

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  355078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/04/2024
NAME OF PROVIDER OR SUPPLIER  Eventide Jamestown		STREET ADDRESS, CITY, STATE, ZIP CODE  1300 2nd PI NE Jamestown, ND 58401	

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)
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46477</b></p> <p>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 2 of 20 sampled residents (Resident #2 and #75). 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.</p> <p>Findings include:</p> <p><b>SECTION A - IDENTIFICATION INFORMATION</b></p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, pages A-30 through A-32, Section A: . Coding Instructions . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID [Intellectual Disability] or related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions.</p> <p>- Review of Resident #2's medical record occurred on all days of survey. Diagnoses include mild intellectual disabilities. The annual MDS's reviewed from April 2017, 2018, 2019, and 2021 showed A1500 coded Yes. The annual MDS, dated [DATE], showed staff failed to code yes for A1500.</p> <p>During an interview on 04/03/24 at 11:42 a.m., an administrative staff member (#1) confirmed staff failed to code item A1500 as yes on Resident #2's annual MDS.</p> <p><b>SECTION K - SWALLOWING/NUTRITIONAL STATUS</b></p> <p>The Long-Term Care Facility RAI User's Manual, revised October 2023, page K-8, states, . weight should be monitored on a continuing basis; weight gain should be assessed . Code . yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of . 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician.</p> <p>Review of Resident #75's medical record occurred on all days of survey. The admission MDS, dated [DATE], showed a weight of 168 pounds and the quarterly MDS, dated [DATE], showed a weight of 203 pounds (a weight gain of 20%). The facility failed to code K0310 for a weight gain of greater than 10% on the MDS dated [DATE].</p> <p>(continued on next page)</p>

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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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/19/24 at 12:55 p.m., an administrative staff member (#2) confirmed staff failed to code a weight gain greater than 10% on Resident #75's quarterly MDS.</p> <p>46964</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39685</p> <p>Based on observation, record review, review of the operations manual for the mechanical lift, and staff interview, the facility failed to provide adequate supervision and/or assistive devices for 2 of 20 sampled residents (Resident #29 and #43) with call lights and 1 of 3 sampled residents (Resident #29) with stand lifts. Failure to ensure proper use of a mechanical sit-to-stand lift and/or proper placement of a call lights placed Resident #29 and #43 at risk for injury.</p> <p>Findings include:</p> <p>Review of facility's Operator's Instructions for the [NAME] 3000 Stand Lift, occurred on 04/04/24. The instructions, dated November 2014, stated, . Have patient place feet on the foot plate and position their shins into the shin pad . position the sling around the patient's lower back . with the resident's arms outside the sling . fasten the support strap securely; the strap should be tight, but comfortable for the patient . carefully push the [NAME] 3000 in closer make full lower leg contact with the knee support . fasten support strap around the patient's legs . the strap should be tight, but comfortable . Encourage the resident to lean forward to enable the sling to be placed around his/her lower back . when raising the resident with a standing lift . the resident's body posture shall go from seated to standing position .</p> <p>- Review of Resident #29's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, and skin breakdown. A physician's order, dated March 2024, stated, Heel Boots on at all times except with transfers .</p> <p>The current care plan stated, . Transfer: Assist of 1 with sit to stand . Use caution and go slow with transfers and repositioning . Keep call light within reach . Resident has a soft touch call light . Don't leave resident in the room in wheelchair unattended . Keep at nurses' desk for closer monitoring as needed .</p> <p>Observations showed the following:</p> <p>* 04/01/24 at 3:25 p.m., Resident #29 laid in his bed with heel boots on both feet. A certified nurse aide (CNA) (#5) transferred Resident #29 utilizing a sit-to-stand lift. The CNA (#5) positioned Resident #29's feet on the foot plate and failed to remove the heel boots and apply the support strap around the legs. Resident #29 remained in a semi-seated position while the CNA performed the transfer. The harness straps pulled upward into Resident 29's armpits, raising his shoulders to ear level.</p> <p>* 04/02/24 at 8:40 a m., a CNA (#4) exited Resident #29's room. The resident remained alone until 9:25 a.m. (45 minutes). Resident #29 sat in his wheelchair with his back facing the bed and the soft touch call light on the bed and out of reach. The CNA (#4) failed to ensure Resident #29 could reach the call light and left the resident unattended.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Review of Resident #43's medical record occurred on all days of survey. Diagnoses included dementia, a history of falls, and a left tibia fracture. A physician's order, dated March 2024, stated, . left brace needs to be on for transfers . hoyer lift for transfers .</p> <p>The current care plan stated, . Risk for Injury r/t [related to] potential for falls . fracture of left tibia . anticipate and meet needs . be sure call light is within reach and respond promptly to all requests for assistance . Ambulation: non ambulatory . non weight bearing on left lower extremity .</p> <p>Observations showed the following:</p> <p>* 04/02/24 at 3:22 p.m., Resident #43 laid in bed, calling out, Where is my call light? Where is my urinal? They don't give it to me. Observation showed the call light on the opposite end of the room and out of reach.</p> <p>* 04/02/24 at 4:20 p.m., Resident #43 laid in bed, while two CNAs (#6 and #7) provided cares. After completing the cares, the CNAs exited the room, leaving the call light on the dresser and out of reach of the resident. The CNAs (#6 and #7) failed to ensure Resident #43 had access to his call light.</p> <p>During an interview on the morning on 04/04/24, an administrative staff member (#1) indicated she expects staff to provide adequate supervision and assistive devices to ensure residents' safety.</p>		