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	05/20/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review, review of facility policy and staff interview, the facility failed to fully inform the resident or resident's representative regarding treatment with psychotropic medications for 1 of 5 residents (Resident #8) reviewed for unnecessary medications. Failure to fully inform the resident or resident's representative of the risks, benefits, or alternative options for psychotropic medications does not allow residents the right to choose treatment options.Findings include:Review of the facility policy titled Psychotropic Medication Use occurred on 05/20/26. This policy, dated 02/16/26, stated, . Informed consent for psychotropic medications will be obtained from the resident/resident representative prior to initiation. The resident/resident representative will be provided with information on the medication . will document this information in the medical record.Review of Resident #8's medical record occurred on 05/20/26. Diagnosis list includes insomnia. Physician orders included Mirtazapine (an antidepressant) one time a day related for insomnia.The medical record lacked evidence the facility full informed Resident #8 or the resident's representative of the risks, benefits, and alternative options for the use of a psychotropic medication.During an interview on 05/20/26 at 12:03 p.m., an administrative nurse (#1) confirmed the record lacked a consent form for psychotropic medication.

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, review of facility policy, and staff interview, the facility failed to provide privacy for 2 of 3 sampled residents (Resident #15 and #27) observed during personal cares while positioned in a mechanical sit-to-stand lift. Failure to ensure privacy during personal care infringes on the resident's rights and does not enhance their quality of life. Findings include: Review of the facility policy titled Standards of Care occurred on 05/20/26. This policy, dated 02/17/26, stated, . Dignity . Privacy curtain/door to be closed anytime cares are being completed. -Observation on 05/18/26 at 4:24 p.m. showed Resident #27 upright in the sit to stand lift and two CNAs (certified nurse aides) (#3 and #5) completed a brief change. The CNA's failed to close the blinds in the resident's room and the resident's buttocks were exposed to the courtyard. -Observation on 05/19/26 at 1:05 p.m. showed Resident #15 positioned in a sit-to-stand lift and seated on the toilet. A CNA (#13) raised the resident from the toilet, performed perineal care, and wheeled the resident out of the bathroom to the room. The CNA's failed to close the blinds in the resident's room and the resident's buttocks were exposed to the courtyard. During an interview on 05/20/26 at 11:52 a.m., an administrative staff member (#4) stated she expected staff to close window coverings prior to resident cares.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, review of facility policy and staff interview, the facility failed to ensure a safe, clean, comfortable, and homelike environment for 1 of 1 supplemental residents (Resident #60) on oxygen. Failure to clean personal fans does not provide a safe and clean environment and may place the resident at risk for illness.Findings include:Review of facility policy titled Proper Cleaning of a Room occurred on 05/20/26. This policy, dated 02/09/26, stated, . Clean all surfaces .Review of Resident #60's medical record occurred on 05/20/26. Diagnoses included acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, shortness of breath, and obstructive sleep apnea.Observations on all days of survey showed a layer of dust on the cover/grate and blades of the personal fan in Resident #60's room.Observation on 05/19/26 at 5:00 p.m. showed Resident #60 seated in the room, oxygen administered via nasal cannula, and the dusty, circulating fan blowing air directly on the resident.During an interview on 05/20/26 at 8:17 a.m., a housekeeping staff member (#7) stated the resident's fans are cleaned by the maintenance department.During an interview on 05/20/26 at 1:00 p.m., a maintenance staff member (#6) stated housekeeping should clean the resident's fans during each scheduled room cleaning.

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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** 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 staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 17 sampled residents (Resident #5 and #9). 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: SECTION A: IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2025, pages A-30-32, stated, . Section A1500: Preadmission Screening and Resident Review (PASRR) . Coding Instructions . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness . and continue to A1510 . Section A1510 . Coding instructions Code A, Serious mental illness: if resident has been diagnosed with a serious mental illness .^ - Review of Resident #9's medical record occurred on all days of survey and identified diagnoses of schizophrenia spectrum and psychotic disorder. An annual MDS, dated [DATE], showed the facility failed to code Sections A1500 and A1510 for serious mental illness. During an interview on 05/19/26 at 3:08 p.m., an administrative staff member (#14) confirmed staff failed to accurately code Section A on Resident #9's MDS. SECTION N: MEDICATIONS The Long-Term Care Facility RAI User's Manual, revised October 2025, page N-8, stated, . Coding Instructions . N0415K1: Anticonvulsant: Check if an anticonvulsant medication was taken by the resident at any time during the 7-day observation period.- Review of Resident #5's medical record occurred on all days of survey. Current medications included Gabapentin (an anticonvulsant) three times a day. The quarterly MDS, dated [DATE], showed the facility failed to code the anticonvulsant medication. During an interview on 05/20/26 at 11:45 a.m., an administrative staff member (#14) confirmed the facility failed to accurately code Section N.

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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. Based on observation, record review, review of facility policy, and staff interview, the facility failed to properly utilize assistive devices necessary to prevent accidents for 3 of 5 sampled residents (Resident #8, #15, and #27) observed during transfers with a mechanical sit-to-stand lift. Failure to properly utilize a mechanical sit-to-stand lift during transfers placed the residents at risk for injury and falls.Findings include: Review of the policy titled Standing Lifts occurred on 05/20/26. This policy, dated 02/17/26, stated, Use of this lift is [a] participatory process on the part of the resident, and they must be able to balance and bear-weight. place the sling behind their back. Position the wings of the sling under the resident's arms . Secure the buckle around the lower abdomen . and pull it snug. -Review of Resident #8's medical record occurred on all days of survey. The current care plan stated, . Proper footwear with all transfers . Prevalon [heel support] boots to both feet at all times. To be removed only with transfers. Observation on 05/20/2026 at 8:17 a.m. showed a certified nurse aide (CNA) (#2) utilized a mechanical sit-to-stand lift to transfer Resident #8 from the bed to a wheelchair. The CNA failed to remove the resident's Prevalon boots prior to the transfer. During an interview on 05/20/26 at 10:26 a.m., an administrative staff member (#12) stated she expected staff to remove the Prevalon boots and ensure proper footwear use during Resident #8's transfers. -Review of Resident #15's medical record occurred on all days of survey. The current care plan stated, .PAL [a type of mechanical sit-to-stand lift] assist x 1 [one staff] for all transfers. Observation on 05/19/26 at 1:05 p.m. showed Resident #15 seated on a toilet with a mechanical sit-to-stand lift sling secured around the resident's waist and attached to the lift. A CNA (#13) instructed the resident to hold onto the handlebars and raised the resident to a standing position. The resident briefly held onto the handlebars and then let go and hung in the lift with his arms up and out in front of him. The CNA continued cares without asking the resident to hold onto the handlebars and then transferred the resident into a recliner. -Review of Resident #27's medical record occurred on all days of the survey. The current care plan stated, . I transfer with staff assist x1 with PAL. Observation on 05/18/26 at 4:24 p.m., showed two CNAs (#3 and #5) transferring Resident #27 with a mechanical sit-to-stand lift. The surveyor questioned the CNAs regarding straps hanging on each side of the resident's abdomen. The CNA (#5) stated the CNA (#3) forgot to secure the sling around the resident's waist and both CNAs continued with and completed the transfer without the abdomen strap secured. During an interview on 05/20/26 at 11:52 a.m., an administrative staff member (#4) stated she expected staff to secure the sling around the resident's waist during the mechanical sit-to-stand lift transfers.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, review of the dialysis contract, review of the dialysis communications forms, and staff interview, the facility failed to provide care and services consistent with professional standards of practice for 1 of 1 sampled resident (Resident #7) receiving hemodialysis. Failure to complete dialysis treatment communications may result in an unidentified change in the resident's condition.Findings include: Review of the dialysis contract between the facility and the dialysis center occurred on 05/20/26. This contract, dated 05/10/19, stated, . Collaboration. Both the ESRD [end-stage renal disease center] and SNF [skilled nursing facility] are responsible for ensuring collaboration necessary to provide dialysis care coordination to each SNF resident receiving dialysis treatments. Review of Resident #7's medical record occurred on all days of survey. A physician's order, date 11/13/25, identified hemodialysis three times weekly on Mondays, Wednesdays, and Fridays. Review of Resident #7's dialysis communication forms between the facility and the dialysis center, dated 01/07/26 through 05/18/26 (42 visits), identified the facility failed to complete their resident assessment section prior to the resident's dialysis appointment on 35 of the 42 forms. Five additional dialysis communication forms in Resident #7's medical record lacked a name and/or date. During an interview on 05/20/26 at 9:22 a.m., two administrative staff members (#1 and #2) confirmed facility staff failed to accurately complete the dialysis communication forms.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, review of facility policy, review of professional reference and staff interviews, the facility failed to label over the counter (OTC) medications in accordance with professional standards for 2 of 2 medication carts. Failure to ensure appropriate and legible labels placed residents at risk for potential medication errors.Findings include:Review of facility policy titled Medication Administration and Storage occurred on 05/20/26. This policy, dated 02/16/26, stated, . Purpose: To provide safe and effective drug therapy . Medications will be labeled according to accepted pharmacy standards.Kozier & Erb's Fundamentals of Nursing, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 841, stated, . Always check the medication label to make sure the correct medication is being taken.Observation on 05/19/26 at 10:52 a.m. showed a medication aide (MA) (#10) administered AZO D-Mannose, an OTC medication for urinary tract health, with an illegible pharmacy label over the drug facts and dosage information. Review of the physician's order stated, AZO D-Mannose 500mg [milligram] capsule by mouth once daily. When asked about the label, the MA stated, the label covers the dose capsule serving amount but from experience and administering it for so long, I know it's one capsule.The MA (#10) failed to verify the capsule dose prior to administration of OTC medication.Observation of a medication cart on 05/19/26 at 4:46 p.m. showed a clear bottle containing an OTC medication with an illegible pharmacy label. A sticker on top of bottle cap stated, Iron 325mg. When questioned about the label, the nurse (#8) stated the pharmacy medication labels fade out and the facility placed a handwritten label on the OTC bottle to identify OTC medication.During an interview on 05/20/26 at 12:16 p.m., an administrative nurse (#1) confirmed the pharmacy should replace labels when illegible.

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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, review of professional references, and staff interview, the facility failed to follow professional standards of infection control and prevention for 2 of 9 sampled residents (Resident #15 and #30) observed during cares. Failure to practice infection control standards related to hand hygiene, glove use, and when emptying catheter bags has the potential to spread infection throughout the facility.ˆFindings include: Information found at https://medlineplus.gov/ency/patientinstructions/000142.htm, reviewed 01/01/25, stated, . Urine drainage bags collect urine. Follow these steps for emptying your bag . Hold the bag over the toilet, or special container . Open the spout at the bottom of the bag, and empty it [the urine] into the toilet or container. Clean the spout with rubbing alcohol . Close the spout tightly. Information found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html, dated 02/27/24, stated, . Know when to clean your hands . After touching a patient . Know when to wear (and change) gloves. Gloves are not a substitute for hand hygiene. Always clean your hands after removing gloves. When to change gloves and clean hands . If moving from work on a soiled body site to a clean body site on the same patient . have . body fluids on them after completing a task. -Observation on05/18/26 at 1:28 p.m., showed a certified nurse aide (CNA) (#15) entered Resident #15's room, opened the drainage spout on the catheter bag, drained the urine into a graduate container, and without sanitizing the spout, closed the spout and secured it back into the holder on the bag. -Observation on 05/18/2026 at 2:18 p.m., showed a CNA (#11) entered Resident #30's room, opened the drainage spout on the catheter bag, drained the urine into a graduate container, and without sanitizing the spout, closed the spout and secured it back into the holder on the bag. -Observation on 05/19/26 at 1:05 p.m., showed a CNA (#13) wore a gown and gloves and provided perineal cares for Resident #15. The CNA removed the soiled gloves, and applied clean gloves without performing hand hygiene. The CNA applied a clean brief, pulled up the resident's pants, and transferred the resident to a recliner. With the same gloves, the CNA operated the remote control to adjust the recliner, removed the sling around the resident's waist, removed a pillow from the resident's bed, placed the pillow behind the resident's head, and placed a blanket onto the resident's lap. The CNA rearranged items on top of the resident's bed, removed the gown and gloves, performed hand hygiene, and exited the room. The CNA (#13) failed to perform hand hygiene after removing the soiled gloves and before applying clean gloves and between dirty and clean tasks. During an interview on 05/20/26 at 11:00 a.m., an administrative staff member (#2) confirmed hand hygiene is a concern.