STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 and complaint survey started on 04/01/24 and concluded 04/04/24. The issues identified by the complainant were found to be in compliance with regulatory requirements.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 1.18.11), and staff interview, the facility failed to ensure accurate coding of the Minimum Data Set (MDS) for 2 of 20 sampled residents (Resident #2 and #75). Failure to accurately complete the MDS does not allow each resident's assessment to reflect their current status/needs and may affect the accurate development of a comprehensive care plan and the care provided to the residents. Findings include: SECTION A - IDENTIFICATION INFORMATION The Long-Term Care Facility RAI User's Manual, revised October 2023, pages A-30 through A-32, Section A: ". . . Coding Instructions . . . Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID [Intellectual Disability] or related condition, and continue to A1510, Level II Preadmission	F 641	1. Resident #2□s MDS for section A1500 over the past year was modified and corrected. All residents considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition MDS section A1500 were reviewed and modified if needed to ensure they were accurately coded. 2. All residents have the potential to be affected. 3. Education will be provided to the MDS Coordinator and Social Worker Designee by DON or designee regarding accurate coding of the MDS utilizing the RAI manual. 4. The DON or designee will audit MDS□s weekly for one month, monthly for three months, and then as needed per QA committee recommendation. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at the	5/3/24

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

Electronically Signed | 05/01/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 641	Continued From page 1 Screening and Resident Review (PASRR) Conditions. . . ." - Review of Resident #2's medical record occurred on all days of survey. Diagnoses include mild intellectual disabilities. The annual MDS's reviewed from April 2017, 2018, 2019, and 2021 showed A1500 coded "Yes". The annual MDS, dated 04/10/23, showed staff failed to code "yes" for A1500. During an interview on 04/03/24 at 11:42 a.m., an administrative staff member (#1) confirmed staff failed to code item A1500 as "yes" on Resident #2's annual MDS. SECTION K - SWALLOWING/NUTRITIONAL STATUS The Long-Term Care Facility RAI User's Manual, revised October 2023, page K-8, states, ". . . weight should be monitored on a continuing basis; weight gain should be assessed . . . Code . . . yes, not on physician-prescribed weight-gain regimen: if the resident has experienced a weight gain of . . . 10% or more in the last 180 days, and the weight gain was not planned and prescribed by a physician. . . ." Review of Resident #75's medical record occurred on all days of survey. The admission MDS, dated 12/11/23, showed a weight of 168 pounds and the quarterly MDS, dated 03/04/24, showed a weight of 203 pounds (a weight gain of 20%). The facility failed to code K0310 for a weight gain of greater than 10% on the MDS dated 03/04/24.	F 641	quarterly meeting. 5. Compliance date will be May 3st 2024. 1. Resident #75□s MDS for section K0310 was modified and corrected. All residents who have had a weight gain of 10% or greater in the last 6 months were reviewed and modified, if needed, to ensure they were accurately coded. 2. All residents have the potential to be affected. 3. Education will be provided to the MDS Coordinator and Registered Dietician by DON or designee regarding accurate coding of the MDS utilizing the RAI manual. 4. The DON or designee will audit MDS□s weekly for one month, monthly for three months, and then as needed per QA committee recommendation. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at the quarterly meeting. 5. Compliance date will be May 3rd 2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 641	Continued From page 2 During an interview on 03/19/24 at 12:55 p.m., an administrative staff member (#2) confirmed staff failed to code a weight gain greater than 10% on Resident #75's quarterly MDS.	F 641		
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 observation, record review, review of the operations manual for the mechanical lift, and staff interview, the facility failed to provide adequate supervision and/or assistive devices for 2 of 20 sampled residents (Resident #29 and #43) with call lights and 1 of 3 sampled residents (Resident #29) with stand lifts. Failure to ensure proper use of a mechanical sit-to-stand lift and/or proper placement of a call lights placed Resident #29 and #43 at risk for injury. Findings include: Review of facility's "Operator's Instructions" for the SARA 3000 Stand Lift, occurred on 04/04/24. The instructions, dated November 2014, stated, ". . . Have patient place feet on the foot plate and position their shins into the shin pad . . . position the sling around the patient's lower back . . . with the resident's arms outside the sling . . . fasten the support strap securely; the strap should be	F 689	1. Resident #29 and Resident #43 were assessed for proper call light placement and call lights were placed properly and within reach. Resident #43's care plan was reviewed and updated to include a dual call light as an additional intervention. Resident #29's transfer status was assessed. Education was provided to staff involved regarding proper use of a mechanical sit-to-stand lift and proper placement of a call light on 4/4/2024. 2. All residents have the potential to be affected by improper placement of call lights. All residents using a mechanical sit-to-stand lift have the potential to be affected. 3. Education will be provided to all nursing staff regarding proper placement of call lights and proper use of a mechanical sit-to-stand lift by May 1st. .	5/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 tight, but comfortable for the patient . . . carefully push the SARA 3000 in closer make full lower leg contact with the knee support . . . fasten support strap around the patient's legs . . . the strap should be tight, but comfortable . . ." Encourage the resident to lean forward to enable the sling to be placed around his/her lower back . . . when raising the resident with a standing lift . . . the resident's body posture shall go from seated to standing position . . . " - Review of Resident #29's medical record occurred on all days of survey. Diagnoses included dementia, Parkinson's disease, and skin breakdown. A physician's order, dated March 2024, stated, "Heel Boots on at all times except with transfers . . ." The current care plan stated, ". . . Transfer: Assist of 1 with sit to stand . . . Use caution and go slow with transfers and repositioning . . . Keep call light within reach . . . Resident has a soft touch call light . . . Don't leave resident in the room in wheelchair unattended . . . Keep at nurses' desk for closer monitoring as needed . . ." Observations showed the following: * 04/01/24 at 3:25 p.m., Resident #29 laid in his bed with heel boots on both feet. A certified nurse aide (CNA) (#5) transferred Resident #29 utilizing a sit-to-stand lift. The CNA (#5) positioned Resident #29's feet on the foot plate and failed to remove the heel boots and apply the support strap around the legs. Resident #29 remained in a semi-seated position while the CNA performed the transfer. The harness straps pulled upward into Resident 29's armpits, raising his shoulders to ear level.	F 689	4. The DON or designee will audit placement of call lights and mechanical sit-to-stand lift transfers weekly for one month, monthly for three months, and then as needed per QA committee recommendation. If concerns are identified, immediate corrective action will be implemented. The DON will submit a report of the monitoring results to the QA committee at each scheduled meeting. 5. Compliance date will be May 1st 2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 * 04/02/24 at 8:40 a..m., a CNA (#4) exited Resident #29's room. The resident remained alone until 9:25 a.m. (45 minutes). Resident #29 sat in his wheelchair with his back facing the bed and the soft touch call light on the bed and out of reach. The CNA (#4) failed to ensure Resident #29 could reach the call light and left the resident unattended. -Review of Resident #43's medical record occurred on all days of survey. Diagnoses included dementia, a history of falls, and a left tibia fracture. A physician's order, dated March 2024, stated, ". . . left brace needs to be on for transfers . . . hoyer lift for transfers . . ." The current care plan stated, ". . . Risk for Injury r/t [related to] potential for falls . . . fracture of left tibia . . . anticipate and meet needs . . . be sure call light is within reach and respond promptly to all requests for assistance . . . Ambulation: non ambulatory . . . non weight bearing on left lower extremity . . ." Observations showed the following: * 04/02/24 at 3:22 p.m., Resident #43 laid in bed, calling out, "Where is my call light? Where is my urinal? They don't give it to me." Observation showed the call light on the opposite end of the room and out of reach. * 04/02/24 at 4:20 p.m., Resident #43 laid in bed, while two CNAs (#6 and #7) provided cares. After completing the cares, the CNAs exited the room, leaving the call light on the dresser and out of reach of the resident. The CNAs (#6 and #7) failed to ensure Resident #43 had access to his call light.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355078	A. BUILDING _____ B. WING _____	C 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE JAMESTOWN, ND 58401**

(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 During an interview on the morning on 04/04/24, an administrative staff member (#1) indicated she expects staff to provide adequate supervision and assistive devices to ensure residents' safety.	F 689		