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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 01/27/20 and concluded 01/30/20.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, professional reference, and staff interview, the facility failed to provide the necessary care and services to maintain the highest practicable well-being for 1 of 4 sampled residents (Resident #75) observed throughout the day. Failure to reposition Resident #75 when fatigued limits her ability to function at her highest level and may place the resident at risk for discomfort, pain, and unsafe swallowing which can result in aspiration. Findings include: Nancy B. Swigert, "The Source for Dysphagia: Third Edition," LinguiSystems, Inc, 2007, pages 16, 125, and patient/family handouts identified " . . . patients with dementia may also have problems in the pharyngeal phase, such as delayed institutions of pharyngeal swallow and impaired laryngeal movement . . . During the oral	F 684	F684 1. Resident 75 care plan amended. If resident is not able to be aroused during meal times. Allow resident to rest and offer her something to eat once she is more alert. Allow resident to sleep in until 9:30AM-10:00am to promote alertness. 2. All residents who have a decline in alertness have the potential to be affected. 3. All resident will be identified for alertness during waking hours care plan will be amended to meet the resident needs during meals times and other activities. All nursing staff education will be provided on 2/21/20 4. Director of Nursing or designee will audit all residents for alertness 15 resident weekly x 2 months. Then 10 resident weekly x 2 months. Then 5	3/5/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/25/2020

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 684	Continued From page 1 intake of . . . foods and/or liquids, it is optimal for a patient to be seated at a 90 degree angle, whether in bed or chair. . . . The 90 degree position allow the patient to control material [food/liquid] in the oral cavity . . . This position must be maintained during . . . the meal. . . . Even a slightly reclined position while eating greatly increases the risk of premature loss of food over the back of the tongue . . . Repositioning is frequently required during the meal. . . ." Review of Resident #75's medical record occurred on all days of survey, and included diagnoses of vascular dementia and Alzheimer's disease. The current care plan stated, ". . . EATING: Supervision after setup. . . ." Resident #75's care plan failed to address her alertness level and/or need to be seated as close to 90 degrees as possible during meals. Observations showed the following: * 01/28/20 at 9:50 a.m. - Resident #75 slept in her wheelchair with her head on the table in the activity room. * 01/28/20 at 10:27 a.m. - Resident #75 slept in her wheelchair with her head on her knees in the commons area near the bird cage. * 01/29/20 at 8:49 a.m. - Resident #75 sat in her wheelchair in the dining room with her head on the table. A nurse (#3) reported Resident #75 consumed 100% of her meal. * 01/29/20 at 11:33 a.m. - Resident #75 sat in her wheelchair in the dining room with her head on the table. At 12:10 p.m., a nurse (#3) pushed on Resident #75's forehead,tilting her head backwards,as she continued to feed her several bites of food. Further observations showed	F 684	residents weekly x 2 months. Than 2 residents weekly x 2 months. Then 1 resident weekly x 2 months. All audits to be reviewed for effectiveness at Monthly Quality Assurance committee 5. Substantial compliance will be achieved on or before March, 5th 2020	

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 684	Continued From page 2 Resident #75 eating the evening meal without assistance after she was allowed to rest after the noon meal. During an interview on the morning of 01/30/20, an administrative nurse (#4) stated she would expect staff to lay resident down to rest when Resident #75 is observed hunched over asleep in her wheelchair.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure residents received adequate supervision and/or monitoring to prevent elopements from the facility for 1 of 1 sampled resident (Resident #18). Failure to provide adequate supervision and monitoring resulted in Resident #18's elopement from the facility, experiencing a fall, and exposure to temperatures below zero degrees fahrenheit. Findings include: Review of Resident #18's medical record occurred on all days of the survey. The current care plan stated, ". . . ACTUAL ELOPEMENT . . . wandering and looking for exit secondary to	F 689	F689 1. Resident 18 care plan has been amended with specific intervention to re-direct him when he is exit seeking, and history of attempted removal of wander guard. 2. All residents who elope have the potential to be affected. 3. All residents who have and attempted or actual elopement will have care plan updated with resident specific intervention to prevent future elopements as they occur. Staff to respond to door alarms via the pager system in a timely manner when they occur. The manager will collaborate with nursing staff to come up	3/5/20

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 689	Continued From page 3 cognitive deficits. Has exited the building. . . . Assess/record/report to MD [physician] risk factor for potential elopement. . . . Discuss with family the risks of elopement and wandering. . . . History of removing Wanderguard-see Mood and behavior . . . If resident is missing from facility, follow elopement protocol, notify MD and family immediately and document. . . . Wandergard for safety. Wander guard placed to ankle and wheel chair. See TAR for placement. . . ." The progress notes identified the following: * 02/15/2019 at 8:43 p.m. - "Resident has been very anxious since supper got over. He has been 1 on 1 all evening. He has been wondering [sic] and difficult to redirect. . . . And he attempted to elope out the front door. Staff has been taking turns watching resident 1 on 1. Have tried allowing resident to do what he wants within safety limits. He becomes more agitated with staff assisting him when walking but it is unsafe to have him walking unassisted. . . . Staff is continuing to monitor and watch him 1 on 1." * 2/15/2019 10:12 p.m. - "Resident was found with a large cuticle/nail trimmer he or his wife must have brought in. Staff caught him attempting to cut off his wanderguard. Trimmer was removed from the room for safety." * 2/16/2019 6:25 p.m. - "Resident was noted to be standing in the hallway. Resident and CNA [certified nursing assistant] did walk for a bit. Resident did state that he wanted to go outside. CNA did try to redirect. Resident was going to go outside. 2 staff did try to stop him at the door and resident started to fight with them. He had one CNA pinned up against the door and the other was trying to stop him. Another staff member and writer came to the situation. Resident was not	F 689	with resident specific interventions to prevent future elopements and the nurse will educate nursing staff on new interventions. Implementation of elopement drills to measure effectiveness of elopement process. All staff education provided on 2/21/2020. 4. All elopements and attempts will audited. The plan of care reviewed for resident specific intervention, response time to door alarms and nursing staff education x the next 12 months. All audits to be reviewed for effectiveness at Monthly Quality Assurance Committee. Elopement drills 3 x weekly x 1 month, then 2 x weekly x 1 month, then 1 x weekly x 1 month, then 2 x monthly x 1 month, then 1 x monthly x 4 months. 5. Substantial compliance will be achieved on or before March, 5th 2020	

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(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 689	Continued From page 4	F 689		

safe to be left alone at this time . . . Staff was able to being [sic] him back to the NS [nurses station] to be monitored."
* 2/16/2019 8:10 p.m. - "Time of fall: Approximately 1855 [6:55 p.m.]. . . Resident eloped out the front door and fell in the parking lot next door. . . . Neurochecks initiated per protocol. . . . Full body audit, red hands and knees. No other changes. Redness faded after 15 minutes. . . . 15 minute checks . . . Practitioner Notified . . . Family notified . . ."
* 2/16/2019 11:00 p.m. - "Resident eloped out the front door of the facility at approximately 1850-1855 [6:50 -6:55 p.m.] Staff had seen him just a few minutes before in the vicinity of front station and front family room. Writer was looking for resident and when unable to find him near front station went looking toward the front of the building and heard the front door alarm sounding. Alarm was sounding due to resident's wanderguard. The door does autolock [sic] and alarm when a wonderguard [sic] tries to go through it. However if the door is pushed on for 15 seconds the door will open. I called for assistance finding resident over the walkie and two CNA's responded to assist with looking for resident outside. Resident had taken his wheel chair out the front door and went straight south across the parking lot. When he could not use the wheel chair any longer due to deep snow at the south side between facility's lot and church lot, he started walking through the snow. He left the wheel chair at the south side of the facility's lot. Resident apparently managed to walk through the snow but then fell right at the northern side of the church parking lot. He was found on the ground laying on his back. He was on the edge of the parking lot and out of the

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(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 689	Continued From page 5	F 689		

snow. Resident was assisted up with 2 staff and gait belt. He was walked back to his chair and wheeled back into the facility. He was back in the facility at 1900 [7:00 p.m]. Resident was immediately changed out of any snow covered clothing. A full body assessment was completed. Some redness was noted to resident's hands and his knees and they felt cold to the touch. No other injuries or concerns were noted. The redness went away after less then 15 minutes and the areas begin to no longer feel cool to the touch. Neurochecks were immediately implemented and staff took turns sitting with resident 1 on 1 for the rest of evening shift. At the time of the elopement resident was wearing a pair of jeans, long sleeved shirt, black jacket, regular shoes and socks, and a hat. Manager on call . . . was notified immediately. [Physician name] was notified at 1915 [7:15 p.m.] . . ." The temperature in Devils Lake was below zero.

During an interview on 01/29/20 at 5:45 p.m., an administrative nurse (#1) stated, when a door alarm is triggered the staff are notified on their pagers. Once staff are notified, staff should immediately check the door.

During an interview on 01/30/20 at 11:30 a.m., an administrative staff member (#2) stated the cameras showed Resident #18 eloped at 6:50 p.m. and a staff member brought the resident back into the facility 15 minutes later.

The facility failed to:
* Respond to the door alarm in a timely manner
* Modify/update interventions on care plan
* Immediately educate nursing staff regarding elopements and possible strategies for avoiding

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 689	Continued From page 6 such behavior in the future per facility policy.	F 689		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, resident group interview, resident and staff interview, the facility failed to ensure sufficient staff for meal service on 2 of 2 meal observations (evening meal 1/27/20 and noon meal 1/29/20.) Failure to serve resident meals in a timely manner did not enhance the dining experience for the facility's residents. Findings include: - Observation of the evening meal 01/27/20 showed the following: * 4:50 p.m. - Four residents sitting at the table,	F 802	F802 1. Residents #57, #6, and # 19 will have meal service audited to insure they are served in an orderly and timely manner, Residents who order first will receive meals first. All Dining/ Nursing Staff will be educated in the importance to provide meals in an orderly and timely manner. Goal is serving meals from order placed to the resident in 15 minutes and total meal service in 30 minutes from start of serving.	3/5/20

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	620 14TH AVE NE DEVILS LAKE, ND 58301

(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 802	Continued From page 7 with only one of the four residents receiving their meal at 5:15 p.m. The last resident was served his/her meal at 5:33 p.m., 43 minutes after placing the order. * 4:50 p.m. - Three residents sitting at the table, two of the three residents received their meal at 5:16 p.m. Resident #57 asked unidentified staff member when his/her meal would be delivered. The last resident was served his/her meal at 5:25 p.m., 35 minutes after placing the order. On 01/28/20 at 10:28 a.m., 13 Residents, during a Resident Council Meeting, stated on numerous occasions they have waited, "an awful long time" to get served meals, and "A lot of times the first in the dining room are not the first served." Residents also stated, "Those of us that eat in the Diner are not recognized for 20-30 minutes unless someone happens to walk by, it seems you are forgotten about when you sit over there." - Observation of the noon meal 01/29/20 in the facilities main dining room showed the following: * 11:30 a.m. - Resident #6 sitting at the table. Over the next 15 minutes three other residents arrived at the same table, placed their order, and were served. Resident #6 was served last at 12:00 p.m., 30 minutes after placing his order. * 11:36 a.m. - Resident #19 arrived to the dining room, and placed her order. Over the next ten minutes three other residents arrived, placed their order, and were served. Resident #19 was served last at 12:00 p.m. * 12:01 p.m., Eight Residents seated in the supplemental dining area (called the Diner), had not been served the noon meal. * 12:11 p.m., Noon meal arrives. * 12:44 p.m., all residents in the Diner were	F 802	2. All residents have the potential to be affected 3. a) Changes that will occur, meal times will be modified to provide for a smooth delivery of meals to all dining areas, all fortified and enhanced drinks will be prepared and poured prior, labeled and available at dining times. b) Orders that are taken from a table will be delivered to the server immediately after obtained, only one table order will be taken at a time by dietary personnel before delivery to the server. The server will maintain the orders as received from the table and prepare the plate delivery in that order. Late arrivals to a table will have their order taken and placed in the server que for continuous delivery to continue. c) Dietary and Nursing staff will deliver all meals and drinks to tables and provide any additional requests as made by the resident and as Care Plan allows. 4. Dietary Manager or designee will audit meal delivery times from time of order to meal placed in front of resident, 3 meal deliveries per meal time / day for 4 weeks. 2 meal deliveries per day for 4 weeks, 3 meal delivery times per week for 4 weeks. 5 audits per month for 2 months. All audits will be reviewed monthly by the QA committee for modification and compliance. 5. March 5, 2020	

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 _____	01/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE DEVILS LAKE, ND 58301**

(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 802	Continued From page 8 served, 44 minutes after the noon meal service started. During an interview on the afternoon of 01/30/20, a dietary managers (#5) stated staff serve trays by a first-come, first-serve basis. The goal is for the residents to receive their meal 15 minutes after ordering. The facility failed to serve the residents meals in a timely manner.	F 802		