Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 2, 2023

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

RE: CCN: 245461
Cycle Start Date: March 28, 2023

Dear Administrator:

On April 10, 2023, we notified you a remedy was imposed. On April 28, 2023 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 24, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 10, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 10, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 24, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 10, 2023

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

RE: CCN: 245461
Cycle Start Date: March 28, 2023

Dear Administrator:

On March 28, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 10, 2023.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 10, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 10, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 10, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Eventide Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 10, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 28, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 10, 2023

Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, MN 56560

Re: Event ID: 0VMI11

Dear Administrator:

The above facility survey was completed on March 28, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

(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
E 000	Initial Comments On 3/27/23, to 3/28/23, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was found to be IN compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/27/23, to 3/28/23, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was NOT compliance. In addition, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54619607C (MN00092178) with a deficiency issued at F880. H54619669C (MN00092171) with no deficiencies cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567	F 000		

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

Electronically Signed | 04/17/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	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 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 §483.70(e) 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	F 880		4/24/23

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F 880	Continued From page 2 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. 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, interview and document review, the facility failed to implement the use of	F 880	1. We are unable to correct the historic instances of PPE noncompliance for	

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F 880	Continued From page 3 proper personal protective equipment (PPE) for mask use per Centers for Disease Control and Prevention (CDC) recommendations to prevent and/or minimize further spread of COVID-19 during a COVID-19 outbreak. This deficient practice had the potential to affect all 117 current residents who resided in the facility. Findings include: CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID) Pandemic guidance, updated 9/2022, identified a) recommended to wear an N95 (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) or higher respirator (face mask) when caring for patients with COVID-19. b) when face masks were worn during care of a patient with COVID-19 infection, or during the care of a patient on droplet precautions, they should be removed and discarded after the patient encounter and a new one should be donned. Droplet precautions: used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit, transmitted through coughing, sneezing, and talking. R1's medical record identified on 3/22/23, R1 had tested positive for COVID-19, and was placed on droplet precautions at that time. R2's medical record identified on 3/25/23, and 3/27/23, R2 had been tested for COVID-19, both tests were negative.	F 880	residents whose staff members did not follow appropriate PPE guidelines. 2. All residents in the facility have the potential to be affected. 3. • A root cause analysis was completed on F880 and the causes of this deficiency were identified and interventions have been put into place to prevent future reoccurrence. • The Respiratory Protection Program policy was reviewed and updated in September of 2022 and no further updates are needed at this time as the policy is accurate and adheres to current guidelines regarding N-95 mask use. • The DON, Infection Preventionist, or other designated members of the leadership team will provide education to all facility staff on standard infection control practices, including but not limited to, transmission-based precautions, appropriate PPE use, and donning and doffing of PPE. Competency testing of all staff will be completed as part of this training. • Residents and representatives will be educated on our infection prevention and control program, as appropriate based on residents' cognitive status and capacity. 4. The Infection Preventionist or other designated members of the leadership team will audit PPE donning and doffing with transmission-based precautions routinely on varying shifts four times a week for one week and then twice weekly	

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F 880	Continued From page 4 R3's medical record identified on 3/25/23, and 3/27/23, R3 had been tested for COVID-19, both tests were negative. During an observation on 3/27/23, at 10:29 a.m. R1's room had a sign by the doorway identifying enhanced droplet precautions were in place for R1, which required hand sanitation, N95, face shield, gloves and a gown before entering his room. A five drawer plastic drawer cart was outside of his room which held yellow gowns, a box of gloves and hand sanitizer. At that time, nursing assistant (NA)-A approached R1's room, she wore an N95 mask and a clear, plastic face shield, stopped at his doorway, donned a gown, gloves and entered his room. - at 10:36 a.m. NA-A opened R1's door, walked outside of his room, removed her gloves and gown, placed them in a receptacle, sanitized her hands and walked down the hallway towards other residents room. NA-A was not observed to change her N95 mask. -at 10:38 a.m. R2 was observed seated in a high-back wheelchair in his room, ripped up newspapers were scattered across the floor of his room and his eyes were closed. At that time, NA-A entered R2's room, walked over to him, stood approximately 12 inches from his face, spoke to him, proceeded to then pick up the torn up newspapers from his floor, walked back next to R2, and moved an over the bed table to his right side. NA-A stood next to R2, talked to him briefly and left the room and proceeded down the hallway towards another residents room. NA-A continued to wear the same N95 mask as	F 880	for one week until compliance is met with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting. 5. 4/24/23	

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F 880	Continued From page 5 she had when she provided cares to R1, who was positive for COVID-19 and required isolation. -at 10:40 a.m. R3 was observed seated in a wheelchair in her room, she faced the over the bed table, her call light was on. At that time, NA-A entered her room, approached R3, donned a gait belt around her waist and proceeded to assist R3 transfer from her wheelchair to her bed. Once R3 was seated on the bed, NA-A bent down face to face with R3, removed her gait belt, placed her left arm around R3's shoulder, and her right arm by R3's legs and assisted her to lie down in bed. NA-A covered R3 with a blanket, washed her hands, left R3's room and proceeded to walk towards another residents room. NA-A continued to wear the same N95 mask as she had when she provided cares to R1, who was positive for COVID-19 and required isolation. During an interview on 3/27/23, at 10:45 a.m. NA-A stated R1 was currently positive for COVID-19, was in isolation on droplet precautions which required her to wear an N95, face shield, gown and gloves when providing cares or entering his room. NA-A indicated upon leaving R1's room she had removed her gloves, gown, sanitized her hands with hand sanitizer provided outside of R1's room, and had forgotten to cleanse her face shield with the cleansing wipes. NA-A confirmed she wore the same N95 mask throughout the day and confirmed she did not change her N95 mask when she left R1's room, entered, interacted and provided cares to two other residents R2 and R3. NA-A stated to her understanding, she would only change her N95 mask when it became visibly soiled.	F 880		

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F 880	Continued From page 6 During an interview on 3/27/23, at 10:36 housekeeper (HSK)-A indicated she cleaned both COVID positive, which required droplet precautions, and negative resident rooms throughout the day. She indicated she wore the same N95 mask throughout the day, and would not change it when she moved from a COVID positive to a COVID negative room. During an interview on 3/27/23, at 10:41 a.m. registered nurse (RN)-A stood at a medication cart, which held two small white paper bags, which she identified held her N95 masks. She indicated she used two N95's throughout the day, one for COVID positive rooms and one for COVID negative room. RN-A stated she would change out her masks several times throughout her shift, which required her to re-don the N95 which had been used in a COVID positive room. RN-A indicated the facility had ample supply of N95's, however it was to her understanding she would only don a new N95 at the start of a new day or if it became visibly soiled. Review of R5's medical record revealed R5 had tested positive for COVID-19 on 3/18/23, and was placed on droplet precautions. Review of R15's medical record revealed R15 had tested positive for COVID-19 on 3/17/23, and was placed on droplet precautions. Review of R6's medical record revealed R6 had tested positive for COVID-19 on 3/25/23 and was placed on droplet precautions. During observations on third floor on 3/27/23, at 10:34 a.m. a sign was posted on the outside of	F 880		

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	245461	A. BUILDING _____ B. WING _____	C 03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

(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 880	Continued From page 7 R5's identifying enhanced droplet precautions were in place for R5, which required hand sanitation, N95, face shield, gloves and a gown before entering her room. NA-B wore an N-95 mask covering her nose and mouth area and a clear face shield covering her entire face. NA-B donned a yellow cloth gown and gloves from the plastic bin located outside of R5's room and entered her room. R5 asked NA-B when she would be able to receive her hearing aids and asked when she would be able to go to the dining room for meals again. NA-B proceeded to straighten and clean up R5's room while she informed R5 she would maybe be able to go to the dining room tomorrow. -at 10:38 a.m. NA-B exited R5's room wearing her N-95 mask and face shield while carrying a bag of garbage and sanitized her hands. NA-B proceeded down the hallway, placed the garbage into the biohazard room and proceeded to donn another yellow gown and gloves from the plastic bin. -at 10:40 a.m. a sign was posted on the outside of R15's room identifying enhanced droplet precautions were in place for R15, which required hand sanitation, N95, face shield, gloves and a gown before entering her room. NA-B entered R15's room to assist her and exited R15's room at 10:43 a.m. wearing the same N-95 mask and her face shield. NA-B sanitized her hands, walked down the hallway, obtained several menu slips from another staff member and entered R19 and R20's room who were both negative for COVID-19. NA-B continued to wear the same N-95 mask and her face shield covering her entire face. NA-B proceeded to ask R19 and R20 what they wanted for food choices on their menu	F 880		

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F 880	Continued From page 8 slips. NA-B exited the room, walked down the hallway wearing the same N-95 mask with her face shield covering her entire face and entered R16's room who was negative for COVID-19. NA-B proceeded to ask R16 what he would like for food choices on his menu slip. NA-B was not observed to change her N-95 mask after exiting COVID-19 positive resident rooms or prior to entering COVID-19 negative resident rooms. During observations on third floor on 3/27/23, at 12:23 p.m. NA-C was wearing a N-95 mask covering her nose and mouth area with a clear face shield covering her entire face. NA-C pushed a cart down the hallway containing room trays. NA-C donned a yellow gown and gloves from the plastic bin outside of R15's room. NA-C proceeded to grab a room tray off the cart and entered R15's room, set the tray on the bed side table and assisted R15 to set up her meal. -at 12:25 NA-C exited R15's room while wearing her yellow gown, gloves, N-95 mask, face shield, grabbed another meal tray off the cart, entered R5's room with her meal tray, assisted R5 to set up her meal on her bedside table and exited the room. NA-C grabbed another meal tray off the cart and walked down the entire length of the hallway. A sign was posted on the outside of her room identifying enhanced droplet precautions were in place for R6, which required hand sanitation, N95, face shield, gloves and a gown before entering her room. NA-C entered R6's room and assisted R6 to set up her meal on her bedside table, while NA-D continued down the hallway with meal cart delivering room trays. -at 12:27 NA-C removed her yellow gown, gloves	F 880		

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EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

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F 880	Continued From page 9 and sanitized her hands while exiting R6's room. NA-C continued to have the same N-95 mask on with her face shield covering her face and she walked down the hallway to the other end of the building where NA-D continued to pass room trays. - at 12:29 p.m. NA-C grabbed a room tray off the cart, entered R8's room who was negative for COVID-19, placed the room tray on her walker, visited with R8 and assisted R8 to set up her meal. NA-C exited R8's room, pushed the meal cart down the hallway to R10's room who was negative for COVID-19 and assisted R10 to set up his meal on his bedside table. - at 12:32 p.m. NA-C exited R10's room, grabbed another meal tray off the cart and entered R12's room who was negative for COVID-19. NA-C assisted R12 to set up her meal on her bedside table. NA-C exited R12's room, grabbed another meal tray off the cart and entered R13's room who was negative for COVID-19. NA-C assisted R13 to set up her meal tray on the bedside table, NA-C exited R13's room and pushed the meal cart down the hallway to the dining room area. NA-C did not remove her N-95 mask after exiting resident rooms who were on droplet precautions or prior to entering negative COVID-19 rooms. During an interview on 3/27/23, at 10:24 a.m. NA-B indicated before she entered a COVID-19 positive room, she would sanitize her hands, donn a gown, gloves and wear a N-95 mask with a face shield covering her face. NA-B indicated when she exited a COVID-19 positive room she would remove her gown and gloves in the room, dispose of the and complete hand hygiene. In addition, NA-B stated she would sanitize her	F 880		

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F 880	Continued From page 10	F 880		

hands while coming out of the room and stated "I think that is it." NA-B confirmed she went from COVID-19 positive rooms to negative rooms and had not been changing her N-95 masks. NA-B indicated she wore the same N-95 mask all day and believed the nurses did the same.

During an interview on 3/27/23, at 12:46 p.m. NA-C indicated staff were to wear gowns, gloves, N-95 mask and a face shield when caring for positive COVID-19 residents. NA-C stated when she exited the room, she would remove her gown, dispose of it in the bin inside the room, remove her gloves and wash her hands. NA-C verified she had not changed her N-95 mask after passing room trays from COVID-19 positive rooms to COVID-19 negative rooms. NA-C confirmed she wore the same N-95 mask all day long.

During an interview on 3/27/23, at 3:02 p.m. licensed practical nurse (LPN)-A indicated when staff arrived to work they were expected to apply a N-95 mask and wear a face shield. LPN-A indicated staff were to wear a gown, gloves, N-95 mask and face shield while providing cares for COVID-19 positive residents. LPN-A stated staff were expected to remove their gowns, sanitize their face shields, remove their gloves and complete hand hygiene when exiting a COVID-19 positive resident room. LPN-A indicated staff would only change their N-95 masks if they were visibly soiled or became contaminated such as (coughing, sneezing). LPN-A confirmed she wore her N-95 mask all day and only changed it when it visibly soiled or contaminated.

During an interview on 3/27/23, at 4:45 p.m. LPN-B indicated staff were expected to wear a

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F 880	Continued From page 11 gown, gloves, N-95 mask and face shield when entering COVID-19 positive rooms. LPN-B stated staff were expected to remove their gown, gloves, wash their hands and sanitize their face shields when exiting the rooms. LPN-B indicated she wore her N-95 mask all day unless it became visibly soiled. LPN-A stated she was not aware staff were expected to change their N-95 masks after caring for residents who were COVID-19 positive. During a dual interview on 3/28/23, at 10:19 a.m. the infection prevention (IP) and corporative vice president of clinical services (VP) both confirmed residents who were positive for COVID required isolation and were placed on droplet precautions, which required hand sanitation, the use of N95, face shield, gown and gloves. Both the IP and VP stated the expectation would be for staff to remove their N95 mask when they leave a COVID positive room and don a new N95 mask, prior to entering a COVID negative room. IP indicated the facility had been conducting PPE audits as they could, though the facility had been in staffing crisis, and had been strained for time. IP confirmed the facility was currently in conventional capacity for their PPE and each floor had an area where the N95's were kept. Review of a undated facility policy and procedure titled, Outbreak Protocols and Reminders, identified when leaving a COVID positive room if going into a COVID negative room, must go to the designated area to discard your N95 and don clean N95 before entering a COVID negative room.	F 880		

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	00062	A. BUILDING: _____ B. WING _____	C 04/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/3/23, to 4/4/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure The following complaint was reviewed during the	2 000		

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2 000	Continued From page 1 survey: H52599938C (MN00082276). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		