STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 05/18/26 and concluded on 05/20/26.	F0000		06/17/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: 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:	F0552	Resident #8's guardian was contacted, and the Psychotropic Medication Evaluation and Consent form was completed. Discussion with guardian included review of risks, benefits, and alternative treatment options was received on 05/21/2026 for Mirtazapine. All residents receiving psychotropic medications have the potential to be affected by this practice. Annual psychotropic informed consents were added to the TAR for the nurses to complete as scheduled. DON reviewed all residents receiving psychotropic medication to confirm that the Psychotropic Medication Evaluations and Consent were completed. Education will be provided on 06/09/2026 for all nurses to complete the Psychotropic Medication Evaluation and Consent form according to facility policy. The DON or designee will audit to ensure Psychotropic Medication Evaluation and Consent forms are completed for all residents receiving psychotropic medication, weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and results of audits will be reported to the QA committee for further review and recommendation. Compliance with occur on or before 06/17/2026	06/17/2026

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 reverse for further 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0552 SS = D	Continued from page 1 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.	F0552		06/17/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F0583	Residents #15 and #27 are now receiving personal cares with privacy in place, including ensuring the blinds are closed when care is being provided All residents who receive personal cares have the potential to be affected by this practice. Education on the Standards of Care Policy will be provided on 06/09/2026 to all nursing staff, to ensure staff provide privacy while providing personal cares, including closing the blinds. The DON or designee will audit to ensure privacy is provided during personal cares, weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and results of audits will be reported to the QA committee for further review and recommendation. Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0583 SS = D	Continued from page 2 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: 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.	F0583		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, review of facility policy and staff interview, the facility failed to	F0584	Resident #60's fan was cleaned on 05.21.26 and remains free of dust or buildup. All residents who have a personal fan have the potential to be affected by this practice. Resident personal fans were added to the resident room Housekeeping checklist. This will ensure residents' personal fans are maintained to prevent dust buildup. Housekeeping staff will be educated on this process change on 06/09/2026. The DON or designee will audit to ensure fans are free of dust and buildup weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and the results of audits will be reported to the QA committee for further review and recommendation. Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0584 SS = D	Continued from page 4 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.	F0584		06/17/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F0641	Accurate coding corrections were made to residents #5 and #9’s MDS on 05/22/2026 and submitted with accurate information. All residents who receive Gabapentin and residents with a diagnosis for a severe mental illness have the potential to be affected by this practice. MDS Coordinator and Social Service Director reviewed RAI User’s Manual Section A and Section N to ensure correct coding instructions. MDS coordinator reviewed and corrected MDS assessments who are on Gabapentin and submitted the accurate assessment. MDS coordinator reviewed all residents with a level 2 PASARR to ensure accurate, comprehensive MDS were coded correctly and resubmitted the corrected MDS.	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0641 SS = D	Continued from page 5 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: 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	F0641	Continued from page 5 The DON or designee will audit to ensure section A and N on the MDS are accurate before submission, weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and results of audits will be reported to the QA committee for further review and recommendation. Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0641 SS = D	Continued from page 6 annual MDS, dated 02/26/26, 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 05/08/26, 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.	F0641		06/17/2026
F0689 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 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.	F0689	Residents #8, #15, and #27 are now receiving transfer assistance from staff who are operating assistive devices according to facility policy. All residents who utilize the sit to stand lift with transfers have the potential to be affected by this practice. All staff who operate the sit to stand lift will receive education on the Standing Lift Policy on 6/09/2026. Education includes resident safety, the use of proper footwear, and the use of buckles. The DON or designee will audit to ensure CNAs who transfer residents using sit to stand lifts are following the plan of care and Standing Lift Policy, weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and results of audits will be reported to the QA committee for further review and recommendation.	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0689 SS = D	Continued from page 7 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	F0689	Continued from page 7 Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0689 SS = D	Continued from page 8 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.	F0689		06/17/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: 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. . . ."	F0698	Dialysis communication sheet is now being completed consistently for resident #8 to ensure coordination of care with the dialysis center per the dialysis contract. All residents who receive dialysis have the potential to be affected by this practice. Education regarding the completion of the Dialysis Communication sheet will be provided to all nurses on 06/09/2026. The DON or designee will audit that nurses are completing the dialysis communication sheet according to the dialysis contract weekly for one month, then monthly for three months, and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented, and results of audits will be reported to the QA committee for further review and recommendation. Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0698 SS = D	Continued from page 9 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.	F0698		06/17/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by:	F0761	An audit of all OTC medication labels was completed, and pharmacy was updated on 6.3.26 to provide new, legible labels for all OTC medications, including AZO D-Mannose and Iron, that did not meet accepted pharmacy standards and facility policy. All OTC and stock medications are now labeled according to policy. All stock medication bottles have the potential to be affected by this practice. Informed pharmacy of citations and requested corrective action in regard to label concerns to meet accepted pharmacy standards. The pharmacist stated that the labels that had been fading are no longer in use and that she has informed her staff that they cannot cover dosage information when labeling stock medications. Medication administration and storage policy was reviewed by nurse leadership team and remains appropriate. Education will be provided with nursing staff on 06.09.2026 to include recognizing illegible labels or labels that are placed over medication information and reporting any concerns to the DON or designee. The DON or designee will audit OTC medication labels weekly for one month then monthly for three months and then quarterly for one year, to ensure labels are not covering drugs facts and dose and that labels are legible and meet accepted pharmacy standards and facility policy. If any concerns are identified, immediate corrective action will be	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0761 SS = D	Continued from page 10 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.	F0761	Continued from page 10 implemented and results of audits will be reported to the QA committee for further review and recommendation Compliance will occur on or before 06/17/2026	06/17/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F0880	Residents #15 and #30 are now receiving care according to proper infection control and prevention standards including catheter emptying, glove changes, and hand hygiene practices.	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0880 SS = D	Continued from page 11 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F0880	Continued from page 11 All residents with a catheter and/or who receive personal cares requiring glove changes and hand hygiene have the potential to be affected by this practice The Catheter Indwelling Policy, Guidelines for Wearing Gloves, and Hand hygiene was reviewed by nurse leadership team and remains appropriate. Education regarding these policies will be provided to direct care nursing staff on 06/09/2026. The DON or designee will audit to ensure proper infection control and prevention practices regarding catheter emptying, glove use, and hand hygiene are being followed according to policy weekly for one month then monthly for three months and then quarterly for one year. If any concerns are identified, immediate corrective action will be implemented and results of audits will be reported to the QA committee for further review and recommendation. Compliance will occur on or before 06/17/2026	06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0880 SS = D	Continued from page 12 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: 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. Findings 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	F0880		06/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355069	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE HEARTLAND	**620 14TH AVE NE , DEVILS LAKE, North Dakota, 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
F0880 SS = D	Continued from page 13 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.	F0880		06/17/2026