STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Heartland	620 14th Ave NE Devils Lake, ND 58301

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on review of the facility reported incident (FRI) investigation, record review, review of facility policy, and staff interview, the facility failed to ensure residents remained free from physical abuse for 1 of 1 sampled resident (Resident #1) who displayed physical and verbal aggression toward other residents. Failure to ensure an environment free from physical and verbal abuse placed all residents at risk for injury, fear, anxiety, and/or psychosocial harm. Findings Include:Review of the facility policy titled Vulnerable Adult - North Dakota occurred on 04/08/26. This policy, dated February 2026, stated, . Vulnerable Adult - Every resident of the facility . Abuse - the willful infliction of injury . Physical abuse - conduct that produces pain or injury and is not accidental . Examples of abuse . resident to resident abuse . A FRI report, dated 02/14/26, stated, . Staff heard [resident name] yelling out and went to where he was. When they arrived, [resident name] was on the floor in the hallway . [Resident #1] was seen scurrying away from the area . Mgr [manager] on call checked video footage to investigate incident. Upon review, it was noted that [Resident #1] was back in the hallway where incident occurred and had entered [resident's name] room and then came out. [Resident name] was making his way down the hallway and hadn't come near the room that [Resident #1] had exited. Per video, [Resident #1] exited [resident's name] room and went up to him and pushed him down. After she pushed him, she hurried away. [Resident #1] has a hx [history] of targeting the males in the MCU [Memory Care Unit] . Review of Resident #1's medical record occurred on all days of survey. Diagnoses included Alzheimer's disease and anxiety. A Brief Interview for Mental Status (BIMS), dated 01/08/26, identified a score of 9 indicating moderate cognitive impairment. The current care plan stated, . has hit, pinch [sic], push [sic] staff when staff are helping other residents. Noted to yell at staff/other residents.Review of Resident #1's progress notes identified the following:*01/01/26 at 5:19 p.m., . Resident was getting very irritated and aggravated with resident [resident number] . she then shoved him out of the way from the table . Prior to supper resident was upset that [resident number] was walking by . and grabbed the back of his shirt and shoved him ahead.*01/10/26 at 5:32 p.m., . Resident started becoming verbally aggressive. She was yelling at other residents .*01/12/26 at 11:43 a.m., Fax communication sent to [provider name] regarding residents continued aggressive behaviors.*01/20/26 at 4:10 p.m., Resident was irritated with another female resident this morning, raised up her fist towards other resident .*01/23/26 at 6:12 p.m., Resident began slapping [resident number] arm after he hit a staff member.*01/25/26 at 3:00 p.m., Res [resident] was walking in the dining room and a [resident number] was wandering around in the dining room . and res shoved him out of the way. Then later before breakfast res swatted at [resident number] when other resident was reaching over attempting to help another resident cover up with a blanket. Res [Resident #1] then took blanket from resident and threw the blanket at [resident number]. Later this afternoon, [resident number] was pleasantly wandering in the dining room, then resident shoved a chair at [resident number].*01/28/26 at 1:04 p.m., Resident had a minor verbal altercation with [resident number].*02/01/26 at 6:20 p.m., Resident has been aggressive with staff and other Residents [sic]. Resident [sic] had taken the dining room chairs and barricaded the dining hall . a little while later, a CNA [certified nurse aide] was walking back onto the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355069	A. Building B. Wing	04/09/2026

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Eventide Heartland	620 14th Ave NE Devils Lake, ND 58301

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit and saw resident try and push another resident who was walking through the unit . *02/03/26 at 6:38 a.m., . male resident was pleasantly wandering into the dining room, hands in his pockets . Resident then stood up and grabbed male by the hand and swung him around to get him out of the way.*02/12/26 at 2:21 p.m., . yelled at another resident .*02/14/26 at 2:54 p.m., . Resident was a bit irritable this morning, demanding other residents to sit here or there, demanding other residents to come with her . Res did shove another male resident in the dining room.*The medical record lacked documentation of the incident that occurred on 2/14/26 at approximately 5:51 p.m., the date the facility reported the incident (FRI) when Resident #1 pushed another resident to the floor. *02/15/26 at 9:59 p.m., . pulling chairs out from table and placing in hallway like a barricade.*02/16/26 at 9:03 p.m., . Move to main unit .During an interview on 04/09/26 at 8:11 a.m., an administrative nurse (#1) reported the facility was aware of Resident #1's behaviors toward other residents while on the memory care unit and were adjusting her medications. After the incident on 02/14/26, the facility moved Resident #1 to a different unit in the facility. The administrative nurse (#1) stated she expected staff to monitor all residents, intervene immediately, and report any incidents to management. The facility failed to protect other residents from verbal and/or physical abuse from Resident #1.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 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 3 sampled residents (Resident #3 and #6) observed during cares and 1 of 1 sampled resident (Resident #7) observed during a dressing change. Failure to practice infection control standards related to glove usage and hand hygiene has the potential to spread infection throughout the facility. Findings Include:Review of the facility policy titled Hand Hygiene occurred on 04/09/26. This policy, dated February 2026, stated, . Hand hygiene will be done: A. Before and after resident contact (before you leave the room). B. Before every clean procedure. C. After every dirty procedure. The purpose is to prevent the spread of infection.-Observation on 04/08/26 at 1:00 p.m. showed a nurse (#2) performed hand hygiene, applied a gown, mask, and gloves, and entered Resident #7's room to complete a dressing change. The nurse cleansed the bedside table with a disinfecting wipe, and removed the resident's sock and soiled dressing. The nurse removed the soiled gloves, applied new gloves, cleansed the wound area with normal saline and dried with gauze. The nurse removed the soiled gloves, applied clean gloves, completed the wound dressing change and reapplied the resident's sock. The nurse removed the soiled gloves, gown and mask, performed hand hygiene and exited the room. The nurse failed to remove soiled gloves after disinfecting the table and failed to perform hand hygiene in between glove changes. -Observation on 04/08/26 at 1:31 p.m. showed two certified nurse aides (CNAs) (#3 and #4) performed hand hygiene and entered Resident #3's room to complete cares. After the CNAs washed the resident's upper body, the CNA (#3) completed perineal care and applied barrier cream to the resident's buttocks. The CNA (#3) removed the soiled gloves and without performing hand hygiene, applied clean gloves. Both CNAs placed a new brief on the resident and repositioned the resident in bed. The CNA (#3) gathered the soiled linen, and the other CNA (#4) gathered the garbage. The CNAs (#3 and #4) removed their soiled gloves and without performing hand hygiene, put a clean shirt on the resident and placed a pillow under the left hip. The CNAs failed to perform hand hygiene between glove changes.-Observation on 04/08/26 at 3:21 p.m. showed two CNAs (#4 and #5) performed hand hygiene and entered Resident #6's room to complete toileting cares. After the CNAs transferred Resident #6 to the toilet, the CNA (#5) pulled down the resident's pants and removed the soiled brief. The CNA (#5) removed the soiled gloves and without performing hand hygiene applied clean gloves. The CNA (#5) removed the resident's gripper socks and leg stockings, washed the stockings, and hung them to dry. The CNA (#5) removed the soiled gloves, and without performing hand hygiene applied clean gloves. The CNA (#5) washed and dried the Resident's face, back, chest, arms, and arm pits. Without removing the soiled gloves, the CNA (#5) put a clean shirt on the resident. The CNA (#5) removed the soiled gloves and without performing hand hygiene, obtained wipes from the resident's bedside table, reentered the bathroom and applied clean gloves. The CNA (#5) completed the resident's perineal cares and without removing the soiled gloves, the CNA applied a clean brief, and both CNAs (#4 and #5) pulled up the brief and the resident's pants. Both CNAs (#4 and #5) removed their soiled gloves and without performing hand hygiene, transferred the resident to the wheelchair. The CNAs failed to change soiled gloves and perform hand hygiene between glove changes. During an interview on the morning of 04/09/26, an administrative nurse (#1) confirmed staff should be following the Hand Hygiene policy.