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 _____	11/03/2021

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

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F 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 11/01/21 and concluded 11/03/21.	F 000		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review, review of the North Dakota Provider Manual Preadmission Screening and Resident Review (PASARR) and Level of Care Screening Procedures for Long Term Care Services, and staff interview, the facility failed to complete a status change assessment for 1 of 3 sampled residents (Resident #3) reviewed for PASARR. Failure to complete a change in status assessment with a newly diagnosed mental illness may result in the delivery of care and	F 644	1. Updated Level 1 screening/change in status assessment completed for Resident #3. 2. Any residents with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability) have the potential to be affected. 3. Education will be provided to all nursing staff that new diagnoses must be communicated to Social Services and	12/6/21

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

Electronically Signed | 11/15/2021

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F 644	Continued From page 1 services that are inconsistent with the resident's needs. Findings include: The North Dakota PASARR Provider Manual, revised August 2015, page 13, stated, ". . . Change in Status Process . . . Whenever the following events occur, nursing facility staff must contact Ascend to update the Level I screen for determination of whether a first time or updated Level II evaluation must be performed. These situations suggest that a significant change in status has occurred . . . If an individual with MI, ID, and/or RC (mental illness, intellectual disability, and conditions related to intellectual disability [referred to in regulatory language as related conditions or RC]) was not identified at the Level 1 screen process, and condition later emerged to was discovered . . ." Review of Resident #3's medical record occurred on all days of survey and identified a Level I PASARR completed on 01/22/19. The record showed Resident #3 received new diagnoses of panic disorder and major depressive disorder on 03/05/20. The record lacked evidence the facility completed an updated Level I screening/change in status assessment with the added diagnoses. During an interview on 11/03/21 at 4:01 p.m., a managerial staff member (#2) confirmed the facility failed to submit another PASARR for Resident #3 following the new diagnoses.	F 644	they will make the determination on whether an updated screening/level of care needs to be completed. Social Services will complete as needed. All current residents with appropriate diagnosis will be reviewed and updated Level 1 screening/change of condition completed as needed. 4. Audits will be completed for five residents 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.	
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry	F 677		12/6/21

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F 677	Continued From page 2 out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to provide dining supervision/assistance for 3 of 5 sampled residents (Resident #3, #44, and #67) and 1 supplemental resident (Resident #27) in the special care unit. Failure to cue and to supervise/assist residents during mealtimes may result in decreased intake and/or unplanned weight loss. Findings include: Observation of the special care unit dining room on 11/01/21 showed residents seated in two different areas separated by a kitchenette. During a confidential family member interview on 11/01/21 at 4:47 p.m., the family member (A) stated the residents seated on one side do not receive the supervision and assistance needed during mealtimes. Review of Resident #3, #27, #44, and #67's medical records occurred on all days of survey. The records identified the residents had diagnoses of Alzheimer's and/or dementia and required supervision to physical assist of one person with eating. Observations on 11/01/21 of Residents #3, #44, and #67, seated on the side of the dining room mentioned by the family member, showed the following:	F 677	1. Residents R3, R44, R67, and R27 have been moved to one side of the dining room and are being supervised/provided cues at all meals. A full set of silverware (butter knife, fork, and spoon) are being provided at all meals. 2. All residents on the special care unit that require supervision/cues with meals have the potential to be affected. 3. Education will be provided to all nursing staff that appropriate place settings for all meals include a butter knife, fork, and spoon. Nursing staff will be present in special care unit dining room for all meals and will monitor for residents needing assistance and provide as needed. 4. The DON or designee will observe ten 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.	

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F 677	Continued From page 3 * 11:32 a.m., Resident #44 slept at the dining room table, awoke when the staff set down the plate, and immediately fell asleep with his/her head hanging. At 11:57 a.m. (twenty-five minutes later), a staff member walked by and stated the resident should wake up and eat before the food got cold. The resident looked up at the staff member and immediately fell asleep after the staff member walked away. The resident consumed only a few bites of the meal and at 12:02 p.m., a staff member removed the plate from the table. * 12:03 p.m., Resident #3 picked at the food on the plate with a fork. A staff member walked by and stated, "Are you going to eat anymore?" and walked to the other side of the dining room to feed another resident. The resident consumed approximately 25 percent of the meal. * 4:38 p.m., Resident #67 left the dining room table and returned to her room. A family member brought the resident back to the table. The family member noted no knife or butter available to the resident to cut up the chicken or butter the bun. The family member requested butter and a knife, cut up the chicken, and buttered the bun for the resident. Observations on 11/02/21 of Residents #3, #27, and #44, seated on the side of the dining room mentioned by the family member, showed the following: *11:36 a.m., staff gave Resident #44 a fork and a spoon with the meal and the resident was unable to cut the hot turkey sandwich with the fork. * 11:39 a.m., staff gave Resident #3 a fork and a spoon with the meal and the resident struggled to cut the hot turkey sandwich with the fork, eating only a few bites of the sandwich.	F 677		

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F 677	Continued From page 4 * 11:40 a.m., staff gave Resident #27 a spoon and fork with the meal. The resident ate some of the vegetables off the plate, tried to cut the hot turkey sandwich with a fork, and fell asleep at the table three minutes after staff set down the plate. At 12:13 p.m. (30 minutes later), a staff member walked up to the table, and stated, "[Resident's name], are you going to eat a little bit more? You have oranges here for dessert." The staff member moved the bowl of oranges closer to the resident, walked away, and the resident immediately fell back asleep. During an interview on 11/03/21 at 11:32 a.m., administrative nurse (#3 and #4) agreed the facility needs to look at mealtime processes in the special care unit to ensure all residents are receiving the utensils and assistance needed on both sides of the dining room.	F 677		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and resident and staff interview, the facility failed to ensure residents received the care and services consistent with professional standards of practice for 1 of 2 sampled residents (Resident #1) receiving hemodialysis outside the facility. Failure to ensure physician's orders for hemodialysis, fluid restriction, and to	F 698	1. Orders for dialysis, frequency of dialysis treatments, and fluid restriction were obtained for resident R1. Nursing order to check bruit and thrill of AV fistula added to eTAR. 2. All residents that are receiving dialysis have the potential to be affected. 3. Education will be provided to all	12/6/21

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F 698	Continued From page 5 assess/monitor hemodialysis vascular access site (arterial-venous fistula) on a regular basis can result in missed dialysis appointments, fluid overload, and complications with access function and possible loss of the access site. Findings include: Review of the facility policy titled "Hemodialysis Access Sites" occurred on 11/03/21. This policy, revised September 2019, stated, " . . . AV [arterial-venous] fistula should be monitored for thrill and bruit daily. . . . Thrill - palpated vibration over site . . . Bruit - able to auscultate the "swishing" sound from the turbulence of blood in the fistula . . ." During an interview on the morning of 11/01/21 Resident #1 stated he/she received hemodialysis on Tuesdays, Thursdays, and Saturdays and had an AV fistula to the left arm. Review of Resident #1's medical record occurred all days of survey. Diagnoses include end stage renal disease and dependence on renal dialysis. An annual minimum data set (MDS) dated 10/20/21 indicated Resident #1 received dialysis while a resident. Review of Resident #1's care plan showed a fluid restriction of 1500 ml (milliliters), hemodialysis on Tuesdays, Thursdays, and Saturdays, and assessment of bruit and thrill twice a day. Resident #1's physician's orders lacked orders for dialysis, frequency of dialysis treatments, and fluid restriction. The medical record lacked	F 698	nursing staff that residents receiving dialysis must have orders for dialysis, frequency of dialysis treatments, and fluid restrictions, if any. Education will also be provided that thrill and bruit must be assessed daily for existing AV fistulas and bid for new AV fistulas. 4. The DON or designee will audit the electronic health record of all residents receiving dialysis upon admission/readmission to ensure that orders for dialysis, frequently of dialysis treatments, and fluid restrictions are in place as well as placement on eTAR to monitor for thrill and bruit. Results will be reported at the QA committee and additional action taken 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 698	Continued From page 6 documentation of the twice daily assessment of bruit and thrill of the AV fistula. During an interview on 11/03/21 at 10:20 a.m., two administrative nurses (#3 and #4) agreed the medical record lacked documentation.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a	F 758		12/6/21

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F 758	Continued From page 7 diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview the facility failed to ensure orders for as needed (PRN) psychotropic drugs were limited to 14 days for 1 of 2 sampled resident (Resident #53) receiving a PRN antianxiety medication. Failure to ensure the physician renewed the PRN order after 14 days may result in the resident receiving an unnecessary medication. Findings include: Review of the facility policy titled "Psychotropic Medication Use" occurred on 11/03/21. This policy, revised September 2017, stated, ". . . PRN (as needed) orders for psychotropic medications are limited to 14 days . . . If the physician believes that the PRN order should be extended beyond the 14 days, the physician	F 758	1. Resident # 53's order for prn Alprazolam was discontinued. 2. All residents receiving prn psychotropic medication have the potential to be affected. 3. Chart review will be completed for all residents receiving prn psychotropic medications to ensure physician renewal after 14 days. Education provided to all nurses that prn orders for psychotropic medications are limited to 14 days. 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	

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F 758	Continued From page 8 must document rationale in the medical record. . . ." Review of Resident #53's medical record occurred on all days of survey and identified a physician's order dated 07/14/21, which stated, "Continue PRN Alprazolam then re-evaluate in 30 days." Review of Resident #53's nursing progress notes identified staff administered the PRN Alprazolam on 10/11/21 after the order expired. Staff failed to discontinue the medication or obtain a new physician's order for the PRN Alprazolam after 30 days (August 12, 2021). During an interview on 11/03/21 at 3:30 p.m., an administrative nurse (#4) agreed the staff failed to have the PRN Alprazolam re-evaluated as ordered and obtain a new physician's order for the PRN anti-anxiety medication.	F 758	implemented. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:	F 838		12/6/21

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F 838	Continued From page 9 §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing	F 838		

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F 838	Continued From page 10 patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to conduct a facility-wide assessment to evaluate the resident population and identify the resources needed to competently provide care and services to residents during both day-to-day operations and emergencies. This failure has the potential to affect all residents residing in the facility. Findings include: Review of the Facility Assessment on 11/03/21 showed it lacked information related to personnel listing and staff competencies and lacked completed information related to medical and non-medical equipment. During an interview on 11/03/21 at 2:56 p.m., an administrative staff member (#1) confirmed the current facility assessment lacked all required elements.	F 838	1. The Facility Assessment was completed to include personnel listing, staff competencies, and information on medical and non-medical equipment. 2. All residents have the potential to be affected. 3. Process implemented where Facility Assessment will be reviewed annually and prn. 4. The Facility Assessment will be reviewed at the quarterly QA committee meetings for the next year and changes made as needed. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.	F 849		12/6/21

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F 849	Continued From page 11 (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to	F 849		

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(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 849	Continued From page 12 alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving	F 849		

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 _____	11/03/2021

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F 849	Continued From page 13 mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient	F 849		

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F 849	Continued From page 14 as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on record review, review of the Hospice contract, and staff interview, the facility failed to ensure residents' records contained the most recent hospice plan of care and recertification of	F 849	1. Hospice plan of care and recertification of terminal illness obtained for Resident # 29. 2. All residents receiving hospice services	

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F 849	Continued From page 15 terminal illness for 1 of 3 sampled residents (Resident #29) receiving hospice services. Failure to obtain these documents limits staff's ability to ensure coordination of care between the facility and the hospice. Findings include: The hospice contract for (hospice agency name), dated 07/27/10, stated, ". . . A copy of the POC [plan of care] will be in the SNF's [skilled nursing facility] chart and a matching document will be in the resident's Hospice chart at the Hospice office. The POC will be updated as changes occur . . ." Review of Resident #29's medical record occurred on all days of survey. Diagnoses included chronic respiratory failure with hypoxia. Resident #29 elected hospice services on 06/23/21, with the certification period ending 09/20/21. Resident #29's medical record contained a plan of care and certification of terminal illness, both dated 06/23/21. Resident #29's medical record lacked a current hospice plan of care and certification of terminal illness for the recertification period beginning 09/21/21. During an interview on the afternoon of 11/03/21, an administrative nurse (#2) confirmed Resident #29's medical record lacked the recertification information related to hospice.	F 849	have the potential to be affected. 3. Education will be provided to all nursing staff that residents receiving hospice must have the most recent hospice plan of care and certification/recertification of terminal illness in our electronic health record. Chart reviews will be conducted on all residents who are currently receiving hospice to ensure all required documentation is present. 4. Audits will be completed for five residents 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.	