



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 8, 2023

Licensee
Eventide The Linden
1500 7th Street South
Moorhead, MN 56560

RE: Project Number(s) SL21014015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with

the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Jessica Chenze". The signature is written in a cursive, flowing style.

Jessica Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796
PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21014015 On May 22, 2023, through May 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 187 active residents; 95 of whom were receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 23, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in	0 485		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 485	Continued From page 2 advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a menu a week in advance that was made available to all residents on the secured unit (a unit requiring a key code to enter and exit). This had the potential to affect all 19 residents of the secured unit. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 22, 2023, at 11:27 a.m., licensed assisted living director (LALD)-A stated all meals were prepared on site by the licensee. On May 22, 2023, at 12:37 p.m., during the facility tour with executive director (ED)-D, the surveyor did not observe a posted weekly menu on the secured unit. ED-D stated a weekly menu was	0 485		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 485	Continued From page 3 not posted on the secured unit and was only available on the first-floor level (unsecured unit) for the residents to view. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 810	Continued From page 4 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 24, 2023, at approximately 12:15 p.m. with licensed assisted living director (LALD)-A, maintenance director (MD)-I, housing manager (HM)-J, and executive director (ED)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 810	Continued From page 5 actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
0 810	Continued From page 6 Provided documentation indicated that the only drills were not conducted every other month and failed to provide two drills on second shift and two drills on third shift. During interview, LALD-A, MD-I, HM-J, and ED-D verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01060	Continued From page 7 information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's service plan dated October 26, 2022, indicated R3 received assistance with medication	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01060	Continued From page 8 administration, dressing, grooming, toileting, bathing, laundry, and housekeeping. R3's discharge note dated April 13, 2023, indicated R3 had become acutely ill on March 21, 2023, and was admitted to the hospital. On April 11, 2023, R3 was discharged from the hospital and transferred to a transitional care unit (TCU) for hospice care. R3's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On May 23, 2023, at 2:02 p.m., licensed assisted living director (LALD)-A stated R3 had been hospitalized on March 21, 2023, and transferred onto hospice care at the TCU; "he didn't come back here". LALD-A stated she was unsure if a notice had been completed, "it would be per our policy ". LALD-A stated they had no documentation the OOLTC notification had been completed for R3 as required. The licensee's Admission and Discharge Criteria for Assisted Living policy dated August 2022, noted the facility must provide notice to OOLTC as soon as practical but within 24 hours if the resident has relocated and not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01290	Continued From page 9 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter with the correct affiliation for the assisted living facility for three of four employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01290		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE	
01290	Continued From page 10 CNS-B CNS-B was hired on November 7, 2019, and began providing assisted living services on August 1, 2021. CNS-B's background study dated December 30, 2019, indicated CNS-B was cleared, however, the background study was not affiliated with the assisted living license, but rather the nursing home license. ULP-C ULP-C was hired on November 26, 2018, and had begun providing assisted living services on August 1, 2021. On May 22, 2023, at 12:35 p.m., the surveyor reviewed the medication contents and temperature log for the assisted living medication refrigerator with ULP-C. ULP-C's background study dated November 7, 2018, indicated ULP-C was cleared, however, the background study was not affiliated with the assisted living license, but rather the nursing home license. ULP-G ULP-G was hired June 7, 2022, to provide assisted living services. On May 23, 2023, at 7:40 a.m., the surveyor observed ULP-G apply R7's ted stockings (TEDs) and administer morning medications. ULP-G's background study dated June 7, 2022, indicated ULP-G was cleared, however, the background study was not affiliated with the assisted living license, but rather the nursing home license.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01290	Continued From page 11 On May 23, 2023, at 1:48 p.m., vice president of clinical services (VP)-H stated the employees identified above were currently employed by the facility and the affiliation for the employee's background studies were affiliated with the entire campus (nursing home and assisted living) and not affiliated with the facility's license. A policy was requested, however, the employee handbook that was provided did not cover a cleared background study affiliated with the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01500	Continued From page 12 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01500	Continued From page 13 Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F was hired on October 6, 2020, and had begun providing assisted living services on August 1, 2021. On May 23, 2023, at 7:47 a.m., the surveyor observed ULP-F provide scheduled morning medication administration to R4. ULP-F's employee record did not include the following required annual training: -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; and -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On May 23, 2023, at 2:39 p.m., licensed assisted living director (LALD)-A stated the licensee provided everything they (the licensee) had for	01500		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01500	Continued From page 14 ULP-F's record and all of the required annual training had not been completed for ULP-F. A policy was requested, however, the policy provided did not address employee annual training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01880	Continued From page 15 On May 22, 2023, at 12:35 p.m., the surveyor reviewed the medication refrigerator located in the assisted living area, in a locked medication storage room with unlicensed personnel (ULP)-C. ULP-C stated the night shift records the temperature of the medication refrigerator every night on a paper log and the nurses monitor the log. The current temp was 40 degrees Fahrenheit (F). The Refrigerator Temp. Check log was lying on the top of the refrigerator clipped onto a clipboard. The temp log indicated the last date the temperature was checked prior to survey entrance on May 22, 2023, was May 18, 2023. The Refrigerator Temp. Check logs for April 1, 2023, through May 22, 2023, were reviewed with ULP-C. The temperature log for the refrigerator indicated seven days the temperature had not been checked or recorded and seven additional days the temperature had been recorded below freezing at 32 degrees. The medication refrigerator contained the following medications and was confirmed by ULP-C. - seven unopened Lantus 100 units units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) for R4; - two unopened Novolog 100 units/ml insulin pens for R4; and - 14 unopened Lantus 100 units/ml insulin pens for R10. The manufacturer's instructions for Lantus insulin pens dated November 2018, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Novolog	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01880	Continued From page 16 dated June 2021, indicated the unopened insulin pens should be stored in the refrigerator between 36 to 46 degrees F. Do not allow the Novolog to freeze. The licensee's Medications, Storage of policy dated April 2023, indicated the registered nurse (RN) would establish a system that addresses the storage and handling of medications to include how medications are received and secured and where medications will be stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained with legible information including the expiration date for time sensitive medications for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01890	Continued From page 17 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on May 22, 2023, at 11:27 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. On May 23, 2023, at 7:47 a.m., the surveyor observed unlicensed personnel (ULP)-F prime R4's Novolog pen (a multiple dose pen shaped injector device for insulin administration), drew up 15 units of Novolog, and handed R4 the Novolog pen to self-administer. R4's Novolog 100 units/milliliters (mL) pen was not labeled with the open date and ULP-F was not sure when the insulin pen was opened. ULP-F stated when a new insulin pen was opened it should be labeled. On May 23, 2023, at 1:47 p.m., clinical nurse supervisor (CNS)-B stated insulin pens should be labeled with the open date. The manufacturer's instructions for Novolog insulin pens dated October 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The licensee's Medications, Storage of [sic] dated April 2023, indicated medications would be stored bearing the original prescription label with legible information including the expiration date of time-dated drugs.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01890	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R3) upon discharge. This practice resulted in a level two violation (a	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01910	Continued From page 19 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 22, 2023, at 11:27 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R3's diagnosis included dementia. R3's service plan dated October 26, 2022, indicated R3 received assistance with dressing, grooming, toileting, bathing, laundry and housekeeping. R3's Assessment dated December 27, 2022, indicated R3 received medication administration services. R3's discharge note dated April 13, 2023, indicated R3 had become acutely ill on March 21, 2023, and was admitted to the hospital. R3's Medication Administration Record (MAR) for March 2023, indicated R3 received the following medications: -Allegra allergy tab 180 milligrams (mg) daily; -aspirin 81 mg daily; -atorvastatin 40 mg daily; -metoprolol succinate extended release (ER) 25 mg daily; and	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
01910	Continued From page 20 -triple antibiotic ointment to left buttocks two times daily. R3's discharge note dated April 13, 2023, indicated on April 11, 2023, R3 was discharged from the hospital and transferred to a transitional care unit (TCU) for hospice care. R3's record did not include documentation for the disposition of the above noted medications to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On May 23, 2023, at 9:19 a.m., LALD-A stated R3's record lacked the required content for the disposition of medications noted above. Additionally, LALD-A stated, "we don't have it. We changed to a logging system and he discharged prior to that". The licensee's Medication, Disposition or Disposal policy dated May 2021, noted upon a residents discharge the disposition of the resident's medications, including the medication name, strength, prescription number, quantity, to whom the medications were given or who disposed of them; and the names of staff or others involved in the disposition would be documented in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE
02310	Continued From page 21	02310		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were appropriate based on the needs of residents who reside in the secured unit at the facility with regards to safely storing chemicals. This had the potential to affect all 19 residents, staff, and visitors of the secured unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living with dementia care license. On May 22, 2023, at 12:34 p.m., during the facility tour with executive director (ED)-D, the surveyor opened the laundry room door (the door did not have a locking mechanism) and observed inside the laundry room under the sink contained a $\frac{3}{4}$ full bottle of a green solution labeled Buckeye	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21014	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 05/24/2023
NAME OF PROVIDER OR SUPPLIER EVENTIDE THE LINDEN			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 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) COMPLETE DATE	
02310	Continued From page 22 disinfectant. On May 22, 2023, at 12:35 p.m., ED-D stated residents in the secured unit would have been able to access the Buckeye disinfectant as it was not stored securely. The Buckeye Disinfectant Safety Data Sheet dated September 14, 2017, indicated the disinfectant solution could cause severe skin burns and eye damage. The licensee's Chemicals policy dated April 2017, indicated all chemicals would be stored in a locked environment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			

Type: Full
Date: 05/23/23
Time: 14:35:46
Report: 7935231087

Food and Beverage Establishment Inspection Report

Page 1

Location:

Eventide The Linden
1500 7th Street South
Moorhead, MN56560
Clay County, 14

Establishment Info:

ID #: 0037825
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2182337508
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3

**** Priority 1 ****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

SANITIZING BUCKET WAS 100 PPM. PROVIDE A SOLUTION OF 200 - 400 PPM. BUCKET CHANGED DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit

Location: Dish Machine

Violation Issued: No

Quaternary Ammonia: = 100 ppm at Degrees Fahrenheit

Location: Sanitizing Bucket

Violation Issued: Yes

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit

Location: Dispenser

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 38 Degrees Fahrenheit - Location: Walk In

Violation Issued: No

Type: Full
Date: 05/23/23
Time: 14:35:46
Report: 7935231087
Eventide The Linden

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Prep
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: True
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: Chili
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	0	0

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935231087 of 05/23/23.

Certified Food Protection Manager: Kara Ramey

Certification Number: 108992 Expires: 12/17/24

Signed: _____
Establishment Representative

Signed: 7935
7935

651-201-4500
health.foodlodging@state.mn.us