STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0000	INITIAL COMMENTS The standard Medicare/Medicaid recertification survey started on 07/20/26 and concluded 07/23/26.	F0000		08/27/2026
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on review of nurse staffing schedules and staff interview, the facility failed to provide the services of a registered nurse (RN) for eight consecutive hours a day, seven days a week, for 2 of 45 days reviewed (07/04/26 and 07/05/26). Failure to ensure sufficient, qualified nursing staff are available eight consecutive hours a day has the potential to affect the health and safety of all the residents residing in the facility. Findings include: On 07/20/26, the facility provided a copy of the nurse staffing schedules for the period of June 14-July 18, 2026. A review of the schedules showed the facility failed to have the required RN coverage on 07/04/26 and 07/05/26.	F0727	F727 – RN 8 Hours/7 Days Wk The facility immediately reviewed licensed nurse staffing schedules. RN coverage was secured to ensure an RN is scheduled for at least eight consecutive hours each day, seven days per week. Administrative staff were educated regarding the federal RN coverage requirement. All staffing schedules were reviewed to verify ongoing compliance with RN coverage requirements. Current and future schedules were adjusted as needed. The DON or designee and Staffing Coordinator will verify RN coverage prior to posting schedules. A contingency staffing plan utilizing on-call RNs has been implemented to ensure uninterrupted RN coverage. The DON or designee will audit RN staffing schedules weekly for 1 month, monthly for 2 months, and quarterly thereafter for one year. If concerns are identified, immediate corrective action will be implemented. The DON will report monitoring results to the QA committee at each scheduled meeting. 5. Completion date will be August 27st, 2026.	08/27/2026

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: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0727 SS = F	Continued from page 1 During an interview on 07/22/26 at 11:12 a.m., an administrative nurse (#1) confirmed the facility lacked RN coverage on the above dates.	F0727		08/27/2026
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §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 §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law.	F0801	F 727- Qualified Dietary Staff Current dietary manager is enrolled in Certified Food Manager (CFM) Certificate course as of 8/6/26. All residents residing in the facility have the potential to be affected by not having qualified dietary staff. Facility will ensure Dietary manager obtains CFM Certificate and will continue to receive oversight from previous Certified Dietary Manager and Registered Dietitian. Administrator will verify Dietary manager obtains CFM Certificate to meet CMS qualification requirements. Compliance will be reviewed monthly through QAPI Committee for three months and as needed following CFM Certificate being obtained. Completion date will be August 27th, 2026.	08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0801 SS = F	Continued from page 2 §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on staff interview, the facility failed to ensure 1 of 1 dietary manager (#5) obtained the proper qualifications to serve as the director of food and nutrition services. Failure to ensure staff have the qualifications to carry out the functions of food and nutrition services may place residents at risk for adverse nutritional needs. Findings include: During an interview on 07/20/26 at 9:55 a.m., the dietary director (#5) stated she is currently enrolled in a certified dietary manager (CDM) program	F0801		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0801 SS = F	Continued from page 3 through University of North Dakota (UND) and has not completed a certified program. The facility failed to ensure the dietary director (#5) completed the required education for a certified dietary manager, certified food service manager, or a national certification for food service management and safety from a national certifying body.	F0801		08/27/2026
F0761 SS = E	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: Based on observation, review of the facility policy, and staff interview, the facility failed to ensure medications were secured on 3 of 6 medication carts (Wing 1/Wing 2, Wing 4, and Wing 5). Failure to lock medication carts may result in unauthorized access to the medication. Findings include: Review of the facility policy titled “Medication Administration and Storage” occurred on 07/22/26.	F0761	F761 – Label/Store Drugs and Biologicals Staff will be educated on proper securing of medications and/or biologicals in medication carts whenever unattended. Education was provided to staff who were working during the observations on 7/21/26-7/22/26. All residents residing in the facility have the potential to be affected by unsecured medication carts. Education will be provided to all nurses and medication aids on facility Medication Administration and Storage policy by August 20th, 2026. Audits will be completed by DON or designee for each medication cart five days a week for one month, five days monthly for three months, and then audits will be completed at least quarterly for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will report monitoring results to the QA committee at each scheduled meeting. Completion date will be August 27st, 2026.	08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0761 SS = E	Continued from page 4 This policy, dated February 2026, stated, “Medication storage: Medications will be stored in a designated and secured (locked) area. . . .” - Observation on 07/21/26 at 11:33 a.m. showed a nurse (#2) gathered supplies to administer medication, walked down the hallway and left the unlocked medication cart at the Wing 1/Wing 2 nurses' station. The medication cart remained unsupervised for approximately 5 minutes. - Observation on 07/21/26 at 1:40 p.m. and at 2:55 p.m. showed an unlocked and unsupervised medication cart at the Wing 1/Wing 2 nurses' station. - Observation on 07/21/26 at 4:52 p.m. showed a nurse (#3) gathered supplies to administer medication, walked to a resident's room and left the unlocked medication cart in the Wing 5 hallway. The unlocked medication cart remained unsupervised for approximately 3 minutes. - Observation on 07/22/26 at 8:21 a.m. showed a nurse (#4) gathered supplies to administer medication, walked to a resident's room and left the unlocked medication cart in the Wing 4 commons area. The unlocked medication cart remained unsupervised for approximately 10 minutes. - Observation on 07/22/26 at 11:09 a.m. showed an unlocked unsupervised medication cart in the Wing 4 commons area. A nurse (#4) accessed the medication cart and locked it at 11:17 a.m. During an interview on 07/22/26 at 2:13 p.m., an administrative nurse (#1) stated she expected all unattended medication carts to be locked.	F0761		08/27/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control 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	F0880	F880– Infection Prevention and Control Staff will be educated on proper infection control processes with dressing changes, peri cares, insulin administration, and proper disinfecting of lifts after use. Education was provided to staff who were working during the observations on 7/21/26-7/22/26. All residents have the potential to be affected. Education will be provided to all nursing staff on facility policies Hand Hygiene, Dressing Changes, Perineal Care, Insulin Subq Administration, Glove	08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0880 SS = E	Continued from page 5 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 (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.	F0880	Continued from page 5 Wearing, and proper disinfection of mechanical lifts to ensure infection control standards are met by August 26th, 2026. The DON or designee will audit proper infection control practices related to hand hygiene and glove use during and after peri cares, insulin administration, and dressing changes weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. Proper disinfecting of mechanical lifts after each resident use will be audited weekly for one month, monthly for three months, quarterly thereafter for one year with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The DON will report monitoring results to the QA committee at each scheduled meeting. Completion date will be August 27st, 2026	08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0880 SS = E	Continued from page 6 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, record review, review of facility policy, and staff interview, the facility failed to follow standards of infection control and prevention for 4 of 12 sampled residents (Resident #11, #12, #34, and #50) and one supplemental resident (Resident #16) observed during cares and/or insulin administration. Failure to practice infection control standards related to dressing changes, perineal cares, hand hygiene, and glove usage has the potential to spread infection throughout the facility. Findings include: Review of the facility policy titled "Hand Hygiene" occurred on 07/23/26. This policy, dated 02/11/26, stated, ". . . Hand hygiene will be done: a. Before and after resident contact (before you leave the room) b. Before every clean procedure c. After every dirty procedure . . . Hand Hygiene is a general term that applies to either hand washing or alcohol-based hand rub . . ." Review of the facility policy titled "Simple Dressing Change" occurred on 07/23/26. This policy, dated 02/17/26, stated, ". . . PROCEDURE: . . . 2. Perform hand hygiene and assemble equipment/supplies. . . . 4. Put on gloves and clean working surface with a germicidal wipe . . . 6. Remove gloves and perform hand hygiene. 7. Set up supplies/equipment on clean surface. . . . 10. Apply gloves. 11. Remove dressing. Fold dressings with drainage contained inside and remove gloves inside out. . . . 12. Dispose of gloves and soiled dressing in trash receptacle. 13. Perform hand hygiene. 14. Apply gloves. 15. Cleanse wound as ordered . . . 16. Remove gloves and perform hand hygiene. 17. Apply gloves. 18. Apply clean dressing as ordered. . . . 20. Remove gloves and perform hand hygiene. . . . 22. Clean the working surface with a germicidal wipe . . . 24. Perform hand hygiene. . . ."	F0880		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0880 SS = E	Continued from page 7 Review of the facility policy titled "Insulin - Subcutaneous" occurred on 07/22/26. This policy, dated February 2026, stated, "Procedure: 1. Perform hand hygiene and apply clean gloves. . . . Clean site with an alcohol swab . . . Inject medication. . . ." -Review of Resident #12's medical record occurred on all days of survey. Diagnoses included a non-pressure chronic ulcer to the left foot. A physician's order, dated 05/15/26, stated to cleanse the wound on the left second toe with a wound cleansing solution, cover with an antimicrobial wound dressing, and secure with tape daily. Observation on 07/21/26 at 7:59 a.m. showed a nurse (#2) entered Resident #12's room to perform wound care. The toe showed no prior dressing in place. Without performing hand hygiene, the nurse (#2) applied gloves, cleansed the wound with wound cleanser, dried the area with gauze, and with the same gloves applied the new dressing and tape. Without performing hand hygiene, the nurse left the room with the supplies. During an interview on 07/23/26 at 10:04 a.m., an administrative nurse (#1) stated she expected staff to wash their hands prior to gloving, perform hand hygiene and apply new gloves after removing soiled dressings prior to applying clean dressings, and perform hand hygiene prior to leaving the resident's room. -Review of Resident #34's medical record occurred on all days of survey. A physician's order, dated 07/21/26, stated, "Monitor Skin tear to R [right] upper arm. Xeroform [a type of sterile dressing] applied and covered with non-adherent dressing wrapped with kerlix [gauze roll]. Change . . . every shift for skin tear . . ." Observation on 07/21/26 at 8:17 a.m. showed a nurse (#4) entered Resident #34's room to change the dressing to the resident's arm. Without performing hand hygiene, the nurse (#4) applied gloves obtained from his/her uniform pocket, removed the old dressing and steri-strips, and with the same gloves placed the clean wound care supplies directly on the arm rest and seat of the resident's recliner without cleaning the surface. Without changing gloves, the nurse cut a piece of Xeroform, applied it and the non-adherent dressing	F0880		08/27/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355078	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE JAMESTOWN	**1300 2ND PL NE , JAMESTOWN, North Dakota, 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
F0880 SS = E	Continued from page 8 to the skin tear, wrapped the arm with Kerlix, and taped it in place. With the same gloves, the nurse carried the supplies and placed them on top of the supply cart outside the room, dropped the scissors on floor, picked them up, and without disinfecting, placed them in his/her uniform pocket. During an interview on 07/23/26 at 10:11 a.m., an administrative nurse (#1) stated she expected the nurse to place clean supplies on a clean surface, perform hand hygiene, and change gloves between dirty and clean tasks. -Observation on 07/22/26 at 9:46 a.m. showed a certified nurse aide (CNA) (#6) entered Resident #50's room, completed hand hygiene, and applied clean gloves. The CNA (#6) removed the resident's wet brief, initiated perineal cares, and with the same gloves, placed a clean brief under the resident, and completed perineal cares. The CNA (#6) removed the soiled gloves and without completing hand hygiene, applied clean gloves, applied powder to the resident's groin area, fastened the clean brief, and removed the soiled gloves. Without completing hand hygiene, the CNA put on the resident's pants and grippy socks, assisted the resident into a sitting position, utilized a mechanical sit to stand lift, positioned the resident into a wheelchair, and inserted the resident's hearing aids. The CNA performed hand hygiene and exited the room with the sit to stand lift. The CNA failed to sanitize the lift. - Observation on 07/21/26 at 4:54 p.m. showed a nurse (#3) performed hand hygiene, prepared the insulin pen, and without applying gloves, cleansed Resident #11's skin with an alcohol wipe and administered the insulin injection. - Observation on 07/21/26 at 5:09 p.m. showed a nurse (#3) performed hand hygiene, prepared the insulin pen, and without applying gloves, cleansed Resident #16's skin with an alcohol wipe and administered the insulin injection. The nurse failed to apply gloves prior to administering the injections. During an interview on 07/22/26 at 2:13 p.m., an administrative nurse (#1) stated staff are expected to wear gloves when administering injections.	F0880		08/27/2026