degree angle prior to offering him water, and failed to offer him water without utilizing a straw. * 08/01/17 at 12:10 p.m., three CNAs (#3, #9, and #10) provided Resident #7's cares before transporting him to the dining room. One of the CNAs (#3) raised the head of his bed to an approximate 40 degree angle and offered him a drink of water. Resident #7 presented with an immediate wet, gurgly vocal quality after sipping the water from a straw. The three CNAs (#3, #9, and #10) then transferred him into his Broda chair utilizing the Hoyer lift. Once in the dining	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 309	Continued From page 8	F 309		

room, one of the CNAs (#9) raised his chair to an approximate 60 degree angle and proceeded to feed him. Resident #7 coughed during the meal. The CNAs (#3, #9, and #10) failed to raise Resident #7's bed to a 90 degree angle prior to offering him water, failed to offer him water without utilizing a straw, and failed to raise Resident #7's chair to a 90 degree angle prior to feeding him.

During an interview on 08/03/17 at 11:13 a.m., a speech language pathologist (#11) confirmed staff should ensure proper positioning of residents prior to offering them food/liquids. She stated residents should be "as close to 90 degrees as possible," and indicated a wedge could be used as an assistive device to help ensure proper positioning.

- Review of Resident #6's medical record occurred on all days of survey. Diagnoses included dementia, pharyngeal dysphagia, reflux, silent penetration (material enters the airway and remains above the vocal folds), and recurrent pneumonia. The significant change MDS, dated 06/17/17, identified intact cognition and staff assistance required with meal set-up.

The "Video Fluoroscopy Swallow Evaluation," dated 04/26/16, identified Resident #6 as having a ". . . swallow . . . impairment characterized by impaired tongue based retraction, pharyngeal contraction, and laryngeal elevation . . . as well as . . . absent laryngeal sensation (silent penetration/unable to rule out silent aspiration). . . . Recommendations . . . sitting upright 90 degrees . . ."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 309	Continued From page 9 The "Nutritional Assessment," dated 06/16/17, identified Resident #6 received a regular diet, was observed by staff to be coughing at meals, and has a history of dysphagia. The report also indicated Resident #6 " [is] able to feed [her]self with assist to set up tray. Upright for all intake . . ." Observation on 08/01/17 at 7:44 a.m. showed Resident #6 lying in bed, with the head of her bed raised to an approximate 30 degree angle. A nurse (#5) entered Resident #6's room and administered her oral medication at bedside. The nurse (#5) failed to raise the head of Resident #6's bed to a 90 degree angle prior to administering her medication. During an interview on the morning of 08/03/17, a managerial nurse (#4) confirmed staff should ensure Resident #6 and #7 are seated as close to 90 degrees as possible when offering food/liquids and ensure Resident #6 and #7 are not offered liquids via a straw.	F 309		
F 494 SS=D	483.35(d)(1)(2) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY (d)(1) General rule A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless-- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151	F 494		9/7/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 494	Continued From page 10 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). (d)(2) Non-permanent employees A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. This REQUIREMENT is not met as evidenced by: Based on review of the State Agency (SA) nurse aide registry files, facility record review, and staff interview, the facility failed to ensure 1 of 1 nurse aide (Individual A) working with residents in the facility remained certified. Individual A provided nurse aide related services without verifying competency through certification. Failure to ensure certification of caregivers has the potential to affect resident care. Findings include: The SA received information Individual A worked with residents without certification. Review of the nurse aide registry information showed Individual A's nurse aide certification expired on 06/17/16. Facility's records sent to the SA on 06/15/17, showed Individual A worked with residents without certification a total of 840 hours from 06/17/16 to 06/11/17. During an interview in the morning on 08/03/17, administrative staff members (#12 and #13)	F 494	1. Individual A re-educated regarding responsibility of keeping track of CNA expiration date for timely renewal of certification. Individual A was removed from the schedule immediately and explained that individual A would not be able to work until a valid C.N.A certificate is obtained. Individual A resigned from the facility. A review of our process was completed to ensuring that all Nurses and aides are current on their certifications and/or licenses. 2. All licensed and certified nursing staff are affected by this deficient practice. 2. All licensed and certified nursing staff re-educated regarding timely renewal of licenses and certifications on August 24th, 2017 at 1:30pm. 3. Upon hiring of nurses and CNAs, license or certificate expiration will be entered in the scheduling calendar. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355085	A. BUILDING _____ B. WING _____	C 08/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIM CARE CENTER	**3534 UNIVERSITY DR S FARGO, ND 58104**

(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 494	Continued From page 11 confirmed Individual A had worked at the facility "PRN" [as needed] and his license had expired on 06/17/16.	F 494	licensed and certified staff will not be able to work beyond that date unless renewal has been completed. The licensed or certified staff will also have their expiration date included in their annual evaluation as a reminder when their license or certification expires. 4. Date of Correction: 9/7/2017 5. The Quality Assurance Nurse started auditing in July 2017 and completed an audit on 7/17/2017 and 8/17/2017 audit and will continue to audit monthly x 6 months. Results will be reported to the Director of Nursing. If concerns are identified immediate corrective action will be implemented.	
F9999	FINAL OBSERVATIONS A complaint investigation was conducted in conjunction with the standard Medicare/Medicaid recertification survey. The complaint issues regarding discharge planning could not be substantiated.	F9999		