STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARGO ELIM HEALTH CARE CENTER	**3534 UNIVERSITY DRIVE S , FARGO, North Dakota, 58104**

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F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 03/09/2026 and concluded 04/01/26.	F0000		04/01/2026
F0684 SS = G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that 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. This REQUIREMENT is NOT MET as evidenced by: 1. Based on observation, record review, review of facility policies, and staff and hospice staff interviews, the facility failed to provide the necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 supplemental resident (Resident #62) with uncontrolled pain under hospice care. Failure of staff to effectively assess and treat Resident #62's pain resulted in unnecessary pain and discomfort. Findings include: Review of the facility policy titled "Hospice" occurred on 03/12/26. This policy, dated 03/18/24, stated, ". . . The facility retains primary responsibility for implementing aspects of care . . ." Review of the facility policy titled "Pain management" occurred on 03/12/26. This policy, dated 02/18/26, stated, ". . . Pain management is an interdisciplinary care process that includes . . . Assessing the potential for pain . . . Effectively recognizing the presence of pain . . . Identifying the	F0684	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Resident #62: Pain treatment was reviewed and adjusted as appropriate. Pain monitoring parameters were clarified and reinforced with staff. Resident #27: Medication administration and meal-time coordination were reviewed. Staff were re-educated on insulin administration protocols, including required meal timing and provision of juice when indicated. Resident was re-educated on the importance of diabetic management and recognizing signs of low blood sugar. Resident reported that he can recognize the symptoms of low blood sugar and is aware that he needs to report to the nurse. Resident #67: Proper positioning in the Broda chair was re-assessed.	04/16/2026

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 reverse for further 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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F0684 SS = G	Continued from page 1 characteristics of pain . . . Reports of pain are handled as high priority and handled as such. . . ." During an interview on 03/11/26 at 3:45 p.m., Resident #62's family member (BB) voiced concerns regarding Resident #62's pain not assessed on a regular basis and the timeliness of administering prn (as needed) pain medications. The family member stated when he arrived this morning around 8:30 a.m., the resident was moaning, and when he asked the nurse when she last received a prn pain medication, the nurse stated, "4:00 or 4:15 this morning." Review of Resident #62's medical record occurred on March 11-12, 2026. The current care plan stated, ". . . Monitor level of comfort. Medicate per orders . . . Resident will maintain the highest possible level of comfort . . ." Resident #62's current physician's orders included: * 11/17/25 - Admit to hospice with primary diagnosis of hypertensive heart disease with congestive heart failure. * 03/11/26 - Hydromorphone (a pain medication) 2 milligrams (mg) every four hours. Can give as needed (prn) dose one hour after scheduled dose. * 03/11/26 - Hydromorphone 2 mg every two hours prn. Can give one hour after scheduled dose. * 03/09/26 - Lorazepam (an antianxiety medication) 0.5 mg every four hours prn. Can give two hours after scheduled dose. * 03/10/26 - Lorazepam 0.5 mg every four hours. Review of the electronic medication administration record (emar) showed facility staff administered prn hydromorphone on 03/10/26 at 5:18 p.m. (22.5 hours before the interview with family member (BB) and not 4:00 a.m. or 4:15 a.m. the morning of 03/11/26 as identified by the nurse) and prn lorazepam on 03/10/26 at 5:19 p.m. Observation on 03/11/26 at 5:20 p.m. showed Resident #62 in bed and restless with family and the hospice nurse (#20) at the bedside. The hospice nurse stated she had requested the facility staff nurse administer prn hydromorphone and prn lorazepam related to signs of pain and restlessness. The hospice nurse also stated staff should use prn	F0684	Continued from page 1 The care plan was updated to include individualized positioning and head-support interventions. A lateral support for the Broda Chair was implemented. Nursing staff were educated on resident-specific interventions to ensure proper implementation. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit was conducted by the DON or designee on the week of April 6th, 2026 to identify residents who: Require end of life pain management Receive short acting insulin Utilize a Broda wheelchair Any issues identified were addressed immediately, and care plans were revised as needed. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The facility reviewed and reinforced policies and/or procedures related to: Pain assessment and management Insulin administration and timing relative to meals Proper positioning and use of Broda chairs and equipment Nursing staff were re-educated on:	04/16/2026

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F0684 SS = G	Continued from page 2 pain and anxiety medications more frequently. The hospice nurse educated the facility nurse (#17) on administering prn medications more frequently and timely related to Resident #62's increased pain and restlessness. Observation on 03/12/26 at 7:21 a.m. showed Resident #62 leaned to the right of the bed, used accessory muscles to breathe, moaned, was restless, and fidgeted with the blankets and call light. After approximately 2-3 minutes the resident started grunting louder and attempted to move her upper body with no success. At 7:41 a.m., the resident's moaning and grunting became louder, and she stated, "Help, help" and continued to fidget in the bed. At 7:43 a.m., a nurse (#17) entered the room and administered the scheduled hydromorphone, lasix (to treat fluid retention) and lorazepam by the oral mucosa route. Resident #62 stopped moaning, grunting, fidgeting and appeared comfortable about 4-5 minutes after receiving the medications. The EMAR showed the facility staff administered the last prn hydromorphone on 03/12/26 at 1:10 a.m. (over six hours prior) and administered the last prn lorazepam on 03/11/26 at 5:21 p.m. (over 14 hours prior). During an interview on 03/12/26 at 8:01 a.m. a nurse (#17) confirmed Resident #62 received the last prn dose of hydromorphone at 1:10 a.m. Resident #62's hospice progress notes included the following: * 03/10/26 at 12:16 p.m. ". . . This writer spoke with . . . staff nurse (#21) to encourage use of PRN hydromorphone and lorazepam for symptoms of non verbal signs of pain and restlessness/moaning. . . ." * 03/10/26 at 10:30 p.m. ". . . Visit made to patient per request of daughter for concerns of restlessness. . . . Patient grimace and groans with touch/movement. . . . Encouraged staff to check on patient QH2 (every two hours) through the night, utilize PRNs if warranted and [Hospice agency's name] hospice nurse could increase dose based on PRN use tomorrow. . . ." * 03/11/26 at 5:37 p.m. ". . . Had facility nurse give prn doses of hydromorphone and lorazepam while I was here for signs of pain restless with relief noted. . . . Patient is now resting very comfortable at this	F0684	Continued from page 2 Timely pain assessment, documentation, and follow-up Insulin administration protocols and nutritional coordination Nursing staff and Therapy staff were re-educated on: Maintaining proper positioning to prevent discomfort and injury 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit: Pain assessments, medication administration and documentation of effectiveness for all residents receiving end of life care Provision of juice or other resident preferred food item was given in relation to timing of meals for all residents receiving short acting insulin Positioning of all residents utilizing a Broda chair and use any positioning devices Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter Audit results will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified concerns will result in immediate corrective action and re-education. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED	04/16/2026

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F0684 SS = G	Continued from page 3 time since the prn medications. . . . Facility to continue to use prn medications as needed and to call [Hospice agency's name] hospice at any time if prn medications are not effective. . . ." Review of Resident #62's electronic medication administration record (EMAR) from March 9th to March 12th at 9:00 a.m. showed the following prn medications: * 03/09/26 - Lorazepam prn administered one time at 3:53 p.m. * 03/10/26 - Hydromorphone prn administered at 5:18 p.m. Lorazepam prn administered one time at 5:19 p.m. The emar showed the resident's scheduled 12:00 p.m. dose of hydromorphone administered at 1:25 p.m. (1.25 hours later than scheduled). * 03/11/26 - Hydromorphone prn administered one time. Follow up on Resident #62's pain identified the medication as not effective. Lorazepam prn administered one time at 5:21 p.m. Follow up identified the medications as somewhat effective. * 03/12/26 - Hydromorphone prn administered one time at 1:10 a.m. Per observation and hospice nurse's notes, the hospice nurse requested the facility nurse administer both medications due to Resident #62 experiencing pain and restlessness. The facility failed to appropriately monitor, assess, document, and treat Resident #62's continued pain. 2. Based on observation, record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled resident (Resident #27) observed during insulin administration. Failure to properly administer medications may result in residents receiving an ineffective dose and experiencing adverse reactions. Findings include: Review of manufacturer's instructions for "Fiasp® insulin aspart" occurred on 3/12/26. These	F0684	Continued from page 3 Quality of Care, including pain management, medication safety, and positioning, will remain a standing QAPI agenda item for at least six (6) months. All nursing staff were educated on the importance of pain management related to end of life care, short acting insulin administration and resident comfort and positioning. New nursing staff will receive education on these topics during orientation. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, Charge Nurses, Interdisciplinary Team Members	04/16/2026

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F0684 SS = G	Continued from page 4 instructions, dated June 2023, stated, ". . . Inject FIASP® at the start of a meal or within 20 minutes after starting a meal . . ." Observation on 03/11/26 at 5:00 p.m., showed a nurse (#9) administered Fiasp (rapid-acting insulin) to Resident #27. The resident received the evening meal meal at 6:15 p.m. (1 hour and 15 minutes after insulin administration). During an interview 03/11/26 at 6:13 p.m., a nurse (#9) stated, "He should have his meal tray by now, normally I would offer juice or snack, but I did not today." During an interview on 3/12/26 at 2:55 p.m., an administrative nurse (#1) confirmed the nurse failed to administer the insulin as per manufacturer instructions. 3. Based on observation, record review, and staff interviews, the facility failed to provide the necessary care and services for 1 of 1 sampled resident (Resident #58) reviewed for wheelchair positioning. Failure to ensure correct positioning may result in pain and physical discomfort. Random observations conducted throughout survey showed Resident #58 seated and reclined in a Broda chair (a specialized geriatric tilt-in-space seating device) leaning forward and to the right. Review of Resident #58's medical record occurred on all days of survey identified diagnoses of Parkinson's disease, dementia with behavioral disturbance, osteoarthritis, pain, and restlessness/agitation. The record identified a wheelchair/positioning assessment completed by the Veteran's Administration (VA) on 05/13/23. The current care plan stated, ". . . Skin integrity . . . Resident noted to sleep in Broda instead of bed . . . FALL INTERVENTIONS . . . Recline Broda for positioning. . . ." The care plan failed to include interventions for proper head positioning while in the Broda chair. Resident #58's care conference notes, dated	F0684		04/16/2026

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F0684 SS = G	Continued from page 5 01/13/26, stated, ". . . Education provided to family risk of skin breakdown d/t extended time in Broda . . . Staff do attempt repositioning (reclining) when in Broda to help protect skin integrity. . . ." During an interview on 03/10/26 at 10:05 a.m., an unidentified nurse stated staff used a blanket to support Resident #58's head sometimes and indicated the blanket frequently fell out of place. During an interview on the afternoon of 03/11/26, an occupational therapist (#22) stated she/he expected nursing staff to send a seating and positioning screening referral to therapy department. The therapist confirmed a positioning assessment had been completed since 2023 by the VA.	F0684		04/16/2026
F0550 SS = SQC-F	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F0550	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE All clinical staff were re-educated on: Timely assistance with toileting for dependent residents with toileting schedules All staff were re-educated on: Prompt response to call lights Use of respectful, dignified, and person-centered communication at all times Residents #67's care plan was reviewed and updates were made to reflect current needs and status. Residents were interviewed to ensure needs were being met and that residents felt respected and treated with dignity. The facility ensured affected residents received appropriate care without delay and that dignity was maintained.	04/16/2026

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F0550 SS = SQC-F	Continued from page 6 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policies, confidential resident interviews, family, visitor and staff interview, the facility failed to provide necessary care in a manner that promotes, maintains, or enhances their quality of life for 16 of 35 sampled residents (Resident #67, A, B, D, E, F, G, H, I, J, L, M, N, O, P, and Q) requiring assistance with activities of daily living. Failure to assist dependent residents with toileting, answer call lights timely, and speak to residents in a dignified manner does not enhance the resident's quality of life and has the potential to affect the resident's psychosocial and personal dignity. Findings include: Review of the facility policy titled "Resident dignity, choices and preferences" occurred on 03/12/26. This policy, dated 11/20/25, stated, ". . . It is the expectation that all . . . employees will treat residents with dignity and respect at all times. . . . Residents will be encouraged to voice their concerns and needs at all times to ensure their care needs, choices and preferences are honored. . . ." Review of the facility policy titled "Resident Rights" occurred on 03/12/26. This policy, dated 11/20/25, stated, ". . . facilities recognize they must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. . . .' -Review of Resident #67's medical record occurred on all days of survey. The current care plan stated, ". . . COGNITION-strength: [Resident #67's name] does not have any cognitive diagnoses. He is alert and oriented and is able to make needs known to staff. . . . .TOILETING: Staff to provide assist x2 [times two] with toileting. . . . Offer toileting upon	F0550	Continued from page 6 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit was conducted the week of April 6th, 2026 by the DON or designee to identify residents who: Are dependent for toileting with individualized toileting schedules Have call light on for more than 10 minutes Report not being treated in a dignified manner Resident care plans were reviewed to confirm accuracy, clarity, and staff awareness. Any residents identified as being at risk for delayed response or unmet toileting needs will be included in scheduled audits. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Staff education was provided on Quality of Life, Resident Dignity, and Respectful Communication, with emphasis on: Responsiveness to resident needs Timely toileting assistance Maintaining dignity during all care interactions Expectations for call light response times were reinforced facility-wide. Supervisory rounds will occur on all shifts to audit:	04/16/2026

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F0550 SS = SQC-F	Continued from page 7 arising, after meals, before bed and as resident requests." During an interview on 03/09/26 at 1:42 p.m. Resident #67 stated, "At nights I put the light on and they [facility staff] don't come in. They turn it off out there [nurses' station] and I have had to wet my pants, and I hate to say it, but I've crapped my pants too before because of it. At night when I flip the switch to go to the bathroom, I get an argument from the night aide. They tell me that they just took me an hour earlier. They [facility staff] are telling fibs, they judge how often I should pee, and I tell them my body tells me when I need to pee. Just Friday I wet my pants. One night a few weeks ago, they [facility staff] put me to bed without my call button. Well, it was my fault because I should have checked that I had it before they [facility staff] left. That really scares me because otherwise I have no way to communicate with them [facility staff]. They [facility staff] wouldn't hear me if I yelled. So, I got my reacher and pulled my wheelchair over to me and transferred myself into the wheelchair and I went to hallway, and they [facility staff] gave me hell for getting up myself. They {facility staff] couldn't find it either right away, and I don't know where she [staff] found it." During an interview on 03/10/26 at 1:25 p.m., Resident #67 stated, "During the night shift, closer to the morning, I put my call light on to use the bathroom. A CNA [certified nurse aide] popped her head in the door and asked what I needed, and I said: 'I gotta pee bad.' She [the CNA] said, 'It's not your time to pee now, you're going to have to wait.' I said I can't wait, and then she turned my call light off and left the room. The night staff are rude and disrespectful to me. I've told [CNA #13's name] about the night shift not helping me to the bathroom when I need to pee. And [he/she] shakes [his/her] head." During an interview on 03/10/26 at 1:55 p.m. with the CNA (#13), when asked if Resident #67 has told him about the night shift not assisting him to the bathroom, the CNA (#13) stated, "[Resident #67's name] has told me that a couple of times in the last couple weeks." When asked what he does with that information, the CNA stated, "I report it to the nurse, and I think she lets the case manager know, but that I am not sure about." During an observation on 03/10/26 at 8:22 p.m., two CNAs (#11 and #12) assisted Resident #67 with evening cares and toileting. When the wheelchair	F0550	Continued from page 7 Call light response times Staff-resident interactions Assisting dependent resident with individualized toileting schedule Failure to follow these expectations will be addressed through progressive disciplinary action as applicable. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit 10% of the resident census for: Call light response times Staff assistance with toileting Observed staff communication with residents Auditing will occur weekly for four (4) weeks, then monthly for two (2) additional months, and as needed thereafter. Findings will be documented and reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any trends or issues identified will result in immediate retraining or corrective action. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Quality of Life and Resident Dignity will remain a standing agenda item at QAPI meetings for at least six (6) months.	04/16/2026

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F0550 SS = SQC-F	Continued from page 8 was positioned in front of the toilet, the CNA (#11) told the resident to lock his wheelchair brakes. The resident did not hear the CNA (#11). The CNA (#12) started to lock the brakes on the wheelchair and the CNA (#11) stated, "He can lock it." While sitting on the toilet the resident stated, "My diaper is clean." The CNA (#11) stated, "You've had this diaper on all day and we're going to change it." When the resident stood beside the bed, the CNA (#11) stated in a raised voice, "SIT" to the resident. -During an interview on 03/09/26 at 4:29 p.m., Resident A stated the "night shift CNAs are rude, and I've had some not nice interactions." -During an interview on the evening of 03/10/26, Resident B stated, "I am having trouble with the care here. They [staff] treat me like I am nothing. They make me do things that I do not want to do. I do not appreciate them giving me [explicative] all of the time when I ask for help. It is at night. It is the nurses that are on at night. It takes them more than 20 minutes to answer my call button. When I tell them it took so long for them to come, they disagree and tell me it did not take them that long. Sometimes they do not come at all." -During an interview on 03/10/26 at approximately 9:00 p.m., Resident D stated, "Some of the night shift staff have attitude and are not as nice as they should be." -During an interview on 03/09/26 at 3:26 p.m., Resident E stated, "I need to use the bathroom. Sometimes it takes a long time for them to come help me to the bathroom if they come at all." The surveyor noted a strong bowel movement odor in the room. -During an interview on 03/10/26 at 11:20 a.m., Resident F stated, "The night shift CNAs are not nice and they are rude. They could do better." -During an interview on 03/09/26 at 1:42 p.m., Resident G identified the night crew as rude. Resident G stated one night he/she pressed the call button to ask help due to diarrhea. When a staff member came into the room, he/she told the resident to take care of it him/herself. -During an interview on 03/09/26 at 3:00 p.m., Resident H stated the night shift "grumble about helping me." -During an interview on 03/09/26 at 12:55 p.m.,	F0550	Continued from page 8 New staff will receive education on resident rights, dignity, toileting assistance, and call light responsiveness during orientation. Annual competency reviews will reinforce expectations for respectful, timely, and person-centered care. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: All staff	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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F0550 SS = SQC-F	Continued from page 9 Resident I stated, "They [staff] have no manners. I get bruises from the way they handle me. I wish they would leave my stuff alone; It's my home." -During an interview on 03/10/26 at 8:54 p.m., Resident J stated, "The night shift CNAs [the CNAs from last night and tonight] are rude, they [staff] do not talk to me when they are in my room, unless they are upset with me then they talk back. I know I can be picky where I want things placed, but I need to be able to reach things. Sometimes they answer my call light and say they will come back but they never do. I do not have this problem with other shifts." -During an interview on 03/10/26 at 9:26 p.m., Resident L stated, "I pressed my call button for help at 1:30 a.m. My call button fell on the floor after I pressed it. I needed staff to pick up my call button and readjust the pillow at my feet. I was very uncomfortable. Staff never came, and I finally fell back to sleep." -During an interview on 03/09/26 at 4:44 p.m. Resident M stated, "One of the attendants on the night shift is really mean." Resident M's family member (EE) stated, "A CNA was really mean, it was a couple weeks ago. She was getting her ready to go to breakfast and the CNA told her, 'You need to hurry. I got another person to take care of.'" During an interview on 03/10/26 at 8:18 a.m., Resident M cried and said he/she was upset. Resident M stated, "They [the night shift] got mad at me because I wet the bed. They said, 'Why did you wet the bed. See that call light?' I had pushed the call light, and no one ever came. What was I supposed to do. They speak rough and are mean to me. I don't know what I did. Could you hide in the bathroom so you could hear the way they talk to me, I'd certainly give you permission." -During an observation on 03/10/26 at 9:35 p.m., Resident N sat on the edge of his/her bed threading the catheter bag through his/her pants. The resident stated, "I have to do all of this by myself, because the night ones [staff] are rude. It takes forever for them [staff] to answer my call light." -During an interview on 03/10/26 at 8:37 p.m.,	F0550		04/16/2026

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F0550 SS = SQC-F	Continued from page 10 Resident O stated, "night shift CNAs are still making me use the bed pan to have a bowel movement. I have told them it is difficult for me to go on the bed pan; I can only go a little and I end up needing to use it several times in a row. Physical therapy does not want me using a slide board with staff yet, so I feel like the CNAs do not want to deal with me since it requires a hoyer lift to transfer me to the bathroom," and "The night CNAs [like the two who are on tonight] have attitude." -During an interview on 03/10/26 at 9:37 p.m. regarding Resident P, a visitor (DD) stated staff do not answer the call button at night and are not friendly and they leave Resident P on the toilet for long periods of time. Visitor DD stated Resident P has cried and yelled for staff to transfer him/her off the toilet. -During an interview on 03/10/26 at 9:45 p.m., Resident Q stated, "Staff speak in their native tongue and laugh with each other during cares. Staff do not talk to me. Staff are rough when they put me to bed even when I tell them to be careful, and it is painful. Staff have left me sitting on the toilet for long periods of time. My feet fall asleep and then I cannot walk. I lost my balance and fell one time trying to get up from the toilet myself. I screamed for help and staff came." During an interview on 3/12/26 at 2:55 p.m., an administrative staff member (#1) stated, "It is my expectation that residents are treated with respect and dignity, like you would treat your own family."	F0550		04/16/2026
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F0657	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The Director of Nursing (DON) reviewed the care plans for Residents #5, #11, #27, #38, and #58 on 3/12/2026. The interdisciplinary team (IDT) revised each care plan to accurately reflect: Resident #5: Diuretic use with appropriate diagnosis listed in the problem with goals, monitoring, and interventions.	04/16/2026

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F0657 SS = E	Continued from page 11 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and family and staff interview, the facility failed to review and revise care plans to reflect the residents' current status for 5 of 20 sampled residents (Residents #5, #11, #27, #38, and #58) care plans reviewed. Failure to update care plans limited the staff's ability to communicate needs and ensure continuity of care. Findings include: Review of the facility policy titled "Care plan and baseline care plan" occurred on 03/11/26. This policy, dated 02/18/26, stated, ". . . Care plans are update with MDS [Minimum Data Set]/care conference schedule and as needed to assure that they are an accurate reflection of the resident and their care needs. . . ." - Review of Resident #5's medical record occurred on all days of survey. Physician's orders included spironolactone (a diuretic) once a day for chronic combined systolic and diastolic heart failure. A quarterly MDS, dated 12/12/25, identified diuretics as a high-risk drug/medication. The care plan lacked a problem, goal, and interventions related to Resident #5's diuretic use. - Review of Resident #11's medical record occurred on all days of survey and identified a supra-pubic catheter (a tube inserted into the lower abdomen to drain urine) . ." The care plan stated, ". . . indwelling urethral catheter [a tube inserted into the urethra]. .	F0657	Continued from page 11 Resident #11: Correct catheter type (suprapubic catheter) with accurate care interventions. Resident #27: Smoking safety status consistent with the smoking risk assessment. Resident #38: Added the use of the wander guard, with updated safety interventions as appropriate. Resident #58: Discontinuation of bilateral amplifiers per family request. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE The DON or designee audited all of the residents the week of April 6th, 2026. The audit will focus on: Diuretic use and corresponding problem, goals and interventions Wandergaurd use and corresponding problem, goals and interventions Smoking risk assessments and corresponding problem, goals and interventions Urinary catheters and correct anatomical placement Use of amplifiers Any discrepancies identified were corrected by the IDT. Staff were notified of updates as applicable. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE	04/16/2026

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F0657 SS = E	Continued from page 12 . Requires Suprapubic Catheter. . ." Observation on the morning of 03/11/26 showed Resident #11 with a suprapubic catheter. During an interview on 03/11/26 at 3:24 p.m., an administrative staff member (#1) confirmed Resident #11 had a suprapubic catheter and not an indwelling urethral catheter. -Review of Resident #27's medical record occurred on all days of survey. The care plan stated, ". . . [Resident name] is currently smoking on a regular basis. Smoking materials are kept in the nurse's med [medication] cart. [Resident name] will remain safe when smoking and will follow facility policy regarding smoking . . . Shared Risk Agreement in place for [name] and smoking. Fire safety education has been provided to [name] so he is aware or how to respond in the event of a fire. Staff to continually monitor clothing for any burn holes to ensure safe smoking habits. Encourage [name] to utilize the portable ash tray attached to his wheelchair. Empty the portable ashtray when he comes back inside and dispose of cigarette butts in garbage located in locked med room or he may empty the portable ash tray into the garbage can outside. [name] instructed on smoking policy and appropriate location(s) to smoke. [name] is to have personal cell phone when he goes out to smoke. [name] is to sign out and obtain cigarettes and lighter from nurse. [name] is to sign back in when done smoking and return cigarettes and lighter to nurse. Staff to monitor for safe smoking practices and will report concerns to nursing supervisor. . . ." A smoking risk assessment, dated 02/20/26, identified Resident #27 as not safe to smoke under any circumstances. During an interview on the afternoon of 03/12/26, two administrative staff members (#1 and #2) stated the facility is aware of the risks and continue to monitor Resident #27. Staff member (#1) stated, "It's the wording of the assessment." Resident #27's medical record showed a discrepancy between the smoking risk assessment and care plan. -During an interview on 03/10/26 at 9:07 a.m., a family member of Resident #38 stated, "One day mom, got over to dad's apartment and the facility was not aware of it. Dad is confused and cannot care for mom right now," and "the facility put an	F0657	Continued from page 12 DEFICIENT PRACTICE WILL NOT RECUR The facility's Care Planning Policy and Procedure was reviewed on 4/2/2026 and no changes were needed. Nursing and Case Management staff were re-educated on: Ensuring care plans accurately reflect assessments and MDS findings Updating care plans with changes in condition, treatments, devices, or resident/family preferences Charge nurses are required to communicate care changes to the IDT promptly. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit all new admissions, hospital returns and all resident that have: Diuretic use Wandergaurd use Smoking Preference Urinary catheters Amplifier use Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter Audit findings will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings.	04/16/2026

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F0657 SS = E	Continued from page 13 alert on her now. Now the facility will be notified if dad attempts to take her to the apartment." Review of Resident #38's medical record occurred on all days of survey. Diagnoses include legal blindness and mild cognitive impairment of uncertain/unknown etiology. An admission MDS, dated 12/24/25, identified severe problems with thinking and memory. The medical recorded lack documentation of the incident mentioned by the family member. An electronic message, dated 02/05/26 at 12:30 p.m., sent by administrative staff member (#3) to facility staff, stated, " . . . now has a wanderguard [alarm system] in place effective 02/05/26. . . . her husband . . . has been bringing her over to their apartment without alerting staff. . . ." The care plan lacked a problem, goals, or interventions related to Resident #38's possible elopement incident and application of the wanderguard. -Review of Resident #58's medical record occurred on all days of survey. The current care plan stated, ". . . Problem: Hearing is impaired and utilizes bilateral amplifiers per his & [and] families request . . . Approach: Resident prefers to keep bilateral amplifiers at bedside when not in use. . . ." During an interview on 03/12/26 at 8:45 a.m., a nurse (#10) stated the resident's amplifiers are kept in the top drawer of the nightstand and are no longer utilized per family's request. The facility failed to revise Resident #58's care plan related to the amplifiers.	F0657	Continued from page 13 Any identified failures will result in immediate revision, staff re-education, and follow-up monitoring. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Care plan accuracy and revision will remain a standing agenda item at QAPI meetings for at least six (6) months. Annual education will be provided to interdisciplinary staff on comprehensive, person-centered care planning. New staff will receive education on care planning expectations during orientation. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, MDS Coordinator, Interdisciplinary Team Members	04/16/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.	F0641	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The Director of Nursing (DON) and MDS Coordinator reviewed the MDS assessments for Resident #6 and Resident #64 on April 2nd, 2026. Resident #6's MDS was corrected to remove post-traumatic stress disorder as an active diagnosis, and supporting documentation was	04/16/2026

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F0641 SS = D	Continued from page 14 §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(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. §483.20(j)(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) 3.0 User's Manual (Version 1.20.1), and resident and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 34 sampled residents (Resident #6 and #64). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION I: ACTIVE DIAGNOSES The Long-Term Care Facility RAI User's Manual, revised October 2025, pages I-9 and I-12, stated, ". . . Active Diagnoses . . . Coding Instructions: Code diseases that have a documented diagnosis in the last 60 days and have a direct relationship to the resident's current functional status . . . mood or behavior status, medical treatments, nursing monitoring. . . during the 7-day look-back period . .	F0641	Continued from page 14 reviewed to ensure diagnostic accuracy. Resident #64's MDS was corrected to accurately reflect the presence of an ileostomy. All corrections were documented in the medical record per CMS guidelines. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit of all current residents' MDS assessments was conducted the week of April 6th, 2026 by the DON or designee. The audit focused on: Accurate coding of ostomies Consistency between PTSD coding and supporting clinical documentation Any additional inaccuracies identified will be corrected promptly. Corresponding care plans were reviewed and updated as needed. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The MDS Coordinator and Health Unit Coordinators were re-educated on: Accurate identification and coding of active diagnoses The MDS Coordinator was re-educated on: Proper coding of ostomies	04/16/2026

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F0641 SS = D	Continued from page 15 . Psychiatric/Mood Disorder . . . I6100, post-traumatic stress disorder (PTSD) . . ." - Review of Resident #6's medical record occurred on all days of survey. A quarterly MDS, dated 02/17/26, showed the facility coded Post Traumatic Stress Disorder (PTSD) as an active diagnosis. During an interview on 03/11/26 at 10:54 a.m., Resident #6 stated he "has never been diagnosed with PTSD." The medical record lacked documentation of PTSD diagnosis, behaviors, medical treatments, or nursing monitoring for PTSD. During an interview on 03/11/26 at 11:17 a.m., an administrative staff member (#3) confirmed facility staff coded Resident #6's MDS incorrectly. Section H: BLADDER AND BOWEL The Long-Term Care Facility RAI User's Manual, revised October 2025, pages H-1 to H-2, stated, ". . . H0100: Appliances check all that apply . . . c. ostomy (including . . . ileostomy . . .) . . .Coding Instructions check next to each appliance that was used any time in the past 7 days. . . ." - During an interview on 3/10/26 at 11:20 a.m., Resident #64 confirmed the presence of an ileostomy. Review of Resident #64's medical record occurred on all days of survey. The current care plan stated, ". . . Resident has an alteration in bowel status related to presence of ileostomy. . . ." An admission MDS, dated 01/06/26, showed facility staff failed to code an ileostomy. During an interview on 03/12/26 at 2:55 p.m., an administrative staff member (#1) stated it is an expectation that the MDS reflect a resident's current status.	F0641	Continued from page 15 Verification of MDS data against physician documentation and clinical records 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit: All New Admission MDS's of resident with a diagnosis of PTSD or presence of an ostomy 10% of the resident census MDS's for any resident with a diagnosis of PTSD or presence of an ostomy Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter Results will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified inaccuracies will result in immediate correction, retraining, and additional monitoring. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED MDS accuracy will remain a standing agenda item at QAPI meetings for at least six (6) months. Annual education will be provided to staff involved in assessment and documentation. New nursing and MDS staff will receive education on MDS accuracy and supporting documentation during orientation. 6. DATE OF COMPLETION	04/16/2026

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F0641 SS = D		F0641	Continued from page 16 All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, MDS Coordinator, Interdisciplinary Team Members	04/16/2026
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review, review of facility policy, and resident and staff interviews, the facility failed to provide appropriate toileting for 2 of 6 sampled residents (Resident #4 and #67) who required staff	F0690	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE The Director of Nursing (DON) reviewed the care and toileting needs for Residents #67 and #4 on April 2nd, 2026. The care plans were updated to reflect residents' current needs and status. Individualized toileting needs were reviewed with direct care staff to ensure clarity and consistent implementation. Staff were re-educated on honoring toileting preferences and individualized toileting schedules. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit was conducted by the DON or designee the week of April 6th, 2026 to identify residents who: Require scheduled toileting assistance The audit reviewed: Care plans Documentation of toileting assistance for resident with individualized toileting schedules. Staff will be re-educated on any residents identified as not receiving toileting assistance as care planned.	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FARGO ELIM HEALTH CARE CENTER	3534 UNIVERSITY DRIVE S , FARGO, North Dakota, 58104

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F0690 SS = D	Continued from page 17 assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, decreased self-esteem, urinary tract infections, and falls and/or injuries. Findings include: Review of the facility policy titled "Nursing assistant standard care" occurred on 03/12/26. This policy, dated 02/18/26, stated, ". . . Assist with toileting needs per resident request. Refer to care plan for individualized toileting needs. . . ." - Review of Resident #67's medical record occurred on all days of survey. Diagnosis included fecal urgency. The current care plan stated, ". . . COGNITION-strength: [Resident #67's name] does not have any cognitive diagnoses. He is alert and oriented and is able to make needs known to staff. . . . TOILETING: Staff to provide assist x2 [assistance of two staff] with toileting. . . . Per resident he has no control of bowels. Offer toileting upon arising, after meals, before bed and as resident requests." During an interview on 03/09/26 at 1:42 p.m. Resident #67 stated, "At nights I put the light on and they don't come in, they turn it off out there and I have had to wet my pants, and I hate to say it, but I've crapped my pants too before because of it. At night when I flip the switch to go to the bathroom, I get an argument from the night aide. They tell me that they just took me an hour earlier. They are telling fibs, they judge how often I should pee, and I tell them my body tells me when I need to pee. Just Friday I wet my pants." During an interview on 03/10/26 at 1:25 p.m. Resident #67 stated, "During the night shift, closer to the morning I put my call light on to use the bathroom. A CNA [certified nurse aide] popped her head in the door and asked what I needed and I said: I gotta pee bad. She (the CNA) said, 'It's not your time to pee now, you're going to have to wait.' I said I can't wait, and then she turned my call light off and left the room. The night staff are rude and disrespectful to me. I've told [CNA #13's name] about the night shift not helping me to the bathroom when I need to pee. And he shakes his head." During an interview on 03/10/26 at 1:55 p.m. with a CNA (#13), when asked if Resident #67 has told him about the night shift not assisting him to bathroom, the CNA (#13) stated, "[Resident #67's name] has told me that a couple of times in the last couple weeks." When asked what she/he does with that	F0690	Continued from page 17 Care plans were updated as necessary. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Nursing assistants and licensed staff were re-educated on: Timely toileting assistance per care plan Responding promptly to resident requests Preserving resident dignity during toileting Documenting all toileting occurrences and all refusals Nursing staff will review and discuss toileting needs upon admission and during every Care Conference and with significant change. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit 10% of resident census for: Compliance with individualized toileting schedules Documentation of toileting assistance The DON or designee will audit all New Admissions, all Significant Changes, and 10% or the remaining resident census to ensure: Toileting needs reviewed and discussed Care plan changes were made accordingly	04/16/2026

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F0690 SS = D	Continued from page 18 information, the CNA stated. "I reported it to the nurse, and I think she lets the case manager know, but that I am not sure about." Review of Resident #67's toileting record, dated February 15th, 2026 through March 10th, 2026, showed 72 occasions facility staff failed to assist the resident with toileting as care planned. The log showed gaps of approximately 5 to 16 hours between staff assistance with toileting. During an interview on 03/12/26 at 10:25 a.m., an administrative staff member (#1) verified several gaps in Resident #67's toileting task, and stated, "He might have been offered, but didn't need to go." When asked if he/she expected staff to document if the resident refused, the nurse manager stated, "Yes, they [the staff] should definitely be documenting refused if the resident was offered and refused." - During an interview on 03/09/26 at 3:26 p.m., Resident #4 stated, "I need to use the bathroom. Sometimes it takes a long time for them to come help me to the bathroom if they come at all." The surveyor noted a strong bowel movement odor in the room. Review of Resident #4's medical record occurred on all days of survey. The current care plan stated, ". . . Resident prefers to call for toileting at night and not to be awoken on rounds. . . . TOILETING: Staff to provide assist . . . Offer toileting in the AM [Morning], after every meal, HS [hour of sleep], and as resident requests. . . ." Review of Resident #4's toileting record, dated February 15th, 2026 through March 10th, 2026, showed 94 occasions facility staff failed to assist the resident with toileting per the care plan. The record showed gaps of approximately 4 to 24 hours between staff assistance with toileting. The facility staff failed to provide toileting assistance consistent with Resident #4 and #67's needs/requests, which may result in decreased self-esteem, decreased dignity, and avoidable incontinence.	F0690	Continued from page 18 Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter. Findings will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified failures will result in immediate corrective action and staff retraining. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Continence care and toileting assistance will remain a standing agenda item at QAPI meetings for at least six (6) months. Ongoing education will reinforce expectations for toileting assistance and resident dignity. New staff will receive education on toileting and continence care during orientation. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, Charge Nurses, Nursing Assistants, Interdisciplinary Team Members	04/16/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F0761	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE A correct label was placed on Resident # 46’s eye	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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F0761 SS = D	Continued from page 19 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of professional reference, and staff interview, the facility failed to label medications in accordance with professional standards for 1 of 1 sampled resident (#46) observed for eye drop administration. Failure to ensure appropriate labeling of medications placed resident(s) at risk for medication errors. Findings include: Kozier & Erb's "Fundamentals of Nursing, Concepts, Process and Practice," 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 834, stated, ". . . administer the drug. Read the MAR [medication administration record] carefully and perform three checks with the labeled medications. . . . Box 35.5 Check Three Times for Safe Medication Administration . . . First Check . . . Read the MAR and remove the medication(s) from the client's drawer. Verify that the client's name and room number match the MAR. Compare the label of the medication against the MAR. . . . Second Check While preparing the medication . . . look at the medication label and check against the MAR. Third Check Recheck the label on the container . . . against the MAR . . .”	F0761	Continued from page 19 drops, ensuring the label included: Resident name Medication name Directions for administration The medication administration record (MAR) was reviewed to confirm accurate administration. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE A facility-wide audit of all residents with orders for stock supplied artificial tears was completed by the DON or designee the week of April 6th. The audit included: Ensuring every bottle of artificial tears was labeled with resident name, medication name and administration instructions. Any medications found to be improperly labeled were removed immediately and replaced with correctly labeled medications. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Licensed nursing staff were re-educated on: Medication labeling requirements Verification of labels prior to administration Reporting and replacing improperly labeled medications	04/16/2026

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F0761 SS = D	Continued from page 20 Observation on 03/11/26 at 1:03 p.m. showed a medication assistant (MA) (#8) prepared medications for Resident #46. The MA (#8) removed a bottle of lubricating eye drops from the drawer of the medication cart and administered it to the resident. The bottle identified a room number but lacked a label with the resident's name and instructions for administration. During an interview on 03/12/26 at 2:55 p.m., an administrative nurse (#1) confirmed all medications should have labels.	F0761	Continued from page 20 Pharmacy will now supply all bottles of artificial tears with required labels when the resident's currently supply is gone. Facility will no longer supply artificial tears as a stocked medication. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The DON or designee will audit to ensure: All bottles of artificial tears are properly labeled with resident name, medication name and administration instructions. Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter. Audit findings will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified labeling concerns will result in immediate corrective action and staff re-education. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Medication labeling compliance will remain a standing agenda item at QAPI meetings for at least six (6) months. New licensed staff will receive education on medication labeling during orientation. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, Licensed Nursing	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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F0761 SS = D		F0761	Continued from page 21 Staff, Pharmacy Consultant	04/16/2026
F0812 SS = D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, review of facility policy, and staff interview, the facility failed to maintain a clean and sanitary kitchen environment for 1 of 1 kitchen. Failure to ensure cleanliness of the ventilation system above the grill and removal of ice buildup in the walk-in freezer has the potential for contamination of food and may result in a foodborne illness. Findings Include: Review of the facility policy titled "Food service areas shall be maintained in a clean and sanitary manner" occurred on 03/12/26. This policy, dated 01/09/26, stated ". . . Kitchen . . . surfaces not in contact with food shall be cleaned . . . enough to prevent the accumulation of grime. . . ." The initial observation of the kitchen, occurred on 03/09/26 at 12:35 p.m. with two dietary supervisors (#18 and #19) and showed the following:	F0812	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Kitchen staff completed the cleaning of the ventilation system above the grill and removed of ice buildup in in the walk-in freezer on March 13th, 2026. Dakota Refrigeration repaired the walk-in freezer and replaced a faulty Klixon part that caused the buildup on March 18th, 2026. A cleaning schedule for the ventilation system and walk-in freezer was established. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE An audit of the dietary department was completed by the Dietary Manager the week of April 6th, 2026. The audit focused on cleanliness of the ventilation system and the walk-in cooler. Any identified issues were corrected immediately to prevent resident exposure to unsafe food practices. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR The facility’s Food Safety and Sanitation Policy was reviewed and reinforced on March 18th, 2026. Dietary staff were re-educated on: Professional standards for food service sanitation, emphasizing the importance of completing the updated cleaning requirements to prevent buildup of grime on the ventilation system and prevent ice	04/16/2026

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F0812 SS = D	Continued from page 22 * An accumulation of grease and grime on the ventilation system above the grill. * An accumulation of ice/condensation on the ceiling above and beside the fan of the walk-in freezer and an accumulation of ice on boxes of food under the fan. During interviews on the afternoon of 03/09/26 and 03/11/26, two dietary supervisors (#18 and #19) stated the vents above the grill and the walk-in freezer ceiling were not on a regular cleaning schedule but cleaned as needed.	F0812	Continued from page 22 buildup in the walk-in freezer March 18th, 2026-March 23rd, 2026. Cleaning Schedules: Cleaning schedules were updated, and posted in the kitchen. The Ventilation system and Walk-in freezer cleaning schedule frequency were initiated on April 1st, 2026. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Dietary Manager or designee will audit: Staff completion of the scheduled cleaning duties for the ventilation system and the walk-in cooler. Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter. Audit results will be reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified deficiencies will result in immediate correction and retraining. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Food safety and sanitation will remain a standing agenda item at QAPI meetings for at least six (6) months. Annual food safety education will be provided to all dietary staff. New dietary staff will receive food safety and sanitation training during orientation. 6. DATE OF COMPLETION	04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

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F0812 SS = D		F0812	Continued from page 23 All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Dietary Manager, Food Service Staff, Infection Preventionist	04/16/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	1. HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE Staff involved with Resident #64 and Resident # 86 were re-educated on proper hand hygiene and glove use. No signs or symptoms of infection were noted for either resident at the time of evaluation. 2. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE All resident are at risk of this deficient practice. 3. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR Nursing staff and CNAs were re-educated on: Performing proper hand hygiene after removal of gloves. Removal of gloves between clean and dirty tasks. 4. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR The Infection Preventionist or designee will audit 10 staff for:	04/16/2026

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F0880 SS = D	Continued from page 24 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 2 of 8 sampled residents (Resident #64 and #86) observed during cares. Failure to practice infection control standards related to enhanced barrier precautions (EBP), catheters, glove use, and hand hygiene has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Transmission-based precautions, enhanced barrier precautions and empiric precautions" occurred on 03/12/26. This policy, dated 09/29/25, stated, ". . . Residents with an indwelling medical device, even if the resident is not known to be infected or colonized with an MDRO [multi-drug resistant organism] . . . . Examples of high contact resident care activities	F0880	Continued from page 24 Proper hand hygiene after removal of gloves Removal of gloves between clean and dirty tasks Monitoring will occur weekly for four (4) weeks, then monthly for two (2) additional months and as needed thereafter. Results will be documented and reviewed at Quality Assurance and Performance Improvement (QAPI) meetings. Any identified noncompliance will result in immediate corrective action and retraining. 5. WHAT MEASURES WILL BE PUT INTO PLACE TO ENSURE COMPLIANCE IS SUSTAINED Infection prevention and hand hygiene compliance will remain a standing agenda item at QAPI meetings for at least six (6) months. Annual infection control education will be provided to all clinical staff. New staff will receive infection prevention education, including hand hygiene and glove use, during orientation. 6. DATE OF COMPLETION All corrective actions will be completed by April 16th, 2026. Responsible Staff: Administrator, Director of Nursing, Infection Preventionist, Charge Nurses, Nursing Staff, CNAs	04/16/2026

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FARGO ELIM HEALTH CARE CENTER	**3534 UNIVERSITY DRIVE S , FARGO, North Dakota, 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
F0880 SS = D	Continued from page 25 requiring gown and glove use for enhanced barrier precautions include . . . Device care . . . urinary catheter . . ." Review of the facility policy titled Hand Hygiene occurred on 03/12/26. This policy, dated 07/02/25, stated, ". . . Hand washing/sanitizing is necessary . . . 1. Before and after providing care to resident . . . 6. After removing gloves . . . 11. After handling dressings, catheters, bed pans, specimens or urine . . ." -Review of Resident #64's medical record occurred on all days of survey. The current care plan stated, ". . . requires enhanced barrier precautions . . . related to ileostomy and indwelling catheter . . ." Observation on 03/11/26 at 11:21 a.m. showed an EBP sign on the outside of Resident #64's room. A nurse (#7) completed hand hygiene, applied a gown and gloves, and entered the room. The nurse removed two dressings from Resident #64's buttocks, discarded them in the trash, and cleansed the areas with a damp cloth. The nurse removed the soiled gloves, and without performing hand hygiene applied clean gloves, reached into his uniform pocket, retrieved a pen, and dated the new dressings. The nurse applied the new dressings, applied barrier cream to the left upper buttocks area, removed the soiled gloves, and without performing hand hygiene, applied new gloves. The nurse (#7) then cleaned the supplies off of the resident's bed, placed a pull up brief around the resident's legs, threaded the catheter bag and tubing through the brief and pant leg, and assisted the resident in pulling up the brief and pants. The nurse removed the soiled gloves and performed hand hygiene and exited the resident's room. The nurse failed to perform hand hygiene after removing soiled gloves and before applying clean gloves. -Review of Resident #86's medical record occurred on all days of survey. A current physician's order stated EBP due to indwelling catheter. The current care plan stated, ". . . requires Enhanced Barrier Precautions . . . R/T [related to] indwelling catheter . . ." Observation on the afternoon of 03/10/26 showed an EBP sign located inside Resident #86's room. A certified nurse aide (CNA) (#4) entered the room,	F0880		04/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355129	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 26 performed hand hygiene, and applied gloves and a gown. The CNA (#4) drained the urine from the catheter bag into a clear plastic container. Wearing the same gloves, the CNA transported the resident from the bathroom to the bedroom via wheelchair. The CNA (#4) failed to remove the soiled gloves and perform hand hygiene before transporting the resident out of the bathroom. During an interview on 03/12/26 at 2:55 p.m., an administrative nurse (#1) stated, "staff should follow policy and procedure and always complete hand hygiene after removing gloves."	F0880		04/16/2026