| 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 05/04/2021 |

| 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<br><br>The complaint survey started and concluded on 05/04/21. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on information from the complainants, record review, and staff interview, the facility failed to provide adequate supervision for 1 of 2 sampled resident (Resident #4) who experienced falls with injuries. Failure to ensure supervision as care-planned may have resulted in delayed assessment/treatment of Resident #4 post fall with injury.<br><br>Findings include:<br><br>Information provided by the complainants indicated nursing staff failed to perform rounds/safety checks as care planned.<br><br>Review of Resident #4's medical record occurred on 05/04/21. Diagnoses included anxiety, dementia, hypertension, and femur/radius fractures. The significant change Minimum Data Set (MDS), dated 02/26/21, identified severely impaired cognition and history of falls. | F 689 | F689 Free of Accident/Hazards/Supervision/Devices<br><br>1. Resident #4's care plan was reviewed. Education provided to staff on following care plans. Root cause of 02/14/2021 fall was identified as severe dementia, no safety awareness, no elopement risk and the following intervention: Moved Resident #4 to main floor area for higher stimulation was initiated. No falls since the move to the main unit.<br><br>2. All residents at risk for falls have the potential to be affected.<br><br>3. Education was provided to all staff on May 26 2021 regarding implementing interventions as care planned, determining root cause of falls, and implementing a resident specific | 6/8/21 |

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

Electronically Signed | 06/01/2021

| 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 05/04/2021 |

| 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 1<br><br>The most recent fall risk assessment, dated 02/19/20, identified high risk for falls due to poor reasoning/safety awareness, impaired mobility, and history of falls.<br><br>The current care plan identified, ". . . Scores as high risk for falls. . . . She does have increased weakness. She self-transfers despite education and without regard to safety. She leans forward in the tripod position while sitting on the edge of her bed and while in her wheelchair. Resident does not use her call light. Has fallen in the last 90 days. Impacted left radial fx [fracture] 02/06/21. . . . 02/14/21 Left hip fracture. . . . 30-minute rounding to ensure safety. [Initiated 03/19/19] . . ."<br><br>The progress notes identified the following:<br>* 02/14/21 at 2:10 p.m., ". . . Time of fall: 1135 [11:35 a.m.] . . . Resident was found lying on left side next to her bed. Resident had gripper socks on at time of fall, call light was off. When asked what resident was trying to do when she fell she stated 'I was going to get married' . . . resident denies [hitting head] - neuro checks initiated per protocol . . . Left hip pain 10/10 on the verbal scale . . . skin tear measuring 2.7 cm [centimeter] x 1 cm to left elbow. Area cleansed with normal saline, xeroform [dressing] and Primapore dressing applied per protocol . . . vital and neuro checks initiated per protocol. Resident sent to [Hospital] ER [emergency room] for x-rays and further evaluation . . . Daughter . . . was called and was updated on fall and of plans by [Physician]. . . ."<br>* 02/19/21 at 10:58 a.m., ". . . Obtained report from nurse at [Hospital]. They stated that resident | F 689 | intervention after each fall.<br><br>4. The DON or designee will conduct audits to verify that interventions are being implemented as care planned. An audit will be completed daily for 1 month, weekly for 6 months, biweekly for 3 months, and then monthly for 2 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. Results will be reported at the quality meeting.<br><br>5. 6/8/2021 | |

| 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 05/04/2021 |

| 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 2<br>has a left hip fracture. . . ." .<br><br>During an interview, the afternoon of 05/04/21, two administrative staff members (#1 and #2) confirmed staff failed to complete/record rounds/safety checks. | F 689 | | |