DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1DZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00072

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245461**
2.STATE VENDOR OR MEDICAID NO.
(L2) **827340500**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVENTIDE LUTHERAN HOME**
(L4) **1405 7TH STREET SOUTH**
(L5) **MOORHEAD, MN** (L6) **56560**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/10/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **195** (L18)

13.Total Certified Beds **195** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	195			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII 12/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/24/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/01/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5461

On November 10, 2015, the Minnesota Department of Health completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on November 10, 2015. We presumed, based on their plan of correction, that the facility corrected the deficiencies as of November 4, 2015. Based on our revisit we have found the facility had corrected the deficiencies issued pursuant to the October 14, 2015 PCR, effective November 4, 2015. As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective November 4, 2015.

In addition, the Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 23, 2015. The CMS Region V Office concurred and authorized this Department to notify the facility of the actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 20, 2015, be rescinded. (42 CFR 488.417 (b))

In our letter of October 23, 2015, we advised the facility that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 20, 2015, due to denial of payment for new admissions. Since the facility attained substantial compliance on November 4, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b for the results of this visit.

Effective November 4, 2015, the facility is certified for 195 skilled nursing facility beds.

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245461

December 24, 2015

Mr. Mark Bertilrud, Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, Minnesota 56560

Dear Mr. Bertilrud:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 4, 2015 the above facility is certified for:

195 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 195 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

Electronically delivered
December 4, 2015

Mr. Mark Bertilrud, Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, Minnesota 56560

RE: Project Number S5461023

Dear Mr. Bertilrud:

On October 23, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective October 28, 2015. (42 CFR 488.422)

In addition, on October 23, 2015, as authorized by the Centers for Medicare and Medicaid Services (CMS), we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 20, 2015. (42 CFR 488.417 (b))

Furthermore, we notified you in our letter of October 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 20, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on August 20, 2015, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on October 14, 2015. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On November 10, 2015, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on October 14, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 4, 2015. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on October 14, 2015, as of November 4, 2015. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 4, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of October 23, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 20, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 20, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 20, 2015, is to be rescinded.

In our letter of October 23, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 20, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on November 4, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245461	A. Building B. Wing	11/10/2015

Name of Facility	Street Address, City, State, Zip Code
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**11/04/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**11/04/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**11/04/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	12/02/2015	34088	11/10/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/20/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1DZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00072

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245461**

2.STATE VENDOR OR MEDICAID NO.
(L2) **827340500**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVENTIDE LUTHERAN HOME**
(L4) **1405 7TH STREET SOUTH**
(L5) **MOORHEAD, MN** (L6) **56560**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/14/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **195** (L18)

13.Total Certified Beds **195** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	195			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 11/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/01/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY	**00**	INVOLUNTARY
01-Merger, Closure		05-Fail to Meet Health/Safety
02-Dissatisfaction W/ Reimbursement		06-Fail to Meet Agreement
03-Risk of Involuntary Termination		OTHER
04-Other Reason for Withdrawal		07-Provider Status Change
		00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/01/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5461

On October 14, 2015, the Minnesota Department of Health and on October 2, 2015, the Minnesota Department of Public Safety completed a revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 20, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of September 18, 2015. Based on our visit, we have determined that the facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 20, 2015. The deficiencies not corrected are as follows:

F0225 - S/S: D - 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

As a result of our finding that the facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

State Monitoring effective October 28, 2015. (42 CFR 488.422)

In addition, we recommended to the CMS Region V Office (CMS), CMS concurred and is imposed the following remedy and has authorized this Department to notify the facility of the imposition:

Mandatory Denial of payment for new Medicare and Medicaid admissions (DPNA) effective November 20, 2015. (42 CFR 488.417 (b))

If DPNA goes into effect the facility would be subject to a two year loss of NACTCEP beginning November 20, 2015.

Refer to the CMS 2567 along with the facility's plan of correction and CMS 2567b for the results of this visit. Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 23, 2015

Mr. Mark Bertilrud, Administrator
Eventide Lutheran Home
1405 7th Street South
Moorhead, Minnesota 56560

RE: Project Number S5461023

Dear Mr. Bertilrud:

On September 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 20, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On October 14, 2015, the Minnesota Department of Health and on October 2, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 18, 2015. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on August 20, 2015. The deficiencies not corrected are as follows:

F0225 - S/S: D - 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: D -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective October 28, 2015. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 20, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 20, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 20, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Eventide Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 20, 2015. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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:

Jan.Suzuki@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 Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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, Licensing and Certification Program 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 revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 February 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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 _____	R 10/14/2015

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 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 10/12/15 thru 10/14/15. The certification tags that were corrected can be found on the CMS2567B. Also there are tag/s that were not found corrected and were issued at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 225} SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	{F 225}		11/4/15

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

Electronically Signed | 11/06/2015

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.

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 _____	R 10/14/2015

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 225}	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report to the administrator, immediately report to the State Agency (SA) and failed to conduct a thorough investigation for an incident of injury of unknown origin for 1 of 4 (R166) injuries of unknown origin reviewed. Findings Include: R166's quarterly Minimum Data Set (MDS) dated 8/20/15, identified R166 had diagnoses which included adult failure to thrive, anxiety and depression. The MDS identified R166 had severe cognitive impairment and needed extensive	{F 225}	This plan of correction is submitted soley to comply with all applicable state and federal regulatory requirements. These written responses do not constitute an admission of non-compliance with any requirements nor an agreement with any findings. MDH reviewed documentation of bruises R166 obtained on 9/28/2015 from her watch and name band as possible neglect or mistreatment. Current policy on vulnerable adult reporting was reviewed and education	

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 _____	R 10/14/2015

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 225}	Continued From page 2 assistance with all activities of daily living (ADL's.) R166's care plan, dated 5/22/14, identified R166 was a vulnerable adult due to an inability to cope with potentially harmful situations. R166's care plan directed staff to observe for and notify supervisor or Common Entry Point of any suspected abuse or neglect. Review of R166's progress notes from 9/20/15 to 10/13/15, revealed on 9/28/15, R166 was noted to have multiple bruises on both arms. The progress note revealed R166 had three bruises on the right arm and one bruise on the left arm. The progress note identified the following: Right arm -a bruise on the forearm measured 7 centimeters (cm) x 5 cm and was purple and red in color -a bruise on the wrist measured 3 cm x 3 cm and was purple in color -a bruise on the inner forearm measured 3 cm x 2 cm Left arm -a bruise to the top left inner forearm which measured 4 cm x 2.5 cm. The progress note further revealed R166 wore an ID bracelet (a white plastic hospital band) on the right wrist and a watch on the left wrist and documentation revealed the plastic hospital band and watch been determined as the cause of R166's bruising as both would pinch R166's arms when staff would remove or put on R166's blouse. The note lacked documentation if R166 had been questioned as to the cause of the multiple bruising or if staff had been questioned to assist in analyzing the possible causes(s) of multiple bruises observed on R166. The progress	{F 225}	provided to nursing staff on 10/29/2015 and 10/30/2015. Education including the expectation of reporting immediately to the supervisor any vulnerable adult concern including possible neglect or mistreatment when an injury is sustained, ensuring immediate care is provided and thorough assessment with appropriate documentation to include interviewing resident and staff providing care at the time for actual cause of injury. Vulnerable adult policy and practice are current and up to date. All nursing staff will be re educated on the policy expectations by 11/4/2015. All identified resident injuries will be reviewed and audits will be completed 100% of the time for one month and 15/month for one month via staff interviews and chart audits. Results will be reviewed and reported at QA meeting. Responsible Party: Resident Care Managers and DON	

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 _____	R 10/14/2015

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 225}	Continued From page 3 note directed the staff to observe the bruising. No further documentation was found regarding R166's multiple bruises on both arms. On 10/13/15, at 10:36 a.m. the administrator stated the facility's incident reports were destroyed after being reviewed and logged by the staff member responsible for quality assurance (QA) as the incident reports were a part of the facility's QA program. The administrator further stated anything that was on the incident report would be in the individual resident progress notes. The adminstrator stated the facility's usual process when an incident had been identified was to have the staff ask the resident what happened if at all possible, but would expect them to ask if someone had hurt them. The adminstrator also stated the licensed staff were expected to notify the director of nursing (DON) and the DON would notify him. He stated he expected staff to document evidence of the incident, investigation and notifications in the resident progress notes. On 10/13/15, at 11:52 a.m. registered nurse manager (RN)-A stated the facility's usual practice when bruises on a resident were identified was for the nurse to assess for preliminary findings which included: asking the resident how it happened and to ask staff if they knew how the bruising happened to try to determine a cause for the injury. If the nurse and staff could explain how the injury occurred then a "Vulnerable Adult" report would not be made. However, if the injury was not explained then the facility would submit a report of the Office of Health Facility Complaints (OHFC.) RN-A further stated she would expect a follow up note in the progress note. RN-A also stated the progress	{F 225}		

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 _____	R 10/14/2015

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 225}	Continued From page 4	{F 225}		

notes would have the same information that the incident report would have and if the incident was deemed not reportable, then the facility would complete a thorough investigation to determine the root cause of the bruising.

On 10/13/15, at 1:34 p.m. R166's arms were observed with RN-B. R166 was lying in bed and had both arms exposed. On R166's right arm, there was a hospital band on the wrist and a watch was on R166's left wrist. R166's right and left arms had no observed bruising. RN-B indicated R166 had continued to wear both the hospital band and watch consistently and demonstrated that R166's hospital band and watch were able to slide approximately 3 inches up the arms. Both the hospital band and the watch were not able to be slid up R166's entire forearm.

On 10/13/15, at 1:34 p.m. RN-B confirmed R166 had not been asked how the bruises occurred nor had staff been questioned about possible causes. RN-B also stated the facility's usual practice was to ask the resident and other staff if they knew how the injury had occurred. RN-B was not aware of why R166 or other staff had not been questioned about R166's multiple bruises.
On 10/13/15, at 2:02 p.m. the administrator stated he had been notified of R166's bruises but could not recall when he had been notified.
On 10/14/15, at 10:06 a.m. a telephone interview was conducted with licensed practical nurse (LPN)-A. She stated she had been notified of R166's bruises on 9/28/15, by a nursing assistant (NA.) LPN-A stated she had looked at R166's arm and she felt the wrist band and watch lined up with the bruises on both arms when the sleeves of shirts were pulled on or off. LPN-A stated she

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 _____	R 10/14/2015

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 225}	Continued From page 5	{F 225}		

had asked R166 what had happened or if R166 had been hurt by someone, which R166 denied. LPN-A stated an incident report had been filled out and a message was left for the unit supervisor. LPN-A stated she had not informed the administrator of the injuries as the DON usually did. LPN-A further stated it was the facility's usual practice to question the resident and staff regarding when finding an injury and all the information was to be documented on the incident report. She felt since it was in the incident report she did not need to document it in the progress notes. LPN-A stated she was unsure of why she did not follow the facility's usual practice, and indicated she felt the bruises were explainable.

On 10/14/15, at 10:32 a.m. during a follow up interview, the administrator confirmed he had not been notified of R166's injuries until he saw the incident report, though after reading the report he felt the possible cause made sense so nothing further was done. However, the administrator confirmed that facility staff did not follow facility policy with determining a root cause and that a thorough investigation had not been conducted. The adminstrator also stated R166's bruising could have been considered an injury of unknown origin based on the facility policy definition. The administrator confirmed the injury which caused R166's bruising had not been observed, evidence R166 had been questioned about the injuries was not found and R166's bruises were multiple in number and found at one particular point in time. The administrator confirmed R166's injuries were not been reported to the SA.

Review of the facility policy titled, Vulnerable Adult, revised 7/1/15, identified all staff were

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 _____	R 10/14/2015

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 225}	Continued From page 6 required to report suspected abuse or neglect of vulnerable adults, verify the report to the proper officials have been made and that appropriate interventions have been taken. The purpose of the policy was to provide safe services and living environments for vulnerable adults, and to require the reporting of suspected abuse. The policy identified all residents living in the facility were vulnerable adults and injuries of unknown source was defined as; an injury of unknown source should be classified as an "injury of unknown source when both of the following conditions are met, "the source of the injury was not observed or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or incidence of injury over time." The policy directed staff to report any suspected abuse or neglect to the immediate supervisor.	{F 225}		
{F 226} SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the Vulnerable Adult Policy related to the immediate reporting to the administrator, immediately report to the State Agency (SA) of an injury of unknown	{F 226}	MDH reviewed documentation of bruises R166 obtained on 9/28/2015 from her watch and name band as possible neglect or mistreatment.	11/4/15

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 _____	R 10/14/2015

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 226}	Continued From page 7 origin, and failed to conduct a thorough investigation for 1 of 4 residents (R166) reviewed for injuries of unknown origin. Findings Include: Review of the facility policy titled, Vulnerable Adult, revised 7/1/15, identified all staff were required to report suspected abuse or neglect of vulnerable adults, verify the report to the proper officials have been made and that appropriate interventions have been taken. The purpose of the policy was to provide safe services and living environments for vulnerable adults, and to require the reporting of suspected abuse. The policy identified all residents living in the facility were vulnerable adults and injuries of unknown source was defined as; an injury of unknown source should be classified as an "injury of unknown source when both of the following conditions are met, "the source of the injury was not observed or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time or incidence of injury over time." The policy directed staff to report any suspected abuse or neglect to the immediate supervisor. R166's quarterly Minimum Data Set (MDS) dated 8/20/15, identified R166 had diagnoses which included adult failure to thrive, anxiety and depression. The MDS identified R166 had severe cognitive impairment and needed extensive assistance with all activities of daily living (ADL's.) R166's care plan, dated 5/22/14, identified R166	{F 226}	Current policy on vulnerable adult reporting was reviewed and education provided to nursing staff on 10/29/2015 and 10/30/2015. Education including the expectation of reporting immediately to the supervisor any vulnerable adult concern including possible neglect or mistreatment when an injury is sustained, ensuring immediate care is provided and thorough assessment with appropriate documentation to include interviewing resident and staff providing care at the time for actual cause of injury. Vulnerable adult policy and practice are current and up to date. All nursing staff will be re educated on the policy expectations by 11/4/2015. All identified resident injuries will be reviewed and audits will be completed 100% of the time for one month and 15/month for one month via staff interviews and chart audits. Results will be reviewed and reported at QA meeting. Responsible Party: Resident Care Managers and DON Corrective Action Completed by: 11/4/2015	

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 _____	R 10/14/2015

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 226}	Continued From page 8 was a vulnerable adult due to an inability to cope with potentially harmful situations. R166's care plan directed staff to observe for and notify supervisor or Common Entry Point of any suspected abuse or neglect. Review of R166's progress notes from 9/20/15 to 10/13/15, revealed on 9/28/15, R166 was noted to have multiple bruises on both arms. The progress note revealed R166 had three bruises on the right arm and one bruise on the left arm. The progress note identified the following: Right arm -a bruise on the forearm measured 7 centimeters (cm) x 5 cm and was purple and red in color -a bruise on the wrist measured 3 cm x 3 cm and was purple in color -a bruise on the inner forearm measured 3 cm x 2 cm Left arm -a bruise to the top left inner forearm which measured 4 cm x 2.5 cm. The progress note further revealed R166 wore an ID bracelet (a white plastic hospital band) on the right wrist and a watch on the left wrist and documentation revealed the plastic hospital band and watch been determined as the cause of R166's bruising as both would pinch R166's arms when staff would remove or put on R166's blouse. The note lacked documentation if R166 had been questioned as to the cause of the multiple bruising or if staff had been questioned to assist in analyzing the possible causes(s) of multiple bruises observed on R166. The progress note directed the staff to observe the bruising. No further documentation was found regarding	{F 226}		

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 _____	R 10/14/2015

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 226}	Continued From page 9 R166's multiple bruises on both arms. On 10/13/15, at 10:36 a.m. the administrator stated the facility's incident reports were destroyed after being reviewed and logged by the staff member responsible for quality assurance (QA) as the incident reports were a part of the facility's QA program. The administrator further stated anything that was on the incident report would be in the individual resident progress notes. The adminstrator stated the facility's usual process when an incident had been identified was to have the staff ask the resident what happened if at all possible, but would expect them to ask if someone had hurt them. The adminstrator also stated the licensed staff were expected to notify the director of nursing (DON) and the DON would notify him. He stated he expected staff to document evidence of the incident, investigation and notifications in the resident progress notes. On 10/13/15, at 11:52 a.m. registered nurse manager (RN)-A stated the facility's usual practice when bruises on a resident were identified was for the nurse to assess for preliminary findings which included: asking the resident how it happened and to ask staff if they knew how the bruising happened to try to determine a cause for the injury. If the nurse and staff could explain how the injury occurred then a "Vulnerable Adult" report would not be made. However, if the injury was not explained then the facility would submit a report of the Office of Health Facility Complaints (OHFC.) RN-A further stated she would expect a follow up note in the progress note. RN-A also stated the progress notes would have the same information that the incident report would have and if the incident was deemed not reportable, then the facility would	{F 226}		

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 _____	R 10/14/2015

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 226}	Continued From page 10 complete a thorough investigation to determine the root cause of the bruising. On 10/13/15, at 1:34 p.m. R166's arms were observed with RN-B. R166 was lying in bed and had both arms exposed. On R166's right arm, there was a hospital band on the wrist and a watch was on R166's left wrist. R166's right and left arms had no observed bruising. RN-B indicated R166 had continued to wear both the hospital band and watch consistently and demonstrated that R166's hospital band and watch were able to slide approximately 3 inches up the arms. Both the hospital band and the watch were not able to be slid up R166's entire forearm. On 10/13/15, at 1:34 p.m. RN-B confirmed R166 had not been asked how the bruises occurred nor had staff been questioned about possible causes. RN-B also stated the facility's usual practice was to ask the resident and other staff if they knew how the injury had occurred. RN-B was not aware of why R166 or other staff had not been questioned about R166's multiple bruises. On 10/13/15, at 2:02 p.m. the administrator stated he had been notified of R166's bruises but could not recall when he had been notified. On 10/14/15, at 10:06 a.m. a telephone interview was conducted with licensed practical nurse (LPN)-A. She stated she had been notified of R166's bruises on 9/28/15, by a nursing assistant (NA.) LPN-A stated she had looked at R166's arm and she felt the wrist band and watch lined up with the bruises on both arms when the sleeves of shirts were pulled on or off. LPN-A stated she had asked R166 what had happened or if R166 had been hurt by someone, which R166 denied. LPN-A stated an incident report had been filled out and a message was left for the unit	{F 226}		

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 _____	R 10/14/2015

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 226}	Continued From page 11 supervisor. LPN-A stated she had not informed the administrator of the injuries as the DON usually did. LPN-A further stated it was the facility's usual practice to question the resident and staff regarding when finding an injury and all the information was to be documented on the incident report. She felt since it was in the incident report she did not need to document it in the progress notes. LPN-A stated she was unsure of why she did not follow the facility's usual practice, and indicated she felt the bruises were explainable. On 10/14/15, at 10:32 a.m. during a follow up interview, the administrator confirmed he had not been notified of R166's injuries until he saw the incident report, though after reading the report he felt that a the possible cause made sense so nothing further was done. However, the administrator confirmed that facility staff did not follow facility policy with determining a root cause and that a thorough investigation had not been conducted. The adminstrator also stated R166's bruising could have been considered an injury of unknown origin based on the facility policy definition. The administrator confirmed the injury which caused R166's bruising had not been observed, evidence R166 had been questioned about the injuries was not found and R166's bruises were multiple in number and found at one particular point in time. The administrator confirmed R166's injuries had not been reported to the SA.	{F 226}		
{F 441} SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	{F 441}		11/4/15

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 _____	R 10/14/2015

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 441}	Continued From page 12 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate	{F 441}	On 10/30/2015 hand hygiene, glove usage during personal cares and linen	

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 _____	R 10/14/2015

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 441}	Continued From page 13 hand hygiene after perineal care for 1 of 3 residents (R30) observed to receive assistance with personal cares. In addition, the facility failed to handle soiled linen in an appropriate manner to prevent cross contamination during observation of personal cares. Findings include: During observation on 10/13/15, at 8:55 a.m. R30 was seated in a geri chair in the lobby area on the second floor. Nursing assistant (NA)-A approached R30 and transported R30 in her geri chair back to her room. NA-A and NA-B then proceeded to transfer R30 from her geri chair to her bed using a mechanical lift. At 8:58 a.m. NA-A obtained an incontinent brief from R30's closet and wet wipes from her night stand. NA-A donned gloves on both hands and proceeded to remove R30's pants and slid them down to her knees. NA-A indicated R30's incontinent brief was wet and was soiled with a large amount of stool. NA-A picked up the wet wipes off the top of R30's night stand and proceeded to clean R30's perineal area, rolled R30 to her right side and wiped her buttocks with the wet wipes. While cleaning R30's buttocks, R30 was observed to be incontinent of a moderate amount of urine, which ran down from the buttocks, onto the bed linens on the bed. NA-A indicated R30 had some blood in her brief when R30 urinated in her incontinent brief. At 9:00 a.m. NA-A reached down with her left soiled gloved hand and activated the button on her walkie talkie, which was attached to her uniform pants, to alert a nurse to come to R30's room. NA-A continued to clean R30's buttocks, then rolled up the soiled incontinent brief and set it further down on the bed for the nurse to look at.	{F 441}	handling expectations was initially re-educated with employee caring for R30. Additional one on one Training is being provided by the Director of Clinical education. Hand Hygiene, Glove Guidelines, Standards of Care, Perineal Care, Linen Soiled with blood/body fluids and handwashing policy were reviewed and remain current. Education was completed on 10/29/2015 and 10/30/2015 for nursing staff. All nursing staff will be re-educated on proper handwashing techniques and glove use expectations during personal cares and appropriate linen handling expectations. Employee involved with cares of R30 is being audited every time she works for one month. Other nursing staff will have an increase of observational audits on 11/6/2015 to be completed nine/unit/day for one week, then 9/unit/week for one month, then monthly for three months. Ongoing education will be completed as needed with individual staff. Audit information will be reviewed and discussed at QA meetings. Responsible Party: Resident care managers Corrective Action Completed by: 11/4/2015	

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 _____	R 10/14/2015

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 441}	Continued From page 14 At 9:01 a.m. registered nurse (RN)- A entered R30's room, examined the incontinent brief and confirmed R30 had a small amount of blood in the brief. NA-A reached out, picked up a clean incontinent brief with her soiled gloved hands and placed it under R30's buttocks, then repositioned R30 flat on her back in the bed. She picked up another wet wipe, continued to clean R30's perineal, and proceeded to hook the tabs on R30's clean incontinent brief. NA-A then removed her gloves, went into the bathroom and washed her hands. NA-A wore the same dirty gloves during the entire observation while changing R30's soiled incontinent brief and while performing perineal cares. At 9:06 a.m. NA-A briefly exited the room, and returned with clean linen. NA-A rolled R30 to her right side, pulled up her pants, while RN-A removed the soiled linen from the left side of the bed, then rolled it under R30 and placed clean linen on the left side of the bed. RN-A then rolled R30 to her left side, pulled up her pants, while NA-A removed the soiled linen from the bed. NA-A immediately threw the dirty linen on the floor next to the bed and began to place the clean linen on the right side of R30's bed. At 9:10 a.m. NA-A continued to straighten the clean linen under R30, then removed her gloves, while RN-A picked up an additional soiled piece of linen which fell to the floor while assisting R30 to roll, and handed the piece of linen to NA-A. NA-A took the sheet from RN-A and proceeded to again throw the sheet on the floor on with the other soiled linen on the right side of the bed. At 9:11 a.m. NA-A went to the bathroom, removed her gloves and washed her hands. At 9:12 a.m. NA-A returned to the right side of R30's bed, and with both bare hands, picked up	{F 441}		

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 _____	R 10/14/2015

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 441}	Continued From page 15	{F 441}		

the soiled pile of linen off the floor, held the linen to her chest and immediately exited R30's room. NA-A continued to walk down the hallway, holding the soiled linen with her bare hand, on her chest and walked to the dirty utility room. NA-A placed the pile of soiled linen in the soiled laundry bin and then proceeded to wash her hands.

On 10/13/15 at 9:14 a.m. NA-A confirmed she wore the same soiled gloves the entire time while performing perineal cares and changing R30's incontinent brief. NA-A also confirmed she threw the soiled linen on the floor and carried it against her uniform. she indicated the usual facility practice was to bag the soiled linen, not place soiled linen on the floor and not to carry soiled linen next to her clean uniform.

On 10/13/15 at 9:18 a.m. RN-A confirmed NA-A threw the soiled linen on the floor and carried the soiled linen against her clean uniform. RN-A verified staff should bag soiled linen. RN-A also confirmed staff should remove their gloves and wash their hands after completion of a dirty task. RN-A verified in the recent past all staff had received education in regards to hand hygiene, perineal cares and gloving.

Review of facility policy titled, Hand Hygiene, revised on 11/20/13, indicate staff would perform hand hygiene before every clean procedure, and after every dirty procedure.

Review of facility policy titled, Gloves Guidelines For The Wearing, revised on 11/20/13, indicated staff should change gloves clean and dirty procedures on the same resident and always wash hands before and after gloving.

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 _____	R 10/14/2015

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 441}	Continued From page 16 Review of facility policy titled, Linens Soiled with Blood/Body fluids, revised on 12/2013, indicated staff should wear gloves, carefully roll linen enclosing soiled areas into center of linen. Use care to avoid agitation of linen, place in plastic bag to carry soiled utility room for rinsing.	{F 441}		

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245461	A. Building B. Wing	10/14/2015

Name of Facility	Street Address, City, State, Zip Code
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **09/18/2015**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **09/18/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/18/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/18/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **09/18/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/18/2015**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/18/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** GA/mm	**Date:** 10/22/2015	**Signature of Surveyor:** 32600	**Date:** 10/14/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/20/2015

_____ **Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245461	A. Building B. Wing **01 - MAIN BUILDING 01**	10/2/2015

Name of Facility	Street Address, City, State, Zip Code
EVENTIDE LUTHERAN HOME	1405 7TH STREET SOUTH MOORHEAD, MN 56560

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0052	Correction Completed **09/18/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GS/mm	**Date:** 10/22/2015	**Signature of Surveyor:** 27200	**Date:** 10/02/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 8/21/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 1DZW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00072

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245461**

2.STATE VENDOR OR MEDICAID NO.
(L2) **827340500**

3. NAME AND ADDRESS OF FACILITY
(L3) **EVENTIDE LUTHERAN HOME**
(L4) **1405 7TH STREET SOUTH**
(L5) **MOORHEAD, MN** (L6) **56560**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **195** (L18)

13.Total Certified Beds **195** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	195			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Tammy Williams, HFE NEII — 09/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 09/30/2015 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 8, 2015

Mr. Mark Bertilrud, Administrator
Eventide Lutheran Home
1405 Seventh Street South
Moorhead, Minnesota 56560

RE: Project Number S5461023

Dear Mr.. Bertilrud:

On August 20, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Telephone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 26, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 26, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the

deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 20, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 February 20, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Gary Schroeder, Interim Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: gary.schroeder@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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 _____	08/20/2015

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 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		9/18/15

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

Electronically Signed | 09/18/2015

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 _____	08/20/2015

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 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician in a timely manner and failed to consult the physician for orders and treatments after identifying a new stage III pressure ulcer for 1 of 5 residents (R30) reviewed for pressure ulcers. Findings include; R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which included Alzheimer's disease and hypertension. The MDS identified R30 had severe cognitive impairment, required extensive assistance or was totally dependent on staff for all activities of daily living (ADLs), and was at risk for developing pressure ulcers. Review of R30's progress notes from 8/8/15 to 8/13/15, revealed: -On 8/8/15, R30's weekly skin check was completed and skin was intact. -On 8/13/15, a rehab aide came to the nurse and stated during range of motion (ROM) R30 was yelling out in pain. Staff touched toes and pain noted. A 0.8 cm by .9 cm abrasion was noted, area was blanchable, not hard, notified clinical manager and applied bandage to left second toe. -On 8/15/15, Tissue Tolerance Test (TTT) completed and R30 had a pressure sore to her left foot, second toe. She was supposed to be	F 157	This plan of correction is submitted soley to comply with all applicable state and federal regulatory requirements. These written responses do not constitute an admission of non-compliance with any requirements nor an agreement with any findings. F157 Notification of Change Wound team working with R30 were initially reminded and re-educated of the expectations in following the change of condition policy on 8/21/2015. Provider was updated on 8/19/2015 with orders obtained for treatment. Change of Condition policy was reviewed and remains up to date. The Skin Assessment policy was reviewed and continues to be current with expectation to notify provider with any change of skin conditions. The new standard practice will include the wound team to add the pressure ulcer to the treatment record for treatment needs, update the care plan and notify the provider. Nursing staff will notify the provider upon change of condition. All current residents in facility with pressure ulcers were reviewed and are in compliance with current practice expectations.	

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 _____	08/20/2015

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 157	Continued From page 2 turned and repositioned every 2 hours and as needed, and tubigrip to 2nd left toe. Review of R30's TTT, dated 8/15/15, identified R30 had a pressure sore to the left second toe with interventions of turning and repositioning every 2 hours and tubigrip to toe. Review of R30's TTT, dated 8/19/15, identified the pressure area to the 2nd toe on the left foot was a stage III pressure ulcer (full thickness tissue loss subcutaneous fat may be visible but bone, tendon or muscle are not exposed) that developed from 2nd toe resting on side of first toe. On 08/19/15, at 2:45 p.m. a group interview was conducted with clinical manager (CM)-A, CM-B, Minimum Data Set Nurse (MDSN)-B and registered nurse (RN)-C after the group had just completed a wound round assessment for R30. The group confirmed R30 had developed a stage III pressure ulcer to her left 2nd toe because the 2nd toe crossed over onto the bone of the next toe. They stated initially the area had been assessed as an abrasion on 8/13/15, and after the wounds team assessed on 8/14/15, the open area was identified as a new stage III pressure ulcer. They stated the tubigrip had been started as an intervention for her pressure ulcer, but there was not a physician's order for use of the tubigrip. They stated there should be doctor's orders, but they were not sure if R30 had orders for the tubigrip application. On 08/20/15, at 8:00 a.m. during a follow-up interview, CM-A confirmed R30 had developed a new stage III pressure ulcer to her left second toe from the pressure of the big toe identified on	F 157	All nursing staff will be re-educated on policy expectations and by 9/18/2015. Ongoing education will be completed as needed with staff and chart audits will be completed with all new identifications of pressure ulcers which will be reported at quarterly QA meeting. Responsible Party: DON Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 157	Continued From page 3 8/14/15. She confirmed the physician was not notified and the care plan had not updated. She stated she wrote a note to the general nurse practitioner (GNP) on 8/14/15, but the GNP went on maternity leave and and the facility had not received a response to the note. She confirmed she had not done any further follow up with the physician and the physician had not been notified until 8/19/15, of the newly developed pressure ulcer. Review of the facility policy titled, Skin Assessment, dated revised 7/2015 identified if a problem is identified the nurse will notify the practitioner within 24 hours for documentation and orders. The policy also included a decision tree as to when to notify the physician and also directed staff to obtain MD orders for treatment.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent federal survey results were readily	F 167	F 167- Right to survey results It was brought to the DON attention by the MDH that there were 2 pages missing	9/18/15

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 _____	08/20/2015

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 167	Continued From page 4 available and accessible to residents, families and visitors of the facility. This deficient practice had the potential to affect all 188 residents residing in the facility, families and/or visitors. Findings include: During the initial tour of the facility on 8/17/15 at 1:08 p.m. a three ring white binder was observed lying on the end table labeled "state survey results" in the main lobby across from the cafeteria area. The three ring binder contained three letters from the Minnesota Department of Health (MDH) dated, 9/14/14, 9/15/14, and 8/6/14. However, the three ring binder lacked a copy of the results of the most recent recertification survey from 7/14/14, conducted in the facility. On 8/20/15, at 2:11 p.m. the three ring binder remained on the table labeled "state survey results" in the main lobby. However, the binder lacked a copy of the results the most recent survey conducted. During interview on 8/20/15, at 2:11 p.m. the director of nursing (DON) confirmed the federal survey results for the most recent state survey results were not posted for residents and the general public and stated, "I would expect them to be in there [meaning binder]), because they are suppose to be posted." On 8/20/15 at 2:11 p.m. requested policy for posting of state survey results. None was provided by facility.	F 167	from the previous survey posted in the past survey binder located in the main lobby. The survey from 2014 was re-printed in its entirety with in 5 minutes of notification from MDH and replaced in the binder and main lobby per regulation. Staff were re-educated on posting expectations at the nursing staff meeting on 8/27/2015. Random audits to ensure the complete survey remains in the binder located in the main lobby area. This will be reported to the QA committee quarterly. Responsible Party: DON Corrective Action Completed by: 9/18/2015	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		9/18/15

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 _____	08/20/2015

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 225	Continued From page 5 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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 _____	08/20/2015

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 225	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report to the State Agency (SA) and failed to conduct a thorough investigation for an incident of potential neglect of care for 1 of 4 (R30) allegations of abuse reviewed. Findings include: R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which included Alzheimer's disease and hypertension. The MDS identified R30 had severe cognitive impairment and was totally dependent on staff for transfers and required 2 staff assistance for bed mobility. Review of R30's current care pain (CP) dated 8/5/15, identified R30 was a vulnerable adult due to her inability to cope with potentially harmful situations and placement in a skilled nursing facility. CP identified all staff would observe for, intervene if necessary, and report any signs of neglect or abuse to supervisor or common entry point. The CP identified R30 did not ambulate, and required assist of 2 with a hoyer lift for transfers. The CP directed staff to anticipate and meet her needs as needed, and follow her individual plan of care. Review of R30's progress notes from 8/1/15 to 8/20/15, revealed on 8/12/15, R30 had bumped her head into the hoyer lift bar when facility staff were transferring her that morning. A dark purple bruise was noted immediately to her right	F 225	F 225 Investigation report allegations/individuals It was brought to the DON attention on 8/20/2015 regarding possible neglect or mistreatment by a nurse assistant after MDH reviewed documentation of a bruise R30 obtained on 8/12/2015 by bumping of her head on hoyer lift during a transfer. Charge nurse was interviewed on 8/20/2015 regarding incident. He verified that upon assessment of resident, there was no indication that resident sustained any neglect or abuse from nurse assistant during transfer therefore did not report incident to director on call for possible neglect of vulnerable adult. Nursing assistants involved with transfer during the time of the incident were interviewed separately on 8/24/2015. Both nursing assistants reported that resident hit her head on the bar of the hoyer after transferring resident from the bed to the chair accidentally. All 3 employees were able to identify what a vulnerable adult incident would include to report. The progress note and interviews both supported that resident sustained bruise by hitting head on hoyer as an accidental incident. Nursing assistant and nursing staff were initially re-educated to ensure staff are aware of current policy requirements for reporting vulnerable adult concerns on 8/27/2015. Current policy on vulnerable	

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 _____	08/20/2015

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 225	Continued From page 7 forehead measuring 2.8 cm X 3.0 cm. No further documentation was found regarding the injury R30 sustained from the mechanical lift. On 08/19/15, at 7:30 a.m. during observation a large, dark purple bruise to R30's right temple area measuring approximately 3 inches wide by 2 inches long was noted. Nursing assistant (NA)-A was present during observation and stated, "The hoyer lift bumped her in the head, they must have hit her pretty hard, hopefully it wasn't too hard." On 8/20/15, at 8:00 a.m. clinical manager (CM)-A stated she was aware R30's head had been bumped with the hoyer lift. She indicated she was unsure how the injury happened and stated she was not sure if the plan of care was changed after the injury. She confirmed the facility was monitoring R30's bruise. On 08/20/15, at 3:38 p.m. CM-A confirmed R30's bruise at right temple measured 6.9 cm X 3.5 cm. CM-A confirmed R30's progress note on 8/12/15, was the only documentation related to R30's injury during cares from the mechanical lift. She confirmed R30's record lacked any additional documentation, investigation or follow up after the accident. On 08/20/15, at 4:38 p.m. the director of nursing (DON) and the executive director (ED), the DON confirmed R30 had bumped her head on the hoyer lift bar on 8/12/15, during morning cares. The DON indicated she had not been aware of the incident until immediately prior to the interview and stated registered nurse (RN)-B had reported after the accident R30 had no concerns. She stated sometimes R30 got tense when she	F 225	adult reporting was reviewed with the nursing staff. Review included the expectation of reporting immediately to the supervisor any vulnerable adult concern including possible neglect or mistreatment when an injury is sustained. RN charge nurse was initially educated on expectation with documentation of clarity on 8/24/2015 when reviewing incidents that result in an injury to resident. Vulnerable adult policy and practice are current and up to date. All nursing staff will be re educated on the policy expectations by 9/18/2015. Random chart audits will be completed with reported incidents of injury to look for appropriate reporting and investigation process. Random interviews with staff will be conducted to ensure understanding of practice expectations with policy. Audits will be reported at quarterly QA meeting and ongoing education will be completed as needed with staff. Responsible Party: Resident Care Managers and DON Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 225	Continued From page 8 transferred with the hoyer, would sit up quickly and hit her head on the bar. She stated RN-B stated he checked the equipment and felt it was connected correctly, and did not feel it needed to be reported to the SA. She stated RN-B told her the staff had done everything correctly, and it was an accident. She stated he should be more clear when writing his progress notes. The DON stated R30 would not be able to tell them what the cause of the accident was, but if the nurses felt it was neglect of care they would have contacted her. RN-B felt there was not neglect of care, so he didn't feel it needed to be reported to the SA. The DON also verified no investigation was conducted into the injury. Review of the facility policy titled, Vulnerable Adult, identified all staff were required to report suspected neglect of vulnerable adults, verify the report to the proper officials have been made and that appropriate interventions have been taken. The purpose of the policy was to provide safe services and living environments for vulnerable adults, and to require the reporting of suspected abuse. The policy identified every resident residing in the facility was a vulnerable adult and "Neglect," was defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness and defines any injuries of unknown origin as an example of abuse. The policy directed staff to report any suspected neglect immediately to DON or designee. It also identified that the alleged employee will not participate in direct resident care until an internal investigation is completed.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		9/18/15

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 _____	08/20/2015

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 226	Continued From page 9 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow their Vulnerable Adult Policy related to the immediate reporting to the State agency (SA) of allegations of abuse/neglect of care, and failed to conduct a thorough investigation for 1 of 4 residents (R30) reviewed for abuse/neglect of care. Findings include: Review of the facility policy titled, Vulnerable Adult identified all staff were required to report suspected neglect of vulnerable adults, verify the report to the proper officials have been made and that appropriate interventions have been taken. The purpose of the policy was to provide safe services and living environments for vulnerable adults, and to require the reporting of suspected abuse. The policy identified every resident residing in the facility was a vulnerable adult and "Neglect," was defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness and defines any injuries of unknown origin as an example of abuse. The policy directed staff to report any suspected neglect immediately to DON or designee. It also identified that the alleged employee will not participate in direct resident care until an internal investigation is completed.	F 226	F 226 Investigation report allegations/individuals It was brought to the DON attention on 8/20/2015 regarding possible neglect or mistreatment by a nurse assistant after MDH reviewed documentation of a bruise R30 obtained on 8/12/2015 by bumping of her head on hoyer lift during a transfer. Charge nurse was interviewed on 8/20/2015 regarding incident. He verified that upon assessment of resident, there was no indication that resident sustained any neglect or abuse from nursing assistants during transfer therefore did not report incident to director on call for possible neglect of vulnerable adult. Nursing assistants involved with transfer during the time of the incident were interviewed separately on 8/24/2015. Both nursing assistants reported that resident hit her head on the bar of the hoyer after transferring resident from the bed to the chair accidentally. All 3 employees were able to identify what a vulnerable adult incident would include to report. The progress note and interviews both supported that resident sustained bruise by hitting head on hoyer as an	

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 _____	08/20/2015

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 226	Continued From page 10 R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which included Alzheimer's disease and hypertension. The MDS identified R30 had severe cognitive impairment and was totally dependent on staff for transfers and required 2 staff assistance for bed mobility. Review of R30's current care pain (CP) dated 8/5/15, identified R30 was a vulnerable adult due to her inability to cope with potentially harmful situations and placement in a skilled nursing facility. CP identified all staff would observe for, intervene if necessary, and report any signs of neglect or abuse to supervisor or common entry point. The CP identified R30 did not ambulate, and required assist of 2 with a hoyer lift for transfers. The CP directed staff to anticipate and meet her needs as needed, and follow her individual plan of care. Review of R30's progress notes from 8/1/15 to 8/20/15, revealed on 8/12/15, R30 had bumped her head into the hoyer lift bar when facility staff were transferring her that morning. A dark purple bruise was noted immediately to her right forehead measuring 2.8 cm X 3.0 cm. No further documentation was found regarding the injury R30 sustained from the mechanical lift. On 08/19/15, at 7:30 a.m. during observation a large, dark purple bruise to R30's right temple area measuring approximately 3 inches wide by 2 inches long was noted. Nursing assistant (NA)-A was present during observation and stated, "The hoyer lift bumped her in the head, they must have hit her pretty hard, hopefully it wasn't too hard."	F 226	accidental incident. Nursing assistant and nursing staff were initially re-educated to ensure staff are aware of current policy requirements for reporting vulnerable adult concerns on 8/27/2015. Current policy on vulnerable adult reporting was reviewed with the nursing staff. Review included the expectation of reporting immediately to the supervisor any vulnerable adult concern including possible neglect or mistreatment when an injury is sustained with all 3 individuals involved in incident on 8/24/2015. RN charge nurse was initially educated on expectation with documentation of clarity on 8/24/2015 when reviewing incidents that result in an injury to resident. Vulnerable adult policy and practice are current and up to date. All nursing staff will be re educated on the policy expectations by 9/18/2015. Random chart audits will be completed with reported incidents of injury to look for appropriate reporting and investigation process. Random interviews will be conducted with staff to ensure understanding of practice expectations with policy. Audits will be reported at quarterly QA meeting and ongoing education will be completed as needed with staff. Responsible Party: Resident Care Managers and DON Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 226	Continued From page 11	F 226		

On 8/20/15, at 8:00 a.m. clinical manager (CM)-A stated she was aware R30's head had been bumped with the hoyer lift. She indicated she was unsure how the injury happened and stated she was not sure if the plan of care was changed after the injury. She confirmed the facility was monitoring R30's bruise.

On 08/20/15, at 3:38 p.m. CM-A confirmed R30's bruise at right temple measured 6.9 cm X 3.5 cm. CM-A confirmed R30's progress note on 8/12/15, was the only documentation related to R30's injury during cares from the mechanical lift. She confirmed R30's record lacked any additional documentation, investigation or follow up after the accident.

On 08/20/15, at 4:38 p.m. during interview with the director of nursing (DON) and the executive director (ED), the DON confirmed R30 had bumped her head on the hoyer lift bar on 8/12/15, during morning cares She indicated she had not been aware of the incident until immediately prior to the interview and stated registered nurse (RN)-B had reported after the accident R30 had no concerns. She stated sometimes R30 got tense when she transferred with the hoyer, would sit up quickly and hit her head on the bar. She stated RN-B stated he checked the equipment and felt it was connected correctly, and did not feel it needed to be reported to the SA. She stated RN-B told her the staff had done everything correctly, and it was an accident. She stated he should be more clear when writing his progress notes. The DON stated R30 would not be able to tell them what the cause of the accident was, but if the nurses felt it was neglect of care they would have contacted her. RN-B felt there was not neglect of care, so he didn't feel it

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 _____	08/20/2015

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 226	Continued From page 12 needed to be reported to the SA. The DON verified there was no investigation into the injury.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 5 residents (R30) reviewed for pressure ulcers. Findings include: R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which	F 279	F 279 Comprehensive care plans Care plan for R30 was updated to include current treatment plan. Nursing staff were initially reminded and re-educated of the expectations in updating care plan and provider on 8/27/2015. All residents with pressure ulcers charts were reviewed and changes made to reflect current treatment	9/18/15

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 _____	08/20/2015

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 279	Continued From page 13 included Alzheimer's disease and hypertension. The MDS identified R30 had severe cognitive impairment, required extensive assistance or was totally dependent on staff for all activities of daily living (ADLs), and was at risk for developing pressure ulcers. R30's care plan (CP) dated 8/5/15, identified R30 was at risk for skin breakdown due to dementia, incontinence, impaired cognition, knee brace use, impaired mobility, bunion pain with right shoe, and history of stage II pressure ulcer to coccyx. The CP listed various interventions which included: turn and reposition every 2 hours and as needed, skin assessments per policy, lotion arms and legs twice per day with cares, observe for skin changes when providing cares and provide prompt treatment, and treatments as ordered to any areas of impaired skin integrity. The CP failed to identify R30's newly developed stage III pressure ulcer (full thickness tissue loss subcutaneous fat may be visible but bone, tendon or muscle are not exposed) to left 2nd toe, or the tubigrip to protect the current pressure ulcer. Review of progress notes from 8/8/15 to 8/14/15, revealed: -On 8/8/15, R30's weekly skin check had been completed and skin was intact. -On 8/13/15, a rehab aide came to the nurse and stated during range of motion (ROM) R30 was yelling out in pain. Staff touched toes and pain noted. A 0.8 cm by .9 cm abrasion was noted, area was blanchable, not hard, notified clinical manager and applied bandage to left second toe.	F 279	plans on 9/14/2015. The Skin Assessment policy was reviewed and continues to be current with expectation to notify provider for any additional orders of treatment needed as needed. Wound team recommended tubi-foam cushion for newly ID pressure ulcer on R30 toe due to crossing of toes. Cushions are not currently a treatment needed to be ordered by provider and can be completed by nursing team. Provider was updated with recommendations from wound team with approval of current treatment plan on 8/19/2015. The new standard practice will include the wound team to add the pressure ulcer to the treatment record for treatment needs, update the care plan and notify the provider. Wound team will continue to see residents with pressure ulcers for 2 weeks following the resolved pressure ulcer. Nursing staff will review care plans monthly to ensure up to date and current. All nursing staff will be re-educated on policy expectations and by 9/18/2015. Ongoing education will be completed as needed with staff and chart audits will be completed to ensure treatment and care plans are current with orders which will be reported at quarterly QA meeting. Responsible Party: Resident care managers Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 279	Continued From page 14	F 279		

-On 8/14/15, clinical manager (CM)-A assessed R30's left toe, 0.5 cm by 0.4 cm, by <.01 cm., wound bed adherent with granulation tissue present, tubigrip applied.

-On 8/15/15, Tissue Tolerance Test (TTT) was completed and R30 had a pressure sore to her left foot, second toe. R30 was to be turned and repositioned every 2 hours and as needed, and tubigrip to 2nd left toe.

On 08/19/15, at 7:30 a.m. during observation of cares, nursing assistant (NA)-A stated R30 used to have a little sleeve, "foamy thing" on her toe, but the toe looked like it was better. She confirmed R30 did not have the sleeve on at that time. R30's 2nd toe on left foot was observed to have a small blackened, scabbed area on top of her 2nd toe on the left foot. The second toe was sticking up and above other toes, resting on top of first toe with no tubigrip present. The tubigrip was not on her toe upon waking and was not placed on the toe during morning cares.

On 08/19/15, at 2:45 p.m. clinical manager (CM)-A, CM-B, Minimum Data Set Nurse (MDSN)-B and registered nurse (RN)-C (Wound Team), were interviewed after just completing wound care rounds for R30. The group confirmed R30 had developed a stage III pressure ulcer to her left 2nd toe because her toe crosses over and the bone was right there. They stated initially it was assessed as an abrasion, and after the wounds team assessed it was identified as a new stage III pressure ulcer.

On 08/20/15, at 8:00 a.m. during interview CM-A

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 _____	08/20/2015

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 279	Continued From page 15 confirmed the pressure ulcer and the tubigrip were not identified on her CP or the treatment administration record (TAR) until after the interview on 8/19/15, at 2:45 p.m.. CM-A confirmed R30 had developed a new stage III pressure ulcer to her left second toe from the pressure of the big toe on 8/14/15, and at that time the tubigrip was put in place. Review of the facility policy titled, Skin Assessment, dated revised 7/2015, identified by the decision tree attached to the policy directs staff to obtain MD orders for treatment within 24 hours, initiate the wound care flow sheet, weekly skin assessments, put on TAR, perform a comprehensive assessment and update the care plan. Review of the facility policy, Care Plans, dated 5/20/15, identified Resident Care Plans will be updated and changes made as they occur to ensure the most current care plan for the resident.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement the care plan related to positioning for 1 of 1 residents (R105) identified with a current stage 3 pressure	F 282	F 282 Services by qualified person/per care plan Nursing staff caring for R105 were initially	9/18/15

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 _____	08/20/2015

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 282	Continued From page 16 ulcers. Findings include: R105's care plan, last revised 7/20/15, identified R105 was at risk for skin breakdown related to impaired cognition, impaired mobility, history of a cerebrovascular accident (CVA), dementia and incontinence. The care plan identified R105 had a history of stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. may also present as an intact or open/ruptured serum-filled blister). The care plan also indicated the wound to the right second toe and right buttocks, and that R105 currently had a stage 3 pressure ulcer to the right toe bunion area which had resulted from rubbing on left foot cast. In addition, the care plan listed various interventions which included to turn and reposition every 2 hours and as needed, off-loading pressure for at least one minute, assistance of two staff for bed mobility, float right heel at all times in bed, and a pressure relief mattress.The care plan lacked any interventions prior to 4/17/15, to protect R105's right lower extremity skin integrity due to risks of the cast on the left lower extremity. Review of R105's East Care Plan, provided by the facility, and identified as a care sheet for nursing assistants, directed staff to float right heel at all times, reposition every 2 hours and as needed, and identified R105 as non ambulatory. On 8/19/15, at 7:03 a.m. R105 was observed lying on the left side in bed, with covers pulled up	F 282	reminded and re-educated of the expectations in following care plan on 8/21/2015, 8/22/2015, 8/25/2015 and 8/26/2015 during report. R105 care plan was changed on 8/21/2015 to include the use of a dounut device to assist in continuous while in bed pressure relief to heel and toe. Care plan was updated at that time. Family requested on 9/9/2015 to no longer float heels or use any pressure relieving devices during day time hours except the current pressure relieving mattress and only float during time in bed at night. Risks and benefits were explained to family with verbalization of understanding. All residents with positioning needs were reviewed and are current with interventions listed and standard of care expectations. The standard of care policy was reviewed and remains current with expectations. The skin assessment and care plan policy was reviewed and remains current with expectations to adjust care plan needs based on individual assessments. Current expectations for documentation remains the same with documenting per shift cares provided with availability to document more if needed based on individual needs/changes. Future plans/expectations will include documentation to occur at point of service when ipad devices are implemented. All nursing staff will be re-educated on positioning and turning/reposition	

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 _____	08/20/2015

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 282	Continued From page 17 to shoulders. R105's right foot/bunion area was turned inward and rested on the mattress of the bed. At 7:30 a.m., R105 remained lying on the left side covered with a blanket, with the right foot/bunion area turned inward, both the inner aspect of the foot and heel were observed to rest directly on the mattress. At that time, nursing assistant (NA)-D and nursing assistant (NA)-E entered the room and started R105's morning cares. NA-D and NA-E removed a splint from R105's left hand, pulled down the blankets, removed pillow from under R105's left knee stump and a pillow was removed from behind R105's back. R105's right foot/bunion area remained turned inward, with both the inner aspect of foot and heel resting directly on the mattress. R105's right foot/bunion area was observed with a less than one centimeter in diameter, light brown, intact scab with pink skin surrounding the scab present on the right great toe/bunion aea. R105 did not have a pillow in place to elevate the right foot, and R105's pressure ulcer on right great toe rested directly on the mattress. R105's right foot/bunion area and heel continued to rest on the mattress during the remainder of morning cares. Registered nurse (RN)-F briefly entered the room and administered medication to R105 and proceeded to exit the room. RN-F did not reposition R105's foot/bunion area and did not direct staff to reposition R105's foot/bunion area from resting directly on the mattress. On 8/19/15, at 9:50 a.m., NA-E confirmed R105's right lower leg, right heel and right inner foot and toe were directly on the mattress upon removing blankets prior to performing morning cares. NA-E verified no pillow was present under R105's right foot,leg or near the right foot or leg to be used for	F 282	expectations by 9/18/2015. Ongoing education will be completed as needed with staff and observational audits for care plan compliance and correct positioning of resident will be completed which will be reported at quarterly QA meeting Responsible Party: Resident care managers Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 282	Continued From page 18	F 282		

positioning. NA-E confirmed there was a pillow behind R105's back and under the left stump/leg, and stated R105 has a sore on her right foot. NA-E confirmed staff were directed to use pillows to elevate R105's right foot. NA-E indicated the facility utilized a computerized system for documentation for R105's repositioning schedule and was not aware the last time R105 had been repositioned prior to completion of R105's morning cares.

On 8/20/15, at 7:58 a.m. RN-F indicated she was unaware staff were not following R105's care plan to float the foot/heel at all times. RN-F indicated facility staff utilized a computerized system for documenting R105's repositioning schedule and confirmed the documentation on 8/19/15 revealed R105 had not been repositioned timely. She stated, "If it is not documented, it is not done."

On 8/19/15, at 2:26 p.m. the director of nursing (DON) verified she expected all staff to implement care plan interventions to prevent pressure ulcers and promote healing of pressure ulcers. The DON confirmed staff were expected to have elevated R105's foot while in bed. She indicated the facility utilized a computerized system for documenting cares provided and indicated she felt the staff were not consistently documenting in the system. The DON stated the facility is starting to roll out a new project with ipads which will would make it easier for staff to document each time cares are provided.

The facility policy titled Care Plans dated 5/2013, indicated the master care plan would be completed by the 14th day after admission and updated monthly as needed. Pertinent information from the care plan will be added to

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 _____	08/20/2015

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 282	Continued From page 19 the NAR/CNA care plan (care sheets) for continuity of care. .	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implement appropriate interventions to prevent pressure ulcers and/or promote healing of pressure ulcers for 2 of 5 residents (R105, R30) reviewed for pressure ulcers. This resulted in actual harm for R105 who developed an unstageable pressure ulcer while in the facility. Findings include: R105's quarterly Minimum Data Set (MDS) dated 4/16/15, identified R105 had diagnoses which included Alzheimer's disease, fracture and pneumonia. The MDS indicated R105 had severe cognitive impairment and required extensive to total assistance with all activities of daily living (ADL's). Further, the MDS identified	F 314	F314 Treatment to prevent/heal pressure ulcers R105 has had areas on toes reassessed by the wound team on 8/24/2015 with a comprehensive assessment review since April 2015 to current. The nurse practitioner also assessed wound on toe on 8/19/2015 with findings of an abscess related to the history of peripheral vascular disease, immunocompromised status and probably decrease in immunoglobins and noted that the area is not caused from a pressure related concern. The residents condition was reviewed by the medical director on 8/21/2015 and concurred with this conclusion. There were several factors	9/18/15

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 _____	08/20/2015

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 314	Continued From page 20 R105 was at risk for development of pressure ulcers however, did not have any pressure ulcers at that time. R105's significant change MDS dated 6/2/15, identified R105 had diagnoses which included Alzheimer's disease, above the knee amputation, spasm of muscle and a stage 3 pressure ulcer. The MDS indicated R105 had severe cognitive impairment and required extensive to total assistance with all ADL's. R105's Pressure Ulcer Care Area Assessment (CAA) dated 6/8/2015, identified R105 required assistance with bed mobility, turning and repositioning. The CAA identified R105 had a pressure ulcer on the right great toe. The CAA identified R105 was requiring more assistance due to Alzheimer's/dementia, generalized weakness, recent left above the knee amputation, arthritis and depression. Further, the CAA identified contributing factors for increased risk for skin breakdown/pressure areas and slow improvement of current area included risk for infection, risk for abnormal labs, decreased mobility, risk for altered nutrition/hydration, history of pressure ulcers in past, bowel and bladder incontinence, debility and age. The CAA identified R105's Braden Scale for Predicting Pressure Sore Risk (a tool to identify risk for developing pressure ulcers) indicated a risk score of 13 on 6/2/15 which indicated at risk. The CAA identified R105 currently had a pressure ulcer on the right great toe, and identified R105 was on a turning and repositioning schedule every hour and as needed and to float the right foot on the pillow. R105's Urinary Incontinence and Indwelling	F 314	that lead to the pressure ulcer and interventions that are noted in R105 care plan would promote healing of prior to and after the development of the pressure ulcer. On 8/14/2015 it was noted that R30 developed a pressure ulcer to the left toe due to crossing over of the toes. This was found 5 days post the last skin assessment where there were no skin concerns noted. Wound team implemented Tubi-foam treatment at the time of the identification with the pressure ulcer and since has been resolved on 9/2/2015. R30 was identified as a risk and had interventions in place prior and after the development of the pressure ulcer. During a chart review; it is noted that resident has not sustained a pressure ulcer with in the last 2 years. Resident is non ambulatory, wears slippers and has not had any concerns in the past with this area. The skin assessment policy was reviewed and continues to be current. Nursing practice will remain the same with wound team following pressure ulcers and implement treatment plans post assessment and for an additional 2 weeks once resolved. Notification to the provider will occur per policy with any changes in resident condition. Standards of care continue to support resident repositioning every 1 to 2 hours pending individualized plan of care. All current residents in facility who are	

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 _____	08/20/2015

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 314	Continued From page 21 Catheter CAA dated 6/8/15, identified R105 had a fall on 4/5/15, resulted in a fracture of the left leg and required a leg cast. R105 developed pressure ulcers due to the cast, which required readjustments of the cast. The cast was eventually removed and a brace was put into place. R105's left leg fracture continued to not heal and was admitted to the hospital on 5/22/15 for a scheduled amputation of the left leg. R105's care plan, last revised 7/20/15, identified R105 was at risk for skin breakdown related to impaired cognition, impaired mobility, history of a cerebrovascular accident (CVA), dementia and incontinence. The care plan identified R105 had a history of stage 2 pressure ulcers (partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. may also present as an intact or open/ruptured serum-filled blister). The care plan also indicated the wound to the right second toe and right buttocks, and that R105 currently had a stage 3 pressure ulcer to the right toe bunion area which had resulted from rubbing on left foot cast. In addition, the care plan listed various interventions which included to turn and reposition every 2 hours and as needed, off-loading pressure for at least one minute, assistance of two staff for bed mobility, float right heel at all times in bed, and a pressure relief mattress. The care plan lacked any interventions prior to 4/17/15, to protect R105's right lower extremity skin integrity due to risks of the cast on the left lower extremity. Review of R105's East Care Plan provided by the facility, and identified as a care sheet for nursing assistants, directed staff to float right heel at all	F 314	identified with high risk for pressure ulcers were reviewed and care plan current with interventions to assist in prevention of pressure ulcers unless medically unavoidable. Comprehensive skin assessments were completed in the quarter or up to date. All nursing staff will be re-educated on skin policy, turning and repositioning expectations by 9/18/2015. Chart audits for quarterly comprehensive skin assessments, observation audits of resident turning and repositioning, and ongoing education will be completed as needed. All will be reported at the quarterly QA meeting. Responsible party: Resident care managers and MDS coordinators Corrective action completed by: 9/18/2015	

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 _____	08/20/2015

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 314	Continued From page 22	F 314		

times, reposition every 2 hours and as needed, and identified R105 as non ambulatory.

Review of R105's comprehensive skin assessment documented in 4/13/15 progress notes, indicated R105 had no open skin areas. The assessment identified R105 was at risk for skin breakdown and bruising due to impaired mobility, fracture to the left leg, impaired cognition, incontinence of the bowel and bladder, and daily use of Lovenox (blood thinner). A Braden Scale for Predicting Pressure Sore Risk was a 12, which placed R105 at high risk. The documentation identified R105's care plan had been reviewed, and no changes were made at that time, as appropriate interventions where in place.

Review of R105's progress notes from 4/1/15 to 8/19/15, lacked documentation of any further comprehensive skin assessments completed after 4/14/15.

Review of R105's Tissue Tolerance Test (TTT) (tool used to determine the skin's ability to tolerate pressure and to determine appropriate repositioning schedule)-lying, dated 4/12/15, revealed R105's left leg had been casted due to recent fracture and the test determined R105 required assist of 3 staff to reposition every 2 hours and as needed (PRN). The form identified no changes were done to the current care plan at that time.

Review of R105's TTT-lying, dated 4/15/15, revealed skin was intact at that time, no open or pressure areas and left leg remained casted. The form included every 2 hours repositioning and PRN and identified no changes to the current

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 _____	08/20/2015

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 314	Continued From page 23	F 314		

care plan was done at that time.

Review of R105's TTT-lying, dated 4/21/15, revealed R105 had an open wound to the inner right foot on bunion from rubbing on cast on the left foot. The form identified the care plan was changed at that time to include to separate legs with a pillow.

On 8/19/15, at 7:03 a.m. R105 was observed lying on the left side in bed, with covers pulled up to shoulders. R105's right foot/bunion area was turned inward and rested on the mattress of the bed. At 7:30 a.m., R105 remained lying on the left side covered with a blanket, with the right foot/bunion area turned inward, both the inner aspect of the foot and heel were observed to rest directly on the mattress. At that time, nursing assistant (NA)-D and nursing assistant (NA)-E entered the room and started R105's morning cares. NA-D and NA-E removed a splint from R105's left hand, pulled down the blankets, removed pillow from under R105's left knee stump and a pillow was removed from behind R105's back. R105's right foot/bunion area remained turned inward, with both the inner aspect of foot and heel resting directly on the mattress. R105's right foot/bunion area was observed with a less than one centimeter in diameter, light brown, intact scab with pink skin surrounding the scab present on the right great toe/bunion area. R105 did not have a pillow in place to elevate the right foot, and R105's pressure ulcer on right great toe rested directly on the mattress. R105's right foot/bunion area and heel continued to rest on the mattress during the remainder of morning cares. Registered nurse (RN)-F briefly entered the room and administered medication to R105 and proceeded to exit the

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 _____	08/20/2015

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 314	Continued From page 24	F 314		

room. RN-F did not reposition R105's foot/bunion area and did not direct staff to reposition R105's foot/bunion area from resting directly on the mattress.

At 7:45 a.m. on 8/19/15, NA-D and NA-E were observed to assist R105 to roll from side to side to dress R105's upper body, then proceeded to reposition R105 in the bed and completed incontinence and perineal cares, and dressed the lower half of R105's body.

On 08/19/15, at 7:51 a.m. NA-D confirmed R105 had an open area at the bunion/sore on the side of the right foot. NA-D stated staff try to keep the area off the bed and open to the air. NA-D stated R105 required assist of two staff for bed mobility, transfers and utilized a hoyer (full mechanical lift).

At 8:03 a.m., NA-D and NA-E transferred R105 from bed to recliner chair utilizing a mechanical lift. NA-D applied a gripper sock to R105's right foot and repositioned the resident in the reclining chair. R105's right foot was positioned to rest directly on the surface of the leg rest of the recliner. At 9:10 a.m., R105 remained in the reclining chair in the room, with R105's right foot directly resting on the foot rest of the chair. At 10:07 a.m., R105 was observed to be lying flat in the reclining chair in her room. R105's right foot and heel remained resting directly on the surface of the leg rest of the recliner.
R105's right heel/foot was observed to rest directly on the recliner, without use of a pillow or pressure relieving device for the entire observation from 8:03 a.m. to 10:07 a.m.

On 8/19/15, at 8:37 a.m. RN-F confirmed R105 currently had a pressure area on right toe, and

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 _____	08/20/2015

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 314	Continued From page 25	F 314		

indicated she was unsure of the current stage or status of the pressure ulcer. RN-F stated the interventions for the pressure ulcer included floating the right heel all the time while in bed, and no shoes only slipper to right foot.

On 8/19/15, at 9:50 a.m. NA-E confirmed R105's right lower leg, right heel and right inner foot and toe were directly on the mattress upon removing blankets prior to performing morning cares. NA-E verified no pillow was present under R105's right foot,leg or near the right foot or leg to be used for positioning. NA-E confirmed there was a pillow behind R105's back and under the left stump/leg, and stated R105 had a sore on her right foot. NA-E confirmed staff were directed to use pillows to elevate R105's right foot. NA-E indicated the facility utilized a computerized system for documentation for R105's repositioning schedule and was not aware the last time R105 had been repositioned prior to completion of R105's morning cares.

Review of R105's Point Of Care (POC) Response History log dated 8/19/15, for turn and reposition for R105 revealed R105 had been repositioned at 1:57 a.m., at 8:00 a.m., and 10:00 a.m.

On 8/19/15, at 12:39 p.m. RN-G stated R105's abrasion had worsened to a pressure ulcer on the right great toe while in the hospital from rubbing the right foot bunion area onto the cast. RN-G stated the wound has gone through multiple stages, and was currently a scab, an unstageable pressure ulcer. RN-G indicated the current interventions included turning and repositioning every two hours and offloading, and to float the right foot/bunion area off the bed on a pillow.

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 _____	08/20/2015

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 314	Continued From page 26	F 314		

RN-G reported the facility's wound team performed wound care rounding to ensure identified interventions were in place and stated she was aware R105 had been observed with the right foot/bunion area and leg resting directly on the bed in the past. She indicated a pillow or cushion had not been utilized as directed by the care plan. RN-G reported in June of 2015, staff were re-educated to float (elevate off mattress) R105's right foot/bunion area and leg while in bed because of the current pressure ulcer and R105 remained at risk for further pressure ulcers. RN-G stated she would expect staff to float R105's foot off surfaces at all times.

Review of R105's Admission Assessment form dated 4/23/15, identified R105 had returned to he facility after surgery to left lower extremity. The form identified R105 had an abrasion to right inner bunion and a pinpoint scab on the right inner ankle. The form identified the pressure ulcer on the right bunion area as an abrasion, not a pressure ulcer.

Review of R105's Wound Care Flow Sheets from 6/11/15 to 8/19/15, revealed the following:

-4/24/15, stage 2 pressure ulcer on right greater toe present, which measured 1.0 centimeters (cm) in length, 1.6 cm wide and red to dark red in color and had a light scab over the top. The form listed various interventions which included float heels on cushion, and repositioning schedule every 2 hours and PRN.

-5/19/15, unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black)) pressure ulcer on right

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 _____	08/20/2015

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 314	Continued From page 27	F 314		

outer great toe, which measured 1.2 cm in length, 1.4 cm wide, 1.4 by 1.8 area of yellow slough with red to pink skin surrounding slough and listed various interventions which included every 2 hour repositioning, and to float heels on cushion.

-6/6/15, stage 3 (full thickness tissue loss subcutaneous fat may be visible but bone, tendon or muscle are not exposed) pressure ulcer on right outer great toe, which measure 1.0 cm in length, 1.0 cm wide and 0.2 cm deep, red/white in color, and listed various interventions which included to float right heel at all times and repositioning schedule every 1 hour and PRN with 2 staff.

-6/11/15, stage 3 pressure ulcer on right outer great toe present, which measured 0.4 cm in length, 0.5 cm wide , had epithelial tissue, was pink/red and listed various interventions which included repositioning every 1 hour with 2 staff and float right heel at all times.

-6/24/15, stage 3 pressure ulcer on right outer great toe present, which measure 1.0 cm in length, 0.9 cm wide and 0.1 cm deep, had light yellow/pink scab and listed various interventions which included repositioning every 1 hour with 2 staff and float right heel at all times.

7/3/1,5 stage 3 pressure ulcer on right outer great toe present, which measured 1.0 cm in length, 0.6 cm wide and 0.1 cm deep, had light yellow/pink scab and listed various interventions which included repositioning every 1 hour with 2 staff and float right heel at all times.

7/29/15, stage 3 pressure ulcer to right bunion, which measured 0.5 cm in length, 0.5 cm wide,

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 _____	08/20/2015

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 314	Continued From page 28	F 314		

light yellow/brown in color and listed various interventions which included repositioning every 1 hour with 2 staff and float right heel at all times.

-8/12/15, stage 3 pressure ulcer to right bunion, which measured 0.4 cm in length, 0.5 cm wide, had brown scab and listed various interventions which included repositioning every 1 hour with 2 staff and float right heel at all times.

Review of R105's progress notes from 4/14/15 to 8/19/15, revealed the following:

-4/14/15, R105's left leg casted, non-weight bearing status. Required assistance of three for positioning.

-4/15/15, weekly skin check after bath on 4/14/15. R105's skin intact at that time. no red or pressure areas noted. Cast on left leg due to fracture. R105 is assist of three to reposition every two hours in bed and as needed, R105 is incontinent of bowel and bladder, staff check and change every two hours and as needed.

-4/17/15, right foot noted to be bleeding. Small area of skin had been rubbed off from rubbing on cast, area measured 1.5 and was located on the inner aspect of right foot on bunion. Blood noted to inside of cast on left leg. Cleansed with NS (normal saline), applied Allevyn foam dressing to area for protection, to be changed every three days and as needed. Nurse manager assessed area on 4/17/15, skin red, slight blood noted, area of skin is noted to be an abrasion, lines up with R105's left leg cast that is on.

-4/24/15, R105 hospitalized 4/22 & 4/23 received new cast, new cast goes down to ankle, prior cast

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 _____	08/20/2015

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 314	Continued From page 29	F 314		

went down to the left toes. Wound team assessed R105's right outer great toe bunion area after return from the hospital, previous to hospitalization area was an abrasion, now a stage 2 pressure ulcer with pithily tissue noted and red.

-5/2/15, family came to get nurse stating resident had new pressure sore noted to left lower extremity. Nurse notes upon assessment resident noted to have sore to left heel 1.2 cm x 0.8 cm. Family stated this is an old sore that is smaller than it was. Family pointed out a new sore on the back of R105's left lower leg just above the heel where the bottom of the cast meets the skin. The area measured 3 cm x 3.5 cm of red area with a brown colored firm sore in center which measured 1.2 cm by 1 cm. Nurse applied padded dressing to area, sliding padding as far under casted area as possible. The note identified R105's bony prominence on the inner right foot area was open which measured 1 cm x 1 cm, white in color with light red surrounding area.

-5/8/15, back of left heel 1.2 cm x 0.8 cm and back of left lower leg above heel 3 cm x 3.5 cm area redness with 1.2 cm brown sore in center.

-5/26/15, R105 had returned from hospital after left above the knee amputation due to non healing pressure ulcers. Pressure sore to right foot inner bony prominence of great toe which measured 1.5 cm x 1.5 cm.

On 8/20/15, at 7:58 a.m. RN-F indicated she was unaware staff were not following R105's care plan to float the foot/heel at all times. RN-F indicated facility staff utilized a computerized system for documenting R105's repositioning schedule and confirmed the documentation on 8/19/15,

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 _____	08/20/2015

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 314	Continued From page 30	F 314		

revealed R105 had not been repositioned timely. She stated, "If it is not documented, it is not done."

On 8/20/15, at 1:59 p.m. RN-E stated R105 had required extensive assistance of two or three for bed mobility at the time R105 had a cast on left leg. RN-E stated she was working the day R105 was discovered with blood on the right toe, confirmed the skin damage was from rubbing against R105's left leg cast and was considered an abrasion at that time. RN-E confirmed R105's care plan at that time did not direct staff to separate legs and feet with pillow and stated after the abrasion was discovered, staff attempted to keep R105's legs apart with a pillow. RN-E stated positioning with a pillow between the legs would not be specifically identified on the care plan and would be considered part of bed mobility. RN-E confirmed R105's care plan prior to the development of the pressure ulcer on the right great toe/bunion area did not include any identified interventions to prevent the further development of pressure ulcers for R105.

On 8/19/15, at 2:26 p.m. the director of nursing (DON) verified she expected all staff to implement care plan interventions to prevent pressure ulcers and promote healing of pressure ulcers. The DON confirmed staff were expected to have elevated R105's foot while in bed. She indicated the facility utilized a computerized system for documenting cares provided and indicated she felt the staff were not consistently documenting in the system. The DON stated the facility is starting to roll out a new project with ipads which will would make it easier for staff to document each time cares are provided.

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 _____	08/20/2015

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 314	Continued From page 31	F 314		

Review of the facility's Skin Assessment policy dated 1/03 with a revision date of 7/2015, identified a resident admitted to the facility will receive the necessary treatment and services to promote healing and prevent new ulcers from occurring. The facility goal was all residents who enter the facility without pressure ulcers do not develop them unless the clinical condition demonstrates the pressure ulcer was unavoidable. Further the policy identified a resident who scored a Braden of high risk (10-12) or higher to protect heels. In conclusion, the policy identified if a problem is identified the nurse will notify the practitioner within 24 hours for documentation and orders. The decision tree attached to the policy also directed staff to obtain MD (medical doctor) orders for treatment, initiate the wound care flow sheet, weekly skin assessments, put on TAR (treatment administration record), perform a comprehensive assessment in progress notes and update the care plan.

R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which included Alzheimer's disease and hypertension. The MDS identified R30 had severe cognitive impairment, required extensive assistance or was totally dependent on staff for all activities of daily living (ADLs), was always incontinent and was at risk for developing pressure ulcers.

R30's Care Area Assessment (CAA) dated 9/9/14, identified R30 had Alzheimer's dementia, advanced age, edema, pain and osteoarthritis which caused R30 to be non-ambulatory. The CAA further identified R30 had a history of a pressure ulcer to her coccyx, was at risk for further skin breakdown, and had weekly skin

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 _____	08/20/2015

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 314	Continued From page 32	F 314		

assessments done. R30's skin interventions included: apply aquaphor to legs and arms, turn and reposition every 2 hours, use a ROHO cushion (wheelchair seat air cushion) in her wheelchair.

R30's care plan (CP) dated 8/5/15, identified R30 was at risk for skin breakdown due to dementia, incontinence, impaired cognition, knee brace use, impaired mobility, bunion pain with right shoe, and history of stage II pressure ulcer to coccyx. The goal was to minimize her risk for pressure ulcers. CP interventions included: turn and reposition every 2 hours and as needed, skin assessments per policy, lotion arms and legs twice per day with cares, observe for skin changes when providing cares and provide prompt treatment, treatments as ordered to any areas of impaired skin integrity, and ROHO cushion in her wheelchair. The CP failed to identify R30's newly developed stage III pressure ulcer to left 2nd toe, or the tubigrip to protect the current pressure ulcer.

Review of progress notes from 8/8/15 to 8/14/15, revealed:

-On 8/8/15, R30's weekly skin check had been completed and skin was intact.

-On 8/13/15, a rehab aide came to the nurse and stated during range of motion (ROM) R30 was yelling out in pain. Staff touched toes and pain noted. A 0.8 cm by .9 cm abrasion was noted, area was blanchable, not hard, notified Clinical Manager (CM)-A and applied bandage to left second toe.

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 _____	08/20/2015

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 314	Continued From page 33	F 314		

-On 8/14/15, CM-A assessed R30's left toe, 0.5 cm by 0.4 cm, by <.01 cm., wound bed adherent with granulation tissue present, tubigrip applied.

Review of R30's Tissue Tolerance Test (TTT), dated 8/15/15, identified a pressure sore to the left second toe with interventions of turning and repositioning every 2 hours and tubigrip to toe.

On 08/19/15, during continuous observation from 7:30 a.m. to 10:07 a.m., R30 remained in the same position in her tilt and recline wheelchair for 2 hours and 37 minutes without repositioning and lacked application of tubigrip to the left toe.

-7:30 a.m. nursing assistant (NA)-A and nursing assistant student (NAS)-A entered R30's room and woke R30 from sleep to perform morning cares. NA-A stated they used a hoyer lift for her as she is a total assist with transfers. NA-stated R30 used to wear a little sleeve, "foamy" thing on her toe, but the toe looked better now and confirmed R30 did not have the foam sleeve on at present time. R30's 2nd toe on left foot, was observed to have a small blackened, scabbed area on top of her 2nd toe. The 2nd toe was sticking up and above other toes, resting on top of first toe with no tubigrip present. NAS-A applied Ted hose and put gripper socks over both feet. A tubigrip dressing was not observed to be applied to her toe prior to the application of the Ted hose or gripper socks. NA-A applied a knee brace to R30's left knee and proceeded to place the left heel back on the bed. NAS-A assisted R30 to transfer into a recline and tilt wheelchair. A ROHO cushion was observed on the seat of the chair. After R30 was seated, NAS-A assisted R30 to the dining room.

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 _____	08/20/2015

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 314	Continued From page 34	F 314		

-7:45 a.m. R30 seated in her wheelchair at a dining room table in the back of the dining room. R30 remained in the same position in the wheelchair with gripper socks and Ted hose on both feet on the footrests of the wheelchair.

- 8:14 a.m. R30 remained seated in the wheelchair at the dining room table.

-8:43 a.m. R30 seated at the dining room table in her wheelchair.

9:17 a.m. R30 seated at the dining room table in her wheelchair.

-9:46 a.m. R30 seated at the dining room table in her wheelchair.

-10:07 a.m. facility staff wheeled R30 away from the table, and positioned R30's wheelchair facing the dining room doorway. R30 remained seated in the same position in the wheelchair. R30 had not been repositioned from 7:30 a.m. to 10:07 a.m. (2 hours and 37 minutes) when observations ended. Staff did not apply tubigrip to R30's left toe for the entire observation.

On 08/19/15, at 1:15 p.m. NA-B confirmed R30's current CP, and stated she was unaware R30 was on a current repositioning program. NA-B stated she was unaware R30 was to have a tubigrip for her toe.

On 08/19/15, at 1:49 p.m. NA-A stated she had last repositioned R30 at 10:30 a.m. and had not repositioned R30 from 7:30 a.m. until 10:30 a.m. (3 hours). She was unaware R30 was on a repositioning program or was to have a tubigrip

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 _____	08/20/2015

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 314	Continued From page 35	F 314		

on her toe.

On 08/19/15, at 2:45 p.m. CM-A, CM-B, Minimum Data Set Nurse (MDSN)-B and registered nurse (RN)-C (Wound Team), confirmed the team had just completed R30's weekly wound evaluation. The group confirmed R30 had developed a stage III pressure ulcer to her left 2nd toe because her toe crossed over the great toe and the "bone was right there." They stated initially the open area was assessed as an abrasion, and after the wound team assessed the area it was identified as a new stage III pressure ulcer. No one on the team was able to confirm at that time if her care plan identified the pressure ulcer, or if she was on a repositioning program. The group confirmed R30's tubigrip had not been on R30's toe all day until wound rounds when they put it on. They stated the tubigrip was an intervention to be utilized to treat R30's her pressure ulcer, but there was not an order from the physician for it. The group stated there should be doctor's orders for the pressure ulcer, but they were not sure. CM-A stated she would check and provide any additional information.

On 08/20/15, at 8:00 a.m. during a follow-up interview, CM-A confirmed R30's CP and stated the pressure ulcer and the tubigrip were not identified on R30's CP or R30's treatment administration record (TAR) until after the interview on 8/19/15. CM-A confirmed R30 had developed a new stage III pressure ulcer to her left second toe from the pressure of the big toe on 8/14/15, and the physician had not been notified and the care plan had not been updated. She also stated R30's tissue tolerance test had been done on 8/15/15, but the CP and orders

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 _____	08/20/2015

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 314	Continued From page 36 were not changed. She stated she wrote a note to the general nurse practitioner (GNP) on 8/14/15, but the GNP went on maternity leave and did not get it. She confirmed the physician had not been notified until 8/19/15 of the pressure ulcer. She reviewed the most recent MDS and confirmed R30 was at risk for pressure ulcers, and the MDS incorrectly identified not history of pressure ulcers. She confirmed R30's CP did identify she was to be repositioned every 2 hours, and was at risk for skin breakdown. She stated she would expect R30 to be repositioned every 2 hours. Review of the facility policy titled, Skin Assessment, dated revised 7/2015 identified a resident admitted to the facility would receive the necessary treatment and services to promote healing and prevent new ulcers from occurring. Further it identified, a resident who was admitted to the facility without pressure ulcers would not develop them unless the clinical condition demonstrates the pressure ulcer was unavoidable. The policy identified if a problem was identified the nurse would notify the practitioner within 24 hours for documentation and orders. The decision tree attached to the policy also directed staff to obtain MD orders for treatment, initiate the wound care flow sheet, weekly skin assessments,transcribe the order to the resident's TAR, perform a comprehensive assessment and update the care plan.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		9/18/15

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 _____	08/20/2015

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 323	Continued From page 37 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a safe environment utilizing a mechanical lift and sling for 1 of 4 residents (R30) reviewed for accident hazards. Findings include: R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified R30 had diagnoses which included Alzheimer's disease. The MDS identified R30 had severe cognitive impairment, required extensive assistance or was totally dependent on staff for all activities of daily living (ADLs). R30's Care Area Assessment (CAA) dated 9/9/14, identified R30 had diagnoses which included Alzheimer's disease, dementia, arthritis, macular degeneration, edema, history of epitaxis and surgical repair of the left knee after dislocation that made R30 immobile. The CAA identified R30 utilized a head tilt and recline chair (HTR), was propelled by staff to all destinations, a hoyer lift was used for transfers, wore a hinged knee brace to her left knee when out of bed, had contractures to to both ankles, was at risk for falls, and was at high risk for bruising and bleeding due to taking baby aspirin daily. The CAA directed staff to provide a safe environment to prevent falls and injury, assist with activities of daily living (ADLs) and to reorient and redirect as needed.	F 323	F323 Free of accident hazards Staff were re-educated on sizing and identification of slings on 8/27/2015. All hoyer slings in facility had a permanent sizing label attached for easy identification by 8/28/2015. All residents using hoyer lifts were assessed for correct sizing of sling for use and added to care plans. Sizing charts for sling use were located in all nurses stations and will be added to all linen rooms where the extra slings are located. A 3 ring binder has been added to nursing units with most manufacture up to date information to be used as a reference. The safe patient handling act policy was reviewed and remains current. The hoyer/standing lift policy will be updated to include proper sizing of hoyer slings. All nursing units will be re-educated on policy expectations with competency completed by 9/18/2015. Observations on transfers and ongoing education will be completed as needed with staff and chart audits will be completed for proper sling identifications on care plan with reporting to the quarterly QA meeting.	

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 _____	08/20/2015

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 323	Continued From page 38	F 323		

Review of R30's current care pain (CP), dated 8/5/15, identified R30 was at risk for falls, did not ambulate, required assist of 2 with a hoyer lift for transfers, had intermittent periods of lethargy, and was confused. The CP directed staff to anticipate and meet her needs as needed, and follow her individual plan of care. The CP further identified R30 was a vulnerable adult due to her inability to cope with potentially harmful situation, and will live in a safe environment.

Review of R30's progress notes from 8/1/15 to 8/20/15 revealed a note on 8/12/15 that identified R30 had bumped her head into the hoyer lift bar when staff were transferring her that morning. A dark purple bruise was noted immediately to her right forehead measuring 2.8 cm X 3.0 cm. No further documentation was found regarding R30's incident on 8/12/15.

On 08/19/15, at 7:30 a.m. nursing assistant (NA)-A and nursing assistant student (NAS)-A entered R30's room and provided morning cares. NA-A and NAS-A rolled R30 on her left side and put a maroon divided leg sling, measuring appropriately 2' wide and 3.5 feet long under R30 and rolled her on her back on top of the sling. NA-A proceeded to wrap the leg straps around R30's thighs and attached the loops of the straps and sling to the lift. NA-A was at the head of R30's bed and begun operating the mechanical lift. NA-A lifted R30 about 12 inches off the bed. R30 was quiet, and rested both of her hands in her lap. The bottom of the sling was observed to be at crease of R30's buttock cheeks, at the top of her thighs. R30's body was tilted forward in the sling, with both legs hanging down from her hips with both feet pointed downward. R30's legs and

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 _____	08/20/2015

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 323	Continued From page 39	F 323		

feet were observed to drag across the bed during the transfer. NAS-A and NA-A remained at the head of the bed operating the lift, while R30 was transferred from the bed to the chair. NA-A and NAS-A did not provide or offer physical assistance with body positioning for R30 for the entire transfer. R30 remained in the poor body position during the entire transfer to the wheelchair. R30 was observed to have a large, dark purple bruise at her right temple area which measured approximately 3 inches wide by 2 inches long. NA-A indicated R30 has sustained any injury utilizing the mechanical lift in the past and stated, "The hoyer lift bumped her in the head, they must have hit her pretty hard, hopefully it wasn't too hard."

On 08/19/15, at 1:05 p.m. during observation, NA-B and NAS-B brought R30 to her room to transfer her into bed. A mechanical lift was brought to the room, and NA-B proceeded to apply a maroon colored sling under R30. NAS-A applied sling straps between R30's legs, and hooked loops of sling to the lift. R30's body was observed to tilt forward, and the bottom of the maroon sling was observed at the crease of R30's buttocks at thighs. R30's legs were hanging down, and feet pointed downward. R30 remained in the poor body position, with feet pointed downward, during the entire transfer to the bed. At that time, NA-B stated R30 did not have a designated sling for use, and stated if the sling the staff were using got soiled, she would go to the utility room and get another sling.

On 08/19/15, at 1:15 p.m. during follow up interview, NA-B stated she thought the maroon sling used for R30 was either a size large or extra large sling. She stated she felt it was not so much

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 _____	08/20/2015

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 323	Continued From page 40	F 323		

a specific size of sling, but the poundage listed on the tag. NA-B examined the maroon lift sheet previously used for R30's transfer and confirmed the sling tag was unreadable due to fading. NA-B stated, "Normally it will say the size and weight on the sling tag, but you can't read the tag for this one." NA-B stated she felt as long as the resident sat comfortably in the sling she would use it.

On 08/19/15, at 1:49 p.m. during interview, NA-A stated they don't use a specific size sling for R30. She stated, "I determine the correct sling size by holding it up and looking at it to decide which one to use." She stated she thought they used a medium size sling for her. She stated, "I just hold it up, I don't know if they have sizes in them."

On 08/20/15, at 7:05 a.m. NA-A stated she had a little bit of training on sling use during new employee orientation. She stated, "There are different color slings, but I don't think the colors mean anything."

On 08/19/15, at 2:45 p.m. clinical manager (CM)-A, CM-B, minimum data set nurse (MDSN)-B, and registered nurse (RN)-C (wound team) indicated they were unable to provide any information as to how staff know how to select the proper sling for residents or what education the staff received regarding sling use and safety. CM-A stated she thought the sling color guide was in the nurses communication book at the nurses station, but was not sure.

On 08/20/15, at 3:38 p.m. during interview with MDSN-A and CM-A, CM-A confirmed R30's bruise on her face measured 6.9 cm X 3.5 cm. She confirmed the progress note on 8/12/15 was the only documentation related to R30's accident

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 _____	08/20/2015

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 323	Continued From page 41	F 323		

and injury during cares from the mechanical lift. She confirmed there was no additional documentation, investigation or follow up after the accident. MDSN-A and CM-A both confirmed the sling sizing chart with the slings were available in the clean utility room of the facility and provided a copy of the sizing chart titled Volaro Sling sizing chart. CM-A stated, "I'm not exactly sure where we all have these charts." They confirmed sling size using the posted chart did not match the colors of the slings they had available. CM-A confirmed the bright blue sling on the rack was a size small, but was to be tan according to the chart. CM-A and MDSN-A examined 3 resident slings, which the residents were utilizing in the dining room and all of the slings were unable to accurately identify size because the tags were either faded or missing.

On 08/20/15, at 4:38 p.m. during interview of the director of nursing (DON) and the Executive Director, the DON stated she had just got off the phone with RN-B and he said R30 had bumped her head on the hoyer lift on Wednesday morning on 8/12/15, and after the accident R30 had no concerns. DON confirmed she was not aware of the incident with R30 and the mechanical lift until immediately prior to the interview. Both the DON and administrator agreed that there was not a system in place for choosing the correct sling, and that there should be a system in place for staff to choose the appropriate size sling for residents to prevent further accidents. DON confirmed and provided sling use policy and referenced standards of care documentation.

The Pro-Lift User's Manual dated 09/19/00, listed Cautions for use of the Pro lift device which included: **IMPORTANT** USE ONLY PAL

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 _____	08/20/2015

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 323	Continued From page 42 SLINGS AND ACCESSORIES DESIGNED FOR THE PAL-PRO-LIFT MODEL. The manual directed staff to make sure the correct size sling is to be applied, pull padded legs along each side of sling, and wrap inside thigh areas close to the groin area. The manual further identified the divided leg sling should be observed to be in the correct position before lifting a person, and to determine the proper size of the sling by laying the sling across the person's chest. It also identified the slings have a color coded border to easily indicate the size of the sling (purple for small, raspberry for medium, teal for large, and black for extra large). The Use of Nursing Procedure Reference Manual Policy, dated 2014 identified the facility nursing procedures were taken from "Clinical Nursing Skills and Techniques", 8th Ed., Anne Perry, Patricia Potter, and Wendy Ostendorf, 2014 Mosby, Inc. the facility provided copies of the reference, which included images of residents in recommended sling position, resident cradled in sling, tilted back and sling coming directly to the knee. In the safe patient handling, transfer and positioning page 198, identified patients were at risk for complications from improper positioning and have an increased risk of injury during transfer, including residents with alterations in bone formation or joint mobility, and impaired muscle development. The reference also identified if there is an incident that caused injury to evaluate the cause (inadequate assessment, change in patient status, improper use of equipment) and complete and incident report according to agency policy.	F 323		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		9/18/15

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 _____	08/20/2015

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 425	Continued From page 43 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the safe administration of medications for 1 of 1 residents (R17) observed to have medications left in a bowl of hot cereal without continuous observation of ingesting of the medications. Findings Include: R17's significant change Minimum Data Set (MDS) dated 7/13/15, identified R17 had diagnoses which included psychosis, Alzheimer's disease, anxiety state and depression. The MDS identified R17 had both short and long term	F 425	F 425- Pharmaceutical procedure Care Plan for R17 was reviewed and noted that crushed medications and mixed with food was added to care plan on 3/27/2013. Concealed medications were added to care plan on 5/15/2015. R17 has a provider order to conceal and crush medications. Nurse who placed crushed concealed medication in meal with out direct observation of ingestion was initially re-educated on expectations of medication administration practices on 8/24/2015.	

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 _____	08/20/2015

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 425	Continued From page 44 memory problems, had inattention, disorganized thinking and had moderately impaired skills for daily decision making. The MDS identified R17 required extensive assistance with dressing, grooming, toileting and total assistance with ambulation and transfers. In addition, R17 required supervision, (one staff assist) with eating which included set up of her food items, encouragement to eat or cueing R17's Care Area Assessment (CAA) dated 7/16/15, indicated R17 was not able to make needs known, needed to anticipate and meet all needs, rarely understood and rarely understands what was said to her. R17 didn't talk much if any and staff continued to anticipates her needs. R17's undated care plan provided by the facility identified R17 had a short and long term memory loss, needed assistance to make safe decisions daily, was hard of hearing and rarely understood what was said to her and rarely made self understood. The care plan did not address the crushing of medications and placing them in food. During observations of medication administration on 8/20/15, at 7:57 a.m. R17 was seated at a table in the dining room, with a bowl of hot cereal on the table in front of her. Licensed practical nurse (LPN)-A was observed to place R17's medications in a medication cup, crushed the medications and approached R17, put them into R17's cereal and stirred the medications into the cereal. LPN-A had left the table without observation if R17 had ate the cereal the medications were placed in. The medications were Senna 50 mg (laxative) and Seroquel 75 mg (antipsychotic). There were residents sitting on	F 425	Medication administration and concealed medication policy were both reviewed and remain current. All current residents in facility with orders for concealed and crushed medications were reviewed and are in compliance with current care plan expectations. All nursing staff will be re-educated on policy expectations by 9/18/2015. Ongoing education will be completed as needed with staff and observational audits of medication pass will be completed which will be reported at quarterly QA meeting. Responsible Party: Resident care managers Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 425	Continued From page 45	F 425		

both sides of R17 at the dining room table.

On 8/20/15, at 7:57 a.m., LPN-A stated she puts R17's crushed medications in her cereal and either a nurse or a nursing assistant (NA) will watch if she eats her cereal.

On 8/20/15 at 8:41 a.m. LPN-B who was sitting at the dining room table and assisting R17's table mate on R17's right side, was observed to get up from R17's table and push a resident out of the dining room. LPN-A continued to deliver medications to the other residents in the dining room. NA-C was observed sitting at R17's table and assisting a resident on R17's left side.

At 8:44 a.m., LPN-B had brought a resident into the dining room and placed her at R17's table and then reminded R17 to eat all of her cereal that had the medication mixed into it. There had been no continuously monitoring by a licensed staff of R17 eating her cereal during that time period that LPN-B was not at the table.

During observation at 8:54 a.m. and 9:14 a.m., R17 was not eating the cereal with the medications mixed in it and LPN-B had remained at R17's table.

During interview on 8/20/15, at 9:54 a.m. LPN-B stated R17 had medication in her malt o meal and had ate all of her cereal but it took a while. LPN-B stated some one should be at the table at all times when R17 has medication in her cereal, unless they self administer medications but that does not pertain to R17. LPN-B stated the medication nurse passing medications should watch that the medications are taken by the resident. LPN-B stated she does not know the

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 _____	08/20/2015

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 425	Continued From page 46	F 425		

policy if a NA could watch a resident take the medications if the medications are in the resident's food.

When interviewed on 8/20/15, at 10:04 a.m. NA-C stated she was in the dining room from 8:00 a.m. to 8:45 a.m., and had been assisting 2 different residents at R17's table, one on R17's right and left side. NA-C stated she does not pass medications at all. NA-C stated she does not monitor if a resident has taken their medication and she cannot do that. NA-C stated no one had asked her to monitor R17 to see if she had taken in all of her food. NA-C said LPN-B had brought a resident out of the dining room and brought another one in, but NA-C said she had received no direction from LPN-B to monitor any resident.

During interview on 8/20/15, at 10:15 a.m. register nurse (RN)-D stated licensed staff can pass medication. RN-D stated if there is an order to put the medications in the food the nurse should be with them when they are taking it.

During interview on 8/20/15, at 10:21 a.m. LPN-D stated trained medication aide (TMA) or nurses are allowed to pass medications and monitor. LPN-D verified a NA could not watch a resident eat their food that had medications in it.

When interviewed on 8/20/15, at 3:41 p.m. the director of nursing, (DON) stated when the medication is given to a resident you need to watch them swallow it. The DON stated a NA cannot monitor if the resident takes the medication. She stated if the medications is concealed in the food they need to watch the resident swallow it. DON verified a NA could not watch a resident take in medication that is in

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 _____	08/20/2015

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 425	Continued From page 47 food. DON verified the medication was not to be left in R17's cereal and to have the NA monitor it. Review of the policy and procedure titled: Use Nursing Procedure Manual Preferences indicated to see the Nursing Procedure Reference Manual, with no date on it. The policy indicated nursing procedures at Eventide are referenced to a standardized book. The focus of the book references procedures directly involving the resident. Procedures reflect currently accepted practices. The book is tilled Clinical Skills and Technique Book, edition 8th. The current reference date was 2014. It indicated to stay with the patient until medication is taken.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		9/18/15

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 _____	08/20/2015

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 441	Continued From page 48 isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to perform proper hand-washing to prevent the potential for cross contamination after providing care for 1 of 4 residents (R30) observed during personal cares. Findings include: R30's quarterly Minimum Data Set (MDS) dated 6/9/15, identified she required extensive assistance with activities of daily living (ADLs) and had severe cognitive impairment. During observation on 8/19/15, at 7:30 a.m. nursing assistant (NA)-A and nursing assistant student (NAS)-A entered R30's room to perform morning cares. NA-A wore disposable gloves on both hands, and proceeded to assist R30 to wash her face, removed matter from both eyes with a wash cloth, and immediately after washing R30's	F 441	F 441-Infection Control On 8/28/2015 hand hygiene expectations was initially re-educated with employee caring for R30. Hand sanitizers will be added to all soiled utility rooms near door by 9/18/2015. Wash basins will be wiped out with disinfectant wipe prior to replacing in the residents drawer after each use. Standards of care, perineal care, glove guidelines for wearing and hand-washing policy were reviewed and remain current. All nursing staff will be re-educated on proper hand-washing techniques/expectations, use of disinfectant wipes, and glove use during personal cares by 9/18/2015. Ongoing education will be completed as needed	

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 _____	08/20/2015

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 441	Continued From page 49 eyes, reached over and dropped the dirty wash cloth into a clear plastic bag on the floor next to R30's bed. NA-A proceeded to remove R30's incontinent product, which was soiled with a large amount of brown feces, performed perineal cares and immediately dropped the soiled incontinent product and disposable wipes into another clear plastic bag lying on the floor. With the same dirty gloved hands, NA-A immediately opened up a drawer on R30's night stand and removed a box of disposable cloths. NA-A continued to cleanse R30's perineal area, and after the stool was removed, NA-A would drop each dirty wipe into the dirty incontinent product lying on the floor. After NA-A had completed perineal cares for R30, she removed both dirty gloves and discarded the dirty gloves into R30's trash can next to the night stand. NA-A immediately reached out, removed 2 disposable gloves from a box of gloves on R30's night stand. NA-A brought her left hand to her mouth, licked her index finger, and applied a disposable glove to her right hand. She then proceeded to apply a fresh disposable glove to her left hand. NA-A proceeded to assist R30 to dress, and both NA-A and NAS-A assisted R30 to transfer to a wheelchair. NA-A had not performed hand hygiene during the entire observation. At 7:45 a.m., NAS-A assisted R30 to the dining room for breakfast. NA-A remained in R30's room. She picked up the bag of dirty linen and the bag of dirty supplies used for incontinence cares from the floor and closed both dirty bags and dropped them back on the floor. NA-A took a pink basin used during cares into the bathroom and drained the water into the toilet. She proceeded to reach over and remove a paper towel from the holder in the bathroom, wiped out	F 441	with staff and observational audits for compliance will be completed which will be reported at quarterly QA meeting. Responsible Party: Resident care managers Corrective Action Completed by: 9/18/2015	

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 _____	08/20/2015

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 441	Continued From page 50	F 441		

the basin and immediately returned the basin to R30's closet without any disinfection of the basin. NA-A removed the disposable gloves from both hands, washed both hands in the bathroom and proceeded to pick up both plastic bags on the floor and exited R30's room.

At 7:50 a.m. NA-A walked down the hallway and entered a soiled utility room and placed the plastic bags into bins in the soiled utility room. Without performing hand hygiene, NA-A immediately exited the soiled utility room door. NA-A approached R36 in the hallway outside of the soiled utility room, grabbed R36's left hand and assisted R36 to walk down the hallway to the dining room. NA-A assisted R36 to transfer to a chair in the dining room, immediately started to set up food and beverage items for R36's meal. NA-A had not performed hand hygiene for the entire observation.

During interview on 08/19/15, at 1:49 p.m. NA-A confirmed she had not performed hand hygiene appropriately during R30's morning cares, disposing of dirty supplies and linens. She stated she should have washed her hands after handing the dirty linens and supplies. NA-A stated she usually completed hand hygiene, however, stated she had not completed hand hygiene because it was "crazy today."

During interview on 08/20/15, at 8:00 a.m. clinical manager (CM)-A stated the usual facility practice was to perform hand hygiene after handling dirty items, between cares and more if needed. She stated she would expect NA-A to sanitize the wash basin after use, and would have expected staff to perform hand hygiene between cares and after handling bags of soiled supplies.

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 _____	08/20/2015

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 441	Continued From page 51 Review of the facility's policy titled Standards of Care, dated 5/2013, revealed soiled linens should not be placed on the floor of a resident's room, and all staff must perform hand hygiene according to Hand Washing Policy. Review of the facility's Hand Hygiene Policy, dated 11/20/13, directed staff to complete hand hygiene before and after resident contact, before any clean procedure, after every dirty procedure and as needed to prevent the spread of infection.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Eventide Lutheran Home Building 01 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

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

Electronically Signed | 09/18/2015

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2015**

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
K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two building: Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961, is 1 story without a basement, and was determined to be of Type II(222) construction. In 1977, a 3-story addition, without a basement, was constructed north of the original building, and was determined to be of Type II (222) construction. In 1978 an administrative office building that is one story with a basement was constructed to the east of the original building for administrative offices, is separated with a 2-hour fire barrier, does not have any resident use and is a business occupancy. In 1992 an addition was constructed to the north of the 1977 building which is 3-stories, with a basement, was determined to be a Type II (222) building and was separated with at least a 2 hour fire barrier. The facility is divided	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2015**

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
K 000	Continued From page 2 into sixteen smoke zones by 30 minute and 90 minute fire barriers. In 2013 a PT/ Wellness building was added to the north west of the original building. It is 1-story , no basement and Type II (111). The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinklers 1999 edition. The facility has a fire alarm system with corridor smoke detection and smoke detection in common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 195 beds and had a census of 187 at the time of the survey.	K 000		
K 052 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052		9/18/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/21/2015**

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
K 052	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with NFPA 101 Life Safety Code (00), Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72 National Fire Alarm Code (99), Sections 3-9.4 and 7.1. These deficient conditions could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting residents, staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 08/21/2015, observation revealed that the elevator mechanical room located on the lower level for elevators 1 and 2 was not equipped with a shunt trip breaker or a heat detector. This deficient practice was verified by the Maintenance Supervisor (CS).	K 052	Vendors were contacted 09/11/2015 for proposal and cost estimates. Work will be completed based on availability of parts/vendor schedules.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **02 - PT/WELLNESS CENTER** B. WING _____	**08/21/2015**

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
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Eventide Lutheran Home Building 02 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was surveyed as two building: Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961, is 1 story without a basement, and was determined to be of Type II(222) construction. In 1977, a 3-story addition, without a basement, was constructed north of the original building, and was determined to be of Type II (222) construction. In 1978 an administrative office building that is one story with a basement was constructed to the east of the original building for administrative offices, is separated with a 2-hour fire barrier, does not have any resident use and is a business occupancy. In 1992 an addition was constructed to the north of the 1977 building which is 3-stories, with a basement, was determined to be a Type II (222) building and was separated with at least a 2 hour fire barrier. The facility is divided into sixteen smoke zones by 30 minute and 90 minute fire barriers. In 2013 a PT/ Wellness	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/18/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **02 - PT/WELLNESS CENTER** B. WING _____	**08/21/2015**

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
K 000	Continued From page 1 building was added to the north west of the original building. It is 1-story , no basement and Type II (111). The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinklers 1999 edition. The facility has a fire alarm system with corridor smoke detection and smoke detection in common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 195 beds and had a census of 187 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		