

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/10/2022  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>ND202 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |  | (X3) DATE SURVEY<br>COMPLETED<br><br>10/04/2022 |
| NAME OF PROVIDER OR SUPPLIER<br><br>FARGO ELIM HEALTH CARE CENTER |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>3534 UNIVERSITY DRIVE S<br>FARGO, ND 58104                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                 |
| (X4) ID<br>PREFIX<br>TAG                                          | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  | (X5)<br>COMPLETION<br>DATE                      |
| F 000                                                             | INITIAL COMMENTS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | F 000                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  |                                                 |
| F 727<br>SS=E                                                     | <p>The initial Medicare/Medicaid certification survey was completed on 10/04/22.</p> <p>RN 8 Hrs/7 days/Wk, Full Time DON<br/>CFR(s): 483.35(b)(1)-(3)</p> <p>§483.35(b) Registered nurse<br/>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.</p> <p>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.</p> <p>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:<br/>Based on review of the facility's nursing staff schedule and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 4 of 27 days from 09/08/22 to 10/04/22. Failure to ensure sufficient, qualified nursing staff are available daily has the potential to affect all the residents residing in the facility.</p> <p>Findings Include:</p> <p>The facility provided a copy of the nurses' schedule from 09/08/22 to 10/04/22. A review of the schedules showed the facility lacked the required RN coverage on 09/17/22, 09/18/22, 10/01/22 and 10/02/22.</p> | F 727                                                              | <p>It is the policy of Fargo Elim to comply with providing RN services at least 8 consecutive hours a day, 7 days a week, F-727.</p> <p>Although no residents were directly affected by this deficient practice, all residents do have the potential to be affected.</p> <p>To assure continued compliance, the following plan has been put into place:<br/><u>Actions taken to identify other potential residents having similar occurrences:</u><br/>On 10/5/2022, the working schedule was reviewed and updated to ensure there is RN coverage 8 consecutive hours 7 days a week. On 10/7/2022, an audit was completed to ensure there was 8 consecutive hours 7 days a week RN coverage. The audit showed that there was coverage.</p> <p><u>Measures put in place to ensure deficient practice does not recur:</u><br/>The facility's policy, "Nursing Services" and regulation F-727 was reviewed on 10/5/2022. Written and verbal education regarding the need to provide RN services at least 8 consecutive hours a day, 7 days a week was provided to all nursing leadership staff and scheduling staff on 10/5/2022. The education was provided by the Director of Nursing.</p> |  |                                                 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| F 727                                                             | Continued From page 1<br><br>During an interview on 10/04/22 at 4:15 p.m., an administrative nurse (#1) confirmed the facility lacked eight consecutive hours of RN coverage on the days in question. | F 727                                                              | <p><u>Effective implementation of actions will be monitored by:</u><br/>The Director of Nursing, or designee, will complete random weekly audits of the schedule to ensure there is 8 consecutive hours of RN services 7 days a week. Weekly audits will be completed weekly for 4 weeks, then bi-weekly for 8 weeks, then as needed thereafter. The audits will be reviewed by the Quality Assurance Committee or designee until substantial compliance has been achieved as determined by the committee.</p> <p><u>Those responsible to maintain compliance will be:</u><br/>The Director of Nursing or designee is responsible for maintaining compliance.</p> <p><u>Completion date for certification purposes only is:</u> 10/5/2022</p> |                            |                                                 |