STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 03/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification and complaint survey started on 03/13/23 and concluded 03/22/23.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and	F 583		4/17/23

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

Electronically Signed | 04/18/2023

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F 583	Continued From page 1 administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide confidentiality of electronic medication administration records (eMAR) for 1 of 4 medication carts observed during survey. Failure to close or lock the eMAR may result in unauthorized viewing of confidential resident records by other residents, unlicensed staff, and visitors. Findings include: Observations on 03/14/23 between 8:15 a.m. to 8:30 a.m. identified an unattended medication cart located in the 300 hallway with the computer screen open, revealing a resident's picture, name, medications and dosages. During an interview on 03/16/23, an administrative nurse (#1) confirmed nursing staff are expected to close or lock the computer screen when medication carts are left unattended.	F 583	1. Staff member identified and education provided 4/11/23. Education covered the potential for HIPPA concerns while leaving resident information up for unauthorized viewing. Computer screens must be locked or closed while not actively using. 2. Any residents in the facility having an electronic medical record have the potential to be affected. 3. Education will be provided to all nursing staff that computer screens must be locked when not actively in front of the computer screen at mandatory nursing staff meeting April 14th, 2023. All medication cart screens have been assessed to be sure the lock function is available and working properly. 4. Audits will be completed by DON or designee for each computer screen in patient care area five days a week for one month, five days monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 583	Continued From page 2	F 583	5. Compliance date will be April 19th, 2023.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 1.17), and staff interview, the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the residents' status for 1 of 1 sampled resident (Resident #58). Failure to accurately complete Section N (medications) of the MDS, may negatively affect the development of a comprehensive care plan, and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2019, page N-7, stated, ". . . N0410H, Opioid: Record the number of days an opioid medication was received by the resident at any time during the 7-day look-back period. . . ." Review of Resident #58's medical record occurred on 03/15/23. The current physician's orders lacked an order for an opioid. A quarterly MDS, dated 02/11/23, identified staff coded section N for opioid use all seven days of the look-back period. During an interview on 03/16/23 at 8:58 a.m., an	F 641	1. Resident 58 MDS was modified and corrected. Resident 58 MDSs from past year were reviewed and corrected. All previous MDS s submitted in past year on other residents receiving anti-convulsant medication will be reviewed and corrected to ensure they were not incorrectly coded as opioids by April 19th. 2. All residents have the potential to be affected. 3. Education will be provided to MDS coordinator by DON or designee utilizing the RAI manual. 4. The DON or designee will review five residents MDS weekly for one month, five residents monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting.	4/17/23

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F 641	Continued From page 3 administrative nurse (#1) confirmed staff coded section N of the MDS incorrectly for Resident #58.	F 641	5. Compliance date will be April 19th, 2023.	
F 678 SS=G	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on record review, review of the facility reported incident investigation, review of facility policy and procedure, review of personnel records, and staff interview, the facility failed to immediately start Cardiopulmonary Resuscitation (CPR) on 1 of 1 closed resident record (Resident #179) who requested CPR in the event of absence of pulse or respirations. Failure to immediately start CPR may have contributed to Resident #179's death. This citation is considered past non-compliance based on review of the corrective action the facility implemented following the incident. Findings include: Review of the facility policy and procedure titled "CPR/AED [Cardiopulmonary Resuscitation /Automated External Defibrillator] CODE LEVEL" occurred on 03/15/23. This policy, revised May 2021, stated, ". . . All licensed nurses of [facility] will be CPR/AED certified. CPR with the use of AED will be initiated as recommended by the American Heart Association (AHA) . . . The AHA	F 678	Past noncompliance: no plan of correction required.	

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F 678	Continued From page 4	F 678		

urges all potential rescuers to initiate CPR unless: 1) a valid DNR [do not resuscitate] order is in place, 2) obvious signs of clinical death (e.g. [for example] rigor mortis, decapitation, or decomposition) are present . . . CPR is to be performed until an AED arrives on the scene . . . The licensed nurses trained in the use of CPR/AED will do the following . . . determine unresponsiveness, activate the EMS [Emergency Medical Services] system, follow AHA guidelines for CPR and emergency cardiac care . . ."

Review of Resident #179's medical record occurred on 03/15/23. A "CODE LEVEL FOR CARDIOPULMONARY RESUSCITATION" form, signed by Resident #179 on 01/04/22 and by the resident's physician on 01/11/22, stated, "Indicate the Code Level orders for this patient/resident. (Check one). . . ." The resident placed a X mark by "CODE LEVEL 1: All available reasonable technology is used in the event of cardiac or respiratory arrest."

Review of progress notes identified the following:
* 02/03/22 at 10:45 a.m. "Resident's emergency contact was notified that ambulance is in facility and performing live [sic] saving measures on resident."
* 02/03/22 at 11:08 a.m. "Resident had no P [pulse], B/P [blood pressure], or respirations . . ."

The facility's investigation report dated 02/03/22 included the following documentation:
* ". . . After being notified of resident on the floor. [name of nurse] sought out and found 1 CNA [certified nursing assistant] and stated resident was on the floor and asked if CNA would need help getting resident off the floor. CNA reported

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yes. Nurse then walked to other side of the building to find TMA [trained medication aide] to help with lift. CNA arrived at the scene of resident first and attempted to arrouse [sic] and get vitals but was unsuccessful. CNA left room where she met TMA coming toward room and stated a nurse was needed and resident is not responding. TMA turned around and reported this to travel nurse. Travel nurse proceeded to pick up phone and called Resident Care Manager and inform that resident was on the floor and was not responding. No indication of emergency was relayed, and no effort was made by the travel nurse to assess resident or begin CPR. Nurse manager arrived on site with travel nurse and immedietly [sic] assessed resident and activated emergency response and travel nurse left the scene and did not return to [sic]. Upon interview with travel nurse, she informed DON [director of nursing] that she couldn't do CPR because she had work restriction from a prior incident of falling at work. No proof or documentation of these restrictions were brought to any one [sic] in the facility. The facility had no knowledge of restrictions. . . . The travel nurse failed to assess resident and failed to initiate CPR when resident was a Code Level 1. Travel nurse contract ended effective immediately. Report sent to NDBON [North Dakota Board of Nursing]. . . ."

During an interview on 03/15/23 at 2:21 p.m., an administrative staff member (#1) stated they expected nursing staff to immediately initiate CPR on Resident #179.

Review of personnel records on 03/15/23 identified:
* All licensed nurses held current CPR

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F 678	Continued From page 6 certification, including Nurse #6 (at time of employment). * Nurse #6's orientation in 2021 included code status, AED, and how to reach EMS services. Based on the following information, non-compliance at F678 is considered past non-compliance. The facility implemented corrective actions for the deficient practice by: * Completing an investigation with interviews of staff who were present on 02/03/22. * Determining the investigation showed staff failed to follow CPR policy. * Initially suspending (Nurse #6) then terminating the nurse's contract on 02/07/22. * Notifying the appropriate state agencies. The facility addressed measures put in place and implemented systemic changes to ensure the deficient practice does not recur by: * Providing education to all nursing staff on the facility's emergency procedure for CPR during a nursing meeting/education on 02/23/22. * Informing the Risk Management committee on 02/03/22 and determining predisposing factors and what will be implemented. The survey team determined a deficient practice existed on 02/03/22. The facility implemented corrective action on 02/03/22 and completed nursing education by 02/23/22.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		4/17/23

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F 689	Continued From page 7 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, review of professional references, and staff interview, the facility failed to provide assistance and/or assistive devices necessary to ensure safety and prevent accidents or injury for 1 of 9 sampled residents (Resident #40) observed during mechanical sit to stand lift transfers. Failure to transfer residents properly puts the resident at risk for pain, injury, and/or falls. Findings include: Review of the facility policy and procedure document titled "Standing lifts" occurred on 03/16/23. This document, dated September 2020, stated, ". . . 11. Place the resident's feet on the footplate . . . 13. Have the resident hold onto the handle grips . . . 15. Ensure the resident's arms are located outside of the sling . . ." Review of Resident #40's medical record occurred on all days of survey and included a diagnosis of functional quadriplegia and contracture. Observation on 03/14/23 at 10:08 a.m. showed a nurse (#2) and a certified nursing assistant (CNA) (#3) transfer Resident #40 from the wheelchair to the bed and back to the wheelchair with a mechanical sit to stand lift. The resident's feet did not touch the footplate, he/she failed to grasp the handle grips, and he/she arms were on	F 689	1. Resident 40 was assessed and changed to a Hoyer lift. Education provided 3/14/2023 to staff present during observation. 2. All residents using a mechanical Sit to Stand lift have the potential to be affected. 3. All residents utilizing a Sit to Stand lift will be assessed in order to ensure they are appropriate for the type of transfer equipment being utilized. Education will be provided to all nursing staff and competency check off for Sit to Stand completed by all nursing staff mandatory nursing staff meeting April 14th, 2023. 4. The DON or designee will audit five residents weekly for one month, ten residents monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting. 5. Compliance date will be April 19th 2023.	

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F 689	Continued From page 8 the inside of the sling. During an interview on 03/16/23 at 1:10 p.m., an administrative nurse (#1) stated she expected staff to follow policy and procedure for transfers.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, review of professional reference, and resident and staff interview, the facility failed to administer medication in accordance with professional standards for 1 of 1 sampled resident (Resident #45) who reported receiving the wrong type of insulin. Failure to administer the correct insulin may result in adverse health effects for residents. This citation is considered past non-compliance based on review of the corrective action the facility implemented following the incident. Findings include: Berman, Snyder, and Frandsen's "Kozier & Erb's Fundamentals of Nursing: Concepts, Process, and Practice," 11th ed., Pearson Education, Inc., New Jersey, page 835-836, stated, ". . . Certain aspects of medication administration are important for the nurse to check each time a medication is administered. These are referred to as the "rights." . . . Right Medication . . . The medication given was the medication ordered . . . Right Client . . . Medication is given to the intended client . . ."	F 760	Past noncompliance: no plan of correction required.	

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Review of Resident #45's medical record occurred on March 15, 2023. The quarterly Minimum Data Set (MDS), dated 01/22/23, identified intact cognition. Physician's orders included Levemir FlexTouch Solution Pen-injector 30 units subcutaneously daily.

During an interview on 03/15/23 at 8:05 a.m., Resident #45 identified a nurse (#13) gave the resident Lantus insulin instead of the ordered Levemir 30 units subcutaneously. Resident #45, stated, "This happened approximately 6 weeks ago. The nurse didn't notice it, I asked her if I could see the [insulin] pen, and that's when I noticed that the insulin pen was gray colored and my Levemir pen is blue. That is when she realized it. She [the nurse] told me she called the provider and then told me, 'The doctor says that both insulins [the one ordered for resident - Levemir, and the one administered - Lantus] are both long acting, and that nothing needed to be done.' I never heard anything else since then."

During an interview on 03/15/23 at 10:30 a.m., an administrative staff member (#1) stated, "There was an incident report filed and there was no follow-up monitoring [of Resident #45] required by the staff per the provider orders, as resident remained asymptomatic by her own admission."

Review of the facility incident report occurred on 03/15/23, and identified the incident occurred on 12/04/22 at 7:44 p.m.

Based on the following information, non-compliance at F760 is considered past non-compliance. The facility addressed

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F 760	Continued From page 10 measures put in place and implemented the following systemic changes: * Provided education to all nursing staff regarding administering the "right" insulin to the "right" resident during the monthly nurses meeting on 02/01/23.	F 760		
F 880 SS=J	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 §483.70(e) 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	F 880		4/19/23

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F 880	Continued From page 11 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: (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:	F 880		

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F 880	Continued From page 12 Based on record review, review of professional reference, and staff interview, the facility failed to ensure appropriate infection control standards during insulin administration for 1 of 1 sampled resident (Resident #45) who reported receiving another resident's insulin. Failure to ensure residents do not share insulin pens may result in the spread of bloodborne pathogens. During a survey started on 03/13/23, the team determined a deficiency existed regarding insulin administration and bloodborne pathogens. Based on the review of the results of the survey, the State Survey Agency (SSA) team determined an Immediate Jeopardy (IJ) situation existed, but this was not conveyed to the facility until 03/21/23. The IJ situation resulted from an interview and record review of Resident #45, who used insulin pens and received insulin from another resident's insulin pen. This finding placed Resident #45 in immediate danger due to incorrect insulin pen use and the potential for the spread of bloodborne pathogens between residents. See F760. * 03/21/23 at 12:30 p.m., the SSA notified the CMS location of the IJ and the CMS location agreed. * 03/21/23 at 2:03 p.m., the survey team and a SSA manager called the facility and notified the administrator and director of nursing of the IJ and requested a removal plan be submitted to the SSA. The SSA emailed the IJ template to the administrator of the facility. * 03/21/23 at 6:30 p.m., the SSA received by	F 880	Corrective Action The facility will immediately implement an appropriate infection prevention and intervention plan consistent with the requirements of ¿483.80 for the affected resident(s) identified in the deficiency. The infection preventionist (IP), director of nursing (DON), in conjunction with applicable interdisciplinary team (IDT) members, shall identify and implement a consistent system for ensuring a system for: (1) Ensuring staff have adequate knowledge of insulin administration, including the use of insulin pens and ensuring pens are not shared between residents. (2) Ensuring staff have adequate knowledge of protocols related to potential bloodborne pathogen exposure. 2. Identification of Others The IP and DON, in conjunction with the applicable the interdisciplinary team (IDT) members, will review current guidelines from CDC and CMS. The IP, DON and applicable IDT members will evaluate the facility's compliance with the guidelines. The facility will develop action plans to address any newly identified non-compliance. 3. System Changes On or before 04/25/2023 the facility shall complete the following actions: (1) DON, IP, and applicable IDT members will conduct root-cause analysis to identify and address the reasons for non-compliance related to: a. Failure to ensure insulin pens are not	

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	355078	A. BUILDING _____ B. WING _____	C 03/22/2023

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F 880	Continued From page 13 email and then approved the removal plan from the facility. * 03/22/23 at 3:30 p.m., the survey team removed and reduced the IJ situation from a scope/severity of J to a scope and severity of D. * 03/22/23 at 5:00 p.m., the SSA notified the regional office of the immediate jeopardy removal. Findings include: Review of the manufacturer's guidelines for the Lantus SoloStar Pre-filled pen (a long-acting insulin), found at https://products.sanofi.us/Lantus/Lantus.html#S5.5, stated, ". . . WARNINGS AND PRECAUTIONS . . . Never share a LANTUS SoloStar Prefilled Pen, Syringe, or Needle Between Patients. . . Sharing poses a risk for transmission of blood-borne pathogens. . . ." Review of Resident #45's medical record occurred on 03/15/23. Diagnoses included Type II diabetes mellitus (DM). Physician's orders included Levemir FlexTouch Solution Pen-injector 30 units subcutaneously daily. Review of an incident report identified the following: *12/04/22 at 7:44p.m.: "Administered wrong insulin to resident [Resident #45]. Administered 30 Lantus instead of 30 Levmier [sic] for evening dose. Resident asked to see pen. Writer went back and look [sic] at pen and noticed gave the wrong insulin. Resident asked to see insulin pen for evening dose. She noticed it was gray. Called	F 880	shared between residents. b. Failure to follow protocols for post-exposure prophylaxis after potential bloodborne pathogen exposure. Information about root cause analysis can be found at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/GuidanceforRCA.pdf (2) The DON, staff development coordinator (SDC), IP or designee, in conjunction with applicable IDT members, will: a. Educate all staff whose job duties include insulin administration on proper insulin administration and post-exposure protocols. To verify staff understand the training, the staff will complete a return demonstration. (3) The facility leadership will contact the North Dakota Quality Improvement Organization (QIO), to inquire about the assistance and services available from the QIO in improving infection prevention and control within the facility through quality assurance process improvement (QAPI) methods. 4. Monitoring Weekly for no less than 12 weeks, the DON, IP, SDC or a designee will conduct on-going monitoring to ensure, via observation, the approaches to correct deficient practice related to infection control and prevention are consistently implemented and effective. Such monitoring will include: (1) Observations of staff administration of insulin.	

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F 880	Continued From page 14 on-call Doctor. She said do to [sic] nothing. They are both long acting." The facility failed to inform the provider the insulin pen belonged to another resident and the potential for bloodborne pathogen exposure. Information received from the facility on 03/20/23 at 3:30 p.m. identified the insulin pen used for Resident#45 had previously been used for another resident.	F 880	(2) Appropriate follow-up after potential bloodborne pathogen exposure, if applicable. Observations will be made across all shifts and neighborhoods/units. Observations of noncompliance with the above will result in ad hoc education for the involved staff. Such education will be documented on monitoring forms. After twelve weeks of monitoring, provided that such monitoring demonstrates expectations are consistently met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than three months. All monitoring will be reported to the quality assurance process improvement (QAPI) committee as part of QAPI activities. Monitoring will not be discontinued until the facility completes three consecutive rounds of monthly monitoring that demonstrate sustained compliance as approved by the QAPI committee and medical director. 5. Correction Date 04/19/2023 Blood borne exposure policy was updated. Staff education 4/14/2023	
F9999	FINAL OBSERVATIONS Based on observation, record review, and resident, family, and staff interviews, the complaint investigated in conjunction with the standard Medicare/Medicaid survey was not substantiated.	F9999		