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 _____	C 02/15/2023

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 An unannounced onsite investigation survey regarding a facility reported incident and complaints was completed on February 14-15, 2023. The concerns identified by the report were substantiated and the concerns identified by the complainants were partially substantiated.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on information provided by the facility, record review, and staff interview, the facility failed to promote care in a manner that maintained or enhanced the residents' dignity for 1 of 1 closed resident record (Resident #3) requiring assistance with ADLs. Failure to ensure the residents remained dressed/covered in public areas of the facility does not promote mental well-being and may lead to a resident's loss of dignity. Findings included: - Review of Resident #3's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated 01/09/23, identified severe cognitive impairment and	F 557	1. Nursing staff did assist resident to their room where they assisted resident with AM cares including dressing resident in proper clothing. Resident no longer resides at facility. 2. The facility has identified that all residents have the potential to be affected by this practice. 3. Standards of Care policy was reviewed and is appropriate. Education on this policy will be provided on 03-08-2023 to all staff responsible for promoting dignity for our residents. This includes ensuring our residents remain properly clothed while in public areas of the facility.	3/15/23

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

Electronically Signed | 03/07/2023

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.

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F 557	Continued From page 1 extensive assistance with dressing. A nursing progress note, dated 01/14/23 at 5:04 a.m., stated, "Resident awake all night disrobing . . . Behaviors continued throughout the night. . . ." Review of the facility's "Vulnerable Adult Report," dated 01/18/23, stated, "Date/Time of incident: 01/14/2023 @ [at]0545 [5:45 a.m.] . . . housekeeping came to work around 0540 AM. [Housekeeper (#3)] stated that she saw resident sitting in the recliner without any clothes on. . . . At 0545 AM [staff nurse (#4)] came into work. When she walked to the front nurse's station she saw resident sitting in the recliner with no clothes on. . . ." Facility staff failed to maintain Resident #3 ' s dignity by allowing her to remain in public areas unclothed. During an interview on 02/14/23 at 3:05 p.m., two administrative nurses (#1 and #2) stated they expected staff to ensure residents were dressed/covered at all times in public areas of the facility.	F 557	4. The Director of Nursing or Designee will audit to ensure all residents of the facility are and remain appropriately dressed/clothed while in public areas of the facility. The Director of Nursing or Designee will audit 10 residents weekly for one month, then 10 residents monthly for three months and 10 audits will be completed quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Compliance will occur on or before 03-15-2023	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by:	F 558		3/15/23

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F 558	Continued From page 2 Based on information provided by the complainant, observation, record review, and staff interview, the facility failed to provide reasonable accommodation of needs regarding call lights for 1 of 4 sampled residents (Resident #1) observed for ability to access the call lights. Failure to ensure Resident #1 can reach/access the call light may result in an inability to call for help, increased falls, and/or incontinence. Findings include: The complainant reported residents cannot access their call light when needed. Review of Resident #1's medical record occurred on all days of survey. Diagnoses included glaucoma, anxiety, and heart failure. Resident #1's current care plan stated, ". . . Vision: Impaired vision . . . Thought Process: Resident is alert and oriented to person, with short and long term memory deficits. . . keep call light with in reach at times with in room . . ." Observations of Resident #1 showed the following: * 02/14/23 at 1:21 p.m., the resident resting in bed, and the call light hanging on the wall at the head of the bed out of the resident's reach. A sign posted on the wall stated, "Please make sure my call light is in my hand." * 02/14/23 at 4:20 p.m., the resident sitting on the edge of the bed, and the call light lying on the bed approximately three inches from the resident's right hip. When asked if he/she could find the call light, Resident #1 was unable to locate the call light without directions.	F 558	1.An administrative nurse placed call light within residents reach. Residents call light has been care planned to be clipped to residents clothing while resident is in room. 2.The facility has identified that all residents have the potential to be affected by this practice. 3.All staff will receive education on the expectation that all staff members are responsible to ensure residents call lights are within reach at all times when in their rooms. Education will occur on 03-08-2023. 4.The Director of Nursing or Designee will audit to ensure that all residents can have access to their call light while in their rooms. The Director of Nursing or Designee will audit 10 residents weekly for one month, then 10 residents monthly for three months and 10 audits will be completed quarterly for one year. If concerns are identified, immediate corrective action will be implemented. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5.Compliance will occur on or before 03-15-2023	

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F 558	Continued From page 3 During an interview on 02/14/23 at 4:20 p.m., when asked what he/she would do if unable to locate the call light and needed assistance, Resident #1 stated, "I would just get up and walk over there," and indicated the direction of the bathroom. During an interview on 02/14/23 at 5:45 p.m., an administrative nurse (#1) stated the standard of care is for all residents to have access to the call light.	F 558		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policies/procedures, review of the facility's investigation reports, and staff interviews, the facility failed to ensure freedom from neglect for 1 of 1 closed resident record (Resident #3) who experienced exposure of his/her body while residing in the facility. Failure of staff to provide	F 600	1. Nursing staff assisted resident #3 with am cares in residents room which included dressing resident and proper clothing. The staff members responsible for this incident have been terminated from employment. Resident no longer resides at the facility.	3/15/23

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F 600	Continued From page 4 supervision/assistance unnecessary exposure of Resident #3 ' s body in public areas of the facility and may have resulted in emotional distress and loss of dignity. Findings include: Review of the facility policy titled "Vulnerable Adult -North Dakota" occurred 02/15/23. This policy, revised May 2022, stated, ". . . Neglect - failure to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress. . . . Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental and psychosocial well-being . . . caretaker neglect - failure of the caretaker to provide necessary food, clothing, shelter, health care, or supervision . . ." Review of the facility's "Vulnerable Adult Report", dated 01/18/23, stated, "Date/Time of incident: 01/14/2023 @ [at]0545 [5:45 a.m.] . . . housekeeping came to work around 0540 AM [5:40 a.m.]. [Housekeeper (#3)] stated that she saw resident sitting in the recliner without any clothes on. . . . At 0545 AM [5:45 a.m.] [staff nurse (#4)] came into work. When she walked to the front nurse's station she saw resident sitting in the recliner with no clothes on. . . ." Review of Resident #3's medical record occurred on all days of survey. An admission Minimum Data Set (MDS), dated 01/09/23, identified severe cognitive impairment and extensive assistance with dressing. Diagnoses included dementia and left femur fracture.	F 600	2. The facility has identified that all residents of the facility have the potential to affected by this practice. 3. All Staff will receive education on F-600 Abuse, neglect and exploitation of residents on 03-08-2023. Training will include definitions and examples of each with the clear expectations that all staff are mandated reporters. Vulnerable Adult-North Dakota Policy has been reviewed and remains appropriate. 4. The Director of Nursing or Designee will audit to ensure that staff will intervene when a resident is attempting to disrobe to protect the residents dignity. The Director of Nursing or Designee will audit 10 residents weekly for one month, then 10 residents monthly for three months and 10 audits will be completed quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented. 5. Compliance will occur on or before 03-15-2023	

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F 600	Continued From page 5 Review of physician's orders identified the following: * 01/06/23 hydroxyzine HCL (an anxiety medication) 25 milligrams by mouth every 8 hours as needed for agitation. * 01/08/23 oxycodone HCL (a narcotic pain medication) 5 milligrams by mouth every 6 hours as needed for pain. A nursing progress note dated, 01/14/23 at 5:04 a.m., stated, "Resident awake all night disrobing, wandering and yelling at staff. Staff attempted to redirect her offered snacks and activates [sic]. Behaviors continued throughout the night. Staff 1:1 [one to one] with resident this NOC [night]." Resident #3's care plan stated, ". . . alteration in comfort . . . evidence by need of pain management r/t [related to] L) [left] hip fracture . . . give pain Rx [medication] as ordered . . . mood/behavior: resident noted to pull her call light out of wall and swing it at staff . . . medications as ordered . . . 1:1 visits. . . ." During an interview on 02/14/23 at 2:45 p.m., a staff nurse (#4) stated when she arrived to work on 01/14/23, "around 5:40 a.m." she found Resident #3 "sitting in one of our big red recliner chairs with the feet up by the med room, she was naked . . . she had a hospital gown tucked to the side." She identified that the night nurse (#8) was in the nurse's station and then asked the night nurse (#8), "Can we call someone to help her? [The night nurse (#8)] said 'What do you want me to do about it she's been like this all night.' And she wouldn't call a CNA [certified nursing assistant], wouldn't give me a walkie [handheld	F 600		

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F 600	Continued From page 6 communication device]." The staff nurse (#4) identified she found a CNA (#5) walking into work, and they assisted Resident #3 to dress. The staff nurse (#4) stated the undressing was not a new behavior for Resident #3, and as they assisted Resident #3 to dress for the day, the resident was not distressed or aware she had been naked in a public area. During an interview on 02/14/23 at 2:10 p.m., a CNA (#5) confirmed she assisted the staff nurse (#4) to dress Resident #3 when she arrived to work on the morning of 01/14/23 and Resident #3 sat undressed in a recliner by the medication room across from the nurse's station. She also confirmed the undressing behavior was not new for Resident #3, and while assisting Resident #3 she appeared in no distress. The medical record lacked documentation of attempts made or administration of as needed pain or anxiety medications on 01/13/23 from 6:00 p.m. to 6:45 a.m. on 01/14/23. The staff nurse (#4) stated the taped report for the night shift of 01/13/23 did not address Resident #3's behaviors or any interventions implemented by staff to address them. The facility staff failed to provide goods and services to maintain a dignified existence and avoid emotional distress for of Resident #3 by ensuring she was always dressed while in public areas of the facility, and that all interventions were implemented to meet her physical, mental and psychosocial needs.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		3/15/23

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F 609	Continued From page 7 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of State Survey Agency reports, review of the facility investigation reports, review of facility policy, and staff interview, the facility failed to report to the administrator and the State Survey Agency within two hours a potential incident of neglect for 1 of 1 closed resident record reviewed (Resident #3). Failure to report alleged incidents of neglect prevented a timely	F 609	1. Facility is unable to report incident within the required reporting timeframes. Staff Nurse # 4, Housekeeper # 3, and resident care manager received education on required reporting timeframes. 2. The facility has identified that all	

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F 609	Continued From page 8 investigation and placed all residents at risk of neglect. Findings include: Review of the facility policy titled "Vulnerable Adult - North Dakota" occurred 02/15/23. This policy, revised May 2022, stated, ". . . all staff . . . are required to report suspected abuse or neglect of vulnerable adults. . . . Once discovered, report to the North Dakota Department of Health occurs as follow [sic]: . . . All alleged violations involving abuse, neglect . . . are to be reported immediately but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse . . . When resident abuse, neglect . . . is suspected it should be reported immediately and not to exceed two hours, to any of the following . . . Your immediate supervisor . . . Charge Nurse . . . Resident Care Manger . . . Director of Nursing . . . Executive Director . . . Social Services Department . . ." During an interview on 02/14/23 at 3:05 p.m., two administrative nurses (#1 and #2) identified the staff nurse (#4) completed an "Employee Education & Feedback" form about the incident on 01/14/23 and placed it under the door of administrative nurse (#2), and failed to call or notify anyone in any other manner. They confirmed the housekeeper (#3) failed to notify anyone regarding the incident. The State Surveying Agency received an initial allegation report on 01/18/23, four days after the incident of alleged neglect. The facility staff failed to report the incident of alleged neglect to facility administration and the State Survey Agency	F 609	residents residing in the facility have the potential to affected by this practice. 3. The Vulnerable Adult - North Dakota Policy and Procedure has been reviewed and is appropriate. All staff will receive education on requirements to report all incidents of suspected abuse or neglect of vulnerable adults on 03-08-2023. This education includes the requirement of verbal notification to administrator and on-call nursing leader. 4. The Executive Director or Designee will audit to ensure all reportable incidents have been reported to administrator, facility leadership and the state survey agency properly and with in the required time frames. The Executive Director will audit all reportable incidents for three months, 4 per month for 6 months, and 2 per month for 3 months. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Compliance will occur on or before 03-15-2023	

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F 609	Continued From page 9 within 2 hours. See F600	F 609		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on information provided by the complainant, observation, record review, review of facility policy, and staff interview, the facility failed to provide the necessary care and services for 1 of 2 sampled residents (Resident #2) receiving oxygen. Failure of staff to ensure a physician's order is present prior to administering oxygen may complicate a resident's respiratory status. Findings include: The complainant alleged staff failed to provide appropriate care for residents receiving oxygen. Review of the facility policy titled "Oxygen Use & Storage" occurred 02/15/23. This policy, revised March 2021, stated, "Oxygen will be administered per practitioner orders . . . Document use on the eTAR [electronic treatment administration record] . . ."	F 695	1. On 02-14-2023 the facility added resident # 2's Physicians oxygen orders to residents eTAR. 2. The facility has identified that all residents who use oxygen have the potential to affected by this practice. 3. Oxygen Use & Storage and Admission/Hospital return policy were reviewed and are appropriate. Education on these policies will be provided on 03-08-2023 to staff responsible for physician order entry, administering and documenting oxygen use to ensure oxygen orders are entered into the eTAR. 4. The Director of Nursing or Designee will audit to ensure all residents who have a physician's order for oxygen have order available in eTAR and documentation is	3/15/23

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F 695	Continued From page 10 Observation of Resident #2 showed the following: * 02/14/23 at 1:21 p.m., the resident resting in bed with wearing oxygen from a concentrator set at 4 liters (L) via nasal cannula (NC). * 02/14/23 at 4:22 p.m., the resident sitting in the recliner wearing oxygen from the concentrator running at 4L via NC. * 02/15/23 at 8:15 a.m., the resident sitting the wheelchair wearing oxygen from the concentrator running at 4L via NC. Review of Resident #2's medical record occurred on all days of survey and included diagnoses of chronic obstructive pulmonary disease and congestive heart failure. The current physician's orders and eTAR failed to include an order for oxygen or documentation of oxygen administration. During an interview on 02/14/23 at 5:30 p.m., two administrative nurses (#1 and #2) confirmed they expected all residents receiving oxygen to have a physician's order and documentation on the resident's eTAR.	F 695	completed. The Director of Nursing or Designee will audit 5 residents weekly for one month, then 5 residents monthly for three months and 5 audits will be completed quarterly for one year. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review system revisions and/or staff education will be implemented. 5. Compliance will occur on or before 03-15-2023.	