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	04/18/2024

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39685 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 02/15/23. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure reasonable accommodation of needs regarding call lights for 1 of 3 sampled residents (Resident #227) with a soft touch call light. Failure to place Resident #227's call light within reach may result in an inability to call for help, discomfort, increased falls, and/or incontinence. Findings include: Review of the facility's policy titled Standard of Care occurred on 04/18/24. This policy, revised January 2024, stated, . The following standards of care will be followed in proving care to the residents . Call light will be accessible for residents in their rooms . Review of Resident #227's medical record occurred on all days of survey. Diagnoses included weakness and history of falls. The current care plan stated, . High risk for falls . Keep call light within reach at all times when in room (soft touch) . Resident not to be left in room alone in wheelchair without supervision . Resident is assist x [times] 2 for toileting hygiene . Observation on 04/15/24 at 4:08 p.m., showed two certified nurse aides (CNAs) (#2 and #3) entered Resident #227's room and observed him attempting to get out of bed. He indicated he had to use the bathroom. Resident #227 did not have a call light in reach. After toileting, the CNAs (#2 and #3) transferred Resident #227 to a Broda chair (high back recliner) and left him in the room alone with no call light in reach. During an interview on 04/18/24 at 11:32 a.m., an administrative nurse (#1) stated the facility's standard of care is every resident has their call light within reach.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40488 Based on record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual (Version 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 1 of 22 sampled residents (Resident #1). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: The Long-Term Care Facility RAI Manual, revised October 2023, page N-7, stated, . N0415: High-Risk Drug Classes: . N0415A 1. Antipsychotics: Check if an antipsychotic medication was taken by the resident at any time during the 7-day look-back period . Review of Resident #1's medical record occurred on all days of survey. The quarterly MDS, dated [DATE], showed Section N0415A coded as the resident received an antipsychotic medication within the 7-day look back period. The residents medical record lacked documentation Resident #1 received an antipsychotic during the look-back period. During an interview on 04/18/24 at 9:24 a.m., the MDS coordinator (#9) agreed staff miscoded Section N0415A on Resident #1's MDS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 39685 Based on record review, review of facility policy, and staff interview, the facility failed to review and revise the comprehensive care plan to reflect the resident's current status for 1 of 22 sampled residents (Resident #227). Failure to revise the care to reflect Resident #227's current status limited the staff's ability to communicate needs and ensure continuity of care for residents. Findings include: Review of the facility policy titled Care Plans occurred on 04/18/24. This policy, revised November 2021, stated, . Pertinent information to properly care for the resident will be added to the NAR/CNA [nurse aide record/certified nurse aide] care plan for continuity of care . Care plans will be updated and changes will be made as they occur to ensure the most current care plan for the resident . any changes made to the comprehensive care plan will also be updated in the NAR/CNA care plan for accuracy . Review of Resident #227's medical record occurred on all days of survey. Resident #227's care plan, dated 04/10/24, stated, . Transfers: transfer/mobility assist x [times] 2 with pal [sit-to-stand] lift . On 04/15/24, the revised care plan stated, . TRANSFERS: Hoyer [full-body mechanical] lift x 2 for transfers . Observation on 04/16/24 at 11:19 a.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #227 from the wheelchair to the toilet and back utilizing a mechanical sit-to-stand lift. When the CNAs (#4 and #5) raised Resident #227 in the stand lift, he failed to bear weight and remained in a semi-seated position. When asked how Resident #227 should be transferred, the CNAs (#4 and #5) indicated with a sit-to-stand lift as per report and the NAR/CNA care plan. The facility failed to update Resident #227's NAR/CNA care plan to reflect the current transfer method. During an interview on 04/16/24 at 12:11 p.m., an administrative nurse (#1) confirmed Resident #227's NAR/CNA care plan failed to include the new transfer information.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39685 THIS IS A REPEAT DEFICIENCY FROM THE SURVEY COMPLETED ON 04/20/23. 1. Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure residents received adequate supervision/assistance to prevent accidents for 1 of 4 sampled residents (Resident #227) observed during stand lift transfers. Failure to ensure staff utilized the correct lift during transfers caused Resident #227 discomfort/pain and placed him at risk for possible injury. Findings include: Review of the facility policy titled Falls-Resident occurred on 04/18/24. This policy, revised March 2022, stated, . Purpose: To prevent falls, reduce injury . initiate the care plan for high risk of injury related to potential of falls . update the care plan with updated interventions . Review of Resident #227's medical record occurred on all days of survey. Diagnoses included chronic pain, weakness, and history of falls with hip fracture. Resident #227's care plan, dated 04/10/24 stated, . Transfers: transfer/mobility assist x [times] 2 [staff] with pal [sit-to-stand] lift . On 04/15/24, the revised care plan stated, . TRANSFERS: Hoyer [full-body mechanical] lift x 2 for transfers . Observation on 04/16/24 at 11:19 a.m. showed two certified nurse aides (CNAs) (#4 and #5) assisted Resident #227 from the wheelchair to the toilet and back utilizing a mechanical sit-to-stand lift. When the CNAs (#4 and #5) raised Resident #227 in the stand lift, he failed to bear weight and remained in a semi-seated position while they provided perineal cares and throughout the transfers to/from the bathroom. The harness straps pulled upward into Resident #227's armpits, raising his shoulders to ear level, as his left arm hung at his side. Resident #227 grimaced and stated, Ouch, Ouch, I am slipping. When asked how Resident #227 should be transferred, the CNAs (#4 and #5) indicated with a sit-to-stand lift as per report and the CNA pocket care plan. The CNAs stated they were unaware of any changes made to Resident #227's care plan. During an interview on 04/16/24 at 12:11 p.m., an administrative nurse (#1) confirmed staff updated Resident #227's care plan on 4/15/24 but not the CNA's care plan and she expected staff to transfer Resident #227 with a Hoyer lift. 27221 2. Based on observation, review of facility reported incident (FRI) reports, review of medical records and facility policies, and staff interview, the facility failed to provide appropriate supervision to prevent an elopement for 1 of 1 resident (Resident #21) who eloped from the Memory Care Unit (MCU). Failure to ensure a secure environment contributed to Resident #21's ability to elope from the unit on two separate occasions. This citation is considered past non-compliance based on review of the corrective actions the facility implemented immediately following the incident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings include: Review of the facility policy titled Elopement Prevention and Missing Residents occurred on 04/18/24. This policy, revised June 2023, stated, . Conduct a thorough search of the facility and grounds . Upon finding the resident . assess the resident for injuries .The resident's Care Plan will be reviewed and updated. Complete an incident report . Take immediate action to decrease risk of repeated event with resident involved . Review of Resident #21's medical record occurred on April 15-18, 2024. The current care plan stated, . ELOPEMENT: Risk for elopement R/T cognitive deficits and wandering. Assess/record/report to MD [medical doctor] risk factor for potential elopement such as: Wandering, Repeated requests to leave facility, Statements such as 'I'm leaving' or 'I'm going home,' Attempts to leave facility, Elopement attempts from previous facility or hospital. If resident is missing from facility, follow elopement protocol, notify MD and family immediately . An Initial Allegation of Mistreatment, Abuse, Neglect or Theft and Facility Reported Incidents Reporting Form, dated 10/08/23 at 8:00 a.m., stated, . [Resident #21] eloped from the MCU. He was found outside the west door standing in the grass. A Vulnerable Adult Report, dated 10/13/23 at 12:00 p.m., stated, . At that time, one MCU staff was on break and one was left on the floor. They had just done rounds prior to staff going on break and [Resident #21] appeared to be sleeping in bed. The CNA [certified nurse aide] that remained on the floor was not near the west door at the time that [Resident #21] eloped. The CNA heard the alarm and immediately went to the door. [Resident #21] was easily redirected back into the facility and assessed for injury. He was put on 15 min [minute] checks for 24 hours with no further elopement attempts. Facility will implement that when a staff goes on break in the MCU from 6 p [p.m.]-6 a [a.m.], another staff, whether it be another CNA or a nurse, will try [to] help cover the floor to help ensure there is 2 staff present, as possible. An internal memo, dated 10/13/24, stated, . there was an elopement out of the memory care unit. We need to ensure this doesn't happen again. Therefore, from the hours of 6p [p.m.]-6a [a.m.], we will need to make sure that there is always 2 staff back in the MCU. So when anyone takes a break, it will need to be communicated to the nurses on the floor and someone will have to go back and cover the floor while that person is on break. This is also part of the corrective action we submitted to the state. Nurses . this does need to be enforced for the safety of our residents and facility. A progress note, dated 3/22/24 at 5:26 a.m., stated, Resident awake for most of the night, did try getting out main door, was able to be redirected to the TV lounge where he rested in the recliner for the rest of the morning. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Initial Allegation of Mistreatment, Abuse, Neglect or Theft and Facility Reported Incidents Reporting Form, dated 03/24/24 at 3:40 a.m., stated, . [Resident #21] eloped from the facility and made it off premises. He exited the east door of MCU and got down the street. Nurses called the on call MD and they were advised to monitor resident. Distal extremities were initially red but have returned to normal skin color and are blanchable. The Door alarm was sounding, but it did not pick up on the pager system. Had mtnc [Maintenance] check pager system and he discovered that the system was working properly, but the pagers hadn't been cleared at shift change so the alert was delayed getting to the pagers. He reset the pagers and educated the nursing staff on the importance of clearing the pagers at shift change. The progress notes identified: * 03/24/24 at 6:30 a.m., . A body audit was performed. Ears, nose, hands and feet were cold to touch and red. MD was notified and order given to monitor for effects of cold temperature. Family was notified. Resident is currently asleep in his bed and body temperature is 97.5. A Vulnerable Adult Report, dated 03/29/24 at 2:17 p.m., stated, . [Resident #21's] . admission BIMS [cognitive assessment] was 5/15 [indicating severe impairment]. He was unaware of safety and would continue to self-transfer. On 05/04/23 he was transferred into the MCU . [Resident #21] is a frequent exit seeker, but redirects well. [Resident #21] eloped out of the building from the east MCU door. This door is secured but will open after pushing it for 15 seconds. The door alarm did sound but one staff was outside on a break and another staff was in a room. A memo was placed in October informing all staff that there has to be adequate staff back in the MCU at all times and that they are to get a replacement for any break time . The CNA did not have someone . replace her for this break. was aware of the expectations . Education was given to the CNA . that there is to always be two staff on the floor for the safety of our residents. DON [Director of Nursing] reminded the NOC [night] nurses of the expectations. A performance improvement plan is being written up for the employee who failed to follow coverage requirements. NOC nurses . have been monitoring breaks since the time of this elopement and staff are now getting replacements when they leave the floor. Facility did discuss findings of elopement with his Physician in person. No concerns voiced by PCP [primary care provider]. During an observation/interview on 04/17/24 at 4:00 p.m., an administrative nurse (#1) showed the surveyor the location where staff found Resident #21, approximately a block and a half away from the facility. The nurse (#1) stated, The CNA did not get anyone to cover for her when she took her break. The CNAs weren't wearing their walkies [walkie-talkie/pagers]. Although staff outside the unit were wearing their walkies, they were full [unable to take more messages] and would ring delayed. The nurse (#1) stated the facility added the task of monitoring CNA breaks to the RN's duties and later indicated the walkies were considered part of the staff's uniform. Facility staff signed a form that stated, I understand that the pager is part of the uniform . I understand that it is my responsibility to ensure I know how to utilize the pager and its functions to full potential. Based on the following information, non-compliance at F689 is considered past non-compliance. The facility implemented corrective actions for the resident affected by the deficient practice by: * Assessing Resident #21 following each elopement, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	* Completing investigations following each elopement, * Determining the CNA failed to ensure adequate coverage prior to leaving the unit, * Identifying the paging system did not sound, and * Identifying staff failed to wear their pagers. The facility also put measures in place to ensure the deficient practice does not reoccur by: * Placing Resident #21 on 15-minute checks, * Educating/re-educating staff regarding staffing expectations on the unit, * Adding monitor appropriate coverage on the unit to the nurses' job duties, * Having Maintenance check the paging system and then educating staff regarding the importance of clearing their pagers during shift change, * Educating staff regarding the expectation they wear their pagers as part of their uniform, and * Implementing a performance improvement plan for the CNA involved in both elopement incidents. The survey team determined a deficient practice existed on 03/24/24. The facility implemented various corrective actions on 10/08/23 and again after 03/24/24, immediately placing Resident #21 on 15-minute checks, ensuring equipment was functional, educating staff regarding uniform and staffing expectations, and completing quality assurance audits.