DEPARTMENT OF HEALTH AND H	UMAN SERVICES	<b>CENTERS FOR MED</b>	DICARE & MEDICAID SERVICES
	DICARE/MEDICAID CERTIFICATION		ID: AUQH
PAI	<b>RT I - TO BE COMPLETED BY THE ST</b>	ATE SURVEY AGENCY	Facility ID: 00072
1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245461</b>	3. NAME AND ADDRESS OF FACILITY (L3) <b>EVENTIDE LUTHERAN HOME</b>		4. TYPE OF ACTION: <u>7(</u> L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) <b>827340500</b>	(L4) 1405 7TH STREET SOUTH (L5) MOORHEAD, MN	(L6) <b>56560</b>	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9)	P 7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRE	<u>02</u> (L7) 13 PTIP 22 CLIA	<ol> <li>On-Site Visit</li> <li>Other</li> <li>Full Survey After Complaint</li> </ol>
	34) 02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION         From       (a) :         To       (b) :         12. Total Facility Beds       195       (L         13. Total Certified Beds       195       (L		And/Or Approved Waivers Of 7 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN	requirements and of rippiled warvers.	15. FACILITY MEETS	
	SNF ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (	L39) (L42) (L43)		
17. SURVEYOR SIGNATURE <u>Gail Anderson, HFE NEII</u>	PPLICABLE SHOW LTC CANCELLATION DATE): Date : 11/21/2016	18. STATE SURVEY AGENCY	, Enforcement Specialist 12/29/2016
	(L19) D BE COMPLETED BY HCFA REGIONA	L OFFICE OD SINCLE S	(L20)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li><u>X</u> 1. Facility is Eligible to Participate</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	20. COMPLETED BY HEFA REGIONA 20. COMPLIANCE WITH CIVIL RIGHTS ACT: L21)	21. 1. Statement of Finan	ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC A	GREEMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGI 04/01/1987	NNING DATE ENDING DATE	VOLUNTARY     00       01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	
	RNATIVE SANCTIONS spension of Admissions:	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	n <u>OTHER</u> 07-Provider Status Change 00-Active
(L27) B. Res	(L44) cind Suspension Date:		00-20170
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)	_	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	<b>10/28/2016</b> (L33)	DETERMINATION APPR	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245461

December 29, 2016

Mr. Nathan Johnson, Administrator Eventide Lutheran Home 1405 7th Street South Moorhead, Minnesota 56560

Dear Mr. Johnson:

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 October 21, 2016 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 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered November 21, 2016

Mr. Nathan Johnson, Administrator Eventide Lutheran Home 1405 7th Street South Moorhead, Minnesota 56560

RE: Project Number S5461024

Dear Mr. Johnson:

On September 30, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 15, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On November 10, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 15, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 15, 2016, effective October 21, 2016 and therefore remedies outlined in our letter to you dated September 30, 2016, will not be imposed.

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 Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVIS	ЯT
IDENTIFICATION NUMBER	A. Building				
245461 <sub>Y1</sub>	B. Wing	Y	′2	11/10/2016	Y3
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).

ITEM Y4	DATE Y5	ITEM	DATE	ITEM		DATE Y5
¥4	¥5	Y4	Y5	Y4		¥5
ID Prefix F0157	Correction	ID Prefix F0246	Correction	ID Prefix	F0325	Correction
Reg. # 483.10(b)(11)	Completed	Reg. #	(e)(1) Completed	Reg. #	483.25(i)	Completed
LSC	10/21/2016	LSC	10/21/2016	LSC		10/21/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	Completed	Reg. #	Completed	Reg. #		Completed
LSC		LSC		LSC		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) GA/mm	<b>DATE</b> 11/21/2016	SIGNATURE OF SURVEYOR	)34	DATE 11/ <sup>-</sup>	10/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVEY 9/15/2016	COMPLETED ON		R ANY UNCORRECTED DEFICIEN TED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO TH		es 🗌 no

## **POST-CERTIFICATION REVISIT REPORT**

	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		D	DATE OF REVIS	SIT
	B. Wing	Y2	2 1	0/24/2016	Y3
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).

ITE	М	DATE	ITEM	DATE	ITEM		DATE
Y4		Y5	Y4	Y5	Y4		Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	09/28/2016	LSC K0025	09/22/2016	LSC	K0034	09/14/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	NFPA 101	Completed
LSC	K0056	10/21/2016	LSC K0062	09/20/2016	LSC	K0147	10/21/2016
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #	Completed	Reg. #		Completed
LSC			LSC		LSC		
REVIEW		REVIEWED BY (INITIALS) TL/mm	<b>DATE</b> 11/21/2016	SIGNATURE OF SURVEYOR 36536			<b>DATE</b> 10/24/2016
REVIEW CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE			DATE
FOLLOWUP TO SURVEY COMPLETED ON 9/14/2016				RANY UNCORRECTED DEFICIE CTED DEFICIENCIES (CMS-256)	NCIES. WAS	A SUMMARY OF HE FACILITY?	YES 🗌 NO

DEPARTMENT OF HEALTH AND HUMA	N SERVICES	<b>CENTERS FOR MED</b>	ICARE & MEDICAID SERVICES
	ARE/MEDICAID CERTIFICATION A		ID: AUQH
PART I -	TO BE COMPLETED BY THE STAT	TE SURVEY AGENCY	Facility ID: 00072
1. MEDICARE/MEDICAID PROVIDER NO.	3. NAME AND ADDRESS OF FACILITY (L3) <b>EVENTIDE LUTHERAN HOME</b>		4. TYPE OF ACTION: <u>2</u> (L8)
(L1) <b>245461</b> 2.STATE VENDOR OR MEDICAID NO.	(L4) 1405 7TH STREET SOUTH		1. Initial 2. Recertification
(L2) <b>827340500</b>	(L5) MOORHEAD, MN	(L6) <b>56560</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY <b>09/15/2016</b> (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	09/30
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a):	A. In Compliance With	And/Or Approved Waivers Of J	The Following Requirements:
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel	6. Scope of Services Limit
		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 195 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN	· _
13.Total Certified Beds 195 (L17)	X B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room
	Requirements and/or Applied Waivers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
195			
(L37) (L38) (L39)	(L42) (L43)		
16. STATE SURVEY AGENCY REMARKS (IF APPLICA	ABLE SHOW LTC CANCELLATION DATE):		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Sherri Softing, HFE NEII	10/19/2016 (L19)	Mark Meath,	Enforcement Specialist 10/27/2016 (L20)
PART II - TO BE	COMPLETED BY HCFA REGIONAL	OFFICE OR SINGLE ST	TATE AGENCY
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)
<b>X</b> 1. Facility is Eligible to Participate	RIGHTS ACT:	<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible		5. Dour of the Hoove	
(L21)			
22. ORIGINAL DATE   23. LTC AGREE	MENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING	G DATE ENDING DATE	VOLUNTARY 00	INVOLUNTARY
04/01/1987		01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse	oo Fuil to infect i Broomeni
25. LTC EXTENSION DATE: 27. ALTERNATI	VE SANCTIONS	03-Risk of Involuntary Termination	1 <u>OTHER</u>
A. Suspensio	n of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27) P. Passind S.	(L44)		00-Active
B. Rescind S	uspension Date:		
	(L45)		
28. TERMINATION DATE: 29	9. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539 32	2. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APPR	OVAL



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 30, 2016

Mr. Nathan Johnson, Administrator Eventide Lutheran Home 1405 7th Street South Moorhead, Minnesota 56560

RE: Project Number S5461024

Dear Mr. Johnson:

On September 15, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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 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

### **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 October 25, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

### 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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 December 15, 2016 (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 March 15, 2017 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Weath

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245461	B. WING _		09/	/15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTIC	E LUTHERAN HOME			1405 7TH STREET SOUTH		
				MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00		
	signature is not req page of the CMS-2	led in ePOC and therefore a uired at the bottom of the first 567 form. Electronic POC will be used as liance.				
F 157 SS=D	revisit of your facilit validate that substa		F 15	57		10/21/16
	A facility must imme consult with the res known, notify the re or an interested fan accident involving t injury and has the p intervention; a sign physical, mental, or deterioration in hea status in either life t clinical complication significantly (i.e., a existing form of treat consequences, or t treatment); or a deo the resident from th §483.12(a). The facility must als and, if known, the response	ediately inform the resident; ident's physician; and if esident's legal representative hily member when there is an he resident which results in potential for requiring physician ficant change in the resident's psychosocial status (i.e., a lth, mental, or psychosocial chreatening conditions or hs); a need to alter treatment need to discontinue an atment due to adverse to commence a new form of cision to transfer or discharge the facility as specified in so promptly notify the resident esident's legal representative member when there is a				
	change in room or	foommate assignment as 5(e)(2); or a change in				
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE
Electron	ically Signed					10/10/2016

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.

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	IPLE CONSTRUCTION		O. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:	` ´	NG		OMPLETED
		245461	B. WING		c	9/15/2016
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
EVENTIC	DE LUTHERAN HOME	1		1405 7TH STREET SC MOORHEAD, MN 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 157	Continued From pa	age 1	F 1	57		
	· ·	er Federal or State law or				
		cified in paragraph (b)(1) of				
	The facility must re	cord and periodically update				
	the address and ph	none number of the resident's				
	legal representative	e or interested family member.				
	This REQUIREME	NT is not met as evidenced				
		v and record review the facility		This plan of co	rrection is submitted sole	ely
		otify the physician for 2 of 4			all applicable state and	
		R207) who experienced			ry requirements. These	
	significant weight lo	585.			es do not constitute an on-compliance with any	
	Findings include:				or an agreement with any	/
		inimum Data Set (MDS) dated				
		R207 had moderate cognitive quired supervision with eating.			ne provider was complete 7/2016 and R56 had a	be
		lentified R207 had broken or			onsult ordered on 9/2 wit	h
		s on a regular diet, had no			ation to provider on	
	weight loss.	<b>č</b>		9/16/2016 of co	nsult. Clinical Dietician	
					e-educated on the	
	Review of R207's v	veight records from identified:			following the weight	_
	- R207 had a signif	icant weight loss (significant			sment policy in regards to rovider on 9/19/2016.	
		ed as a weight loss of 5% or				
		ys, 7.5% or greater over 90		Weight Change	s Assessment policy was	6
	days, or 10% or gre	eater over 180 days) of 9.1%		reviewed and re	emains up to date.	
		from 6/25/16 to 8/6/16 (42			ess will include nursing	
		R207 weighed 153.4# and on			nical dietician when	
	8/6/16 R207 weigh	eu 139#.			ht is 5 pounds for review. view all weights of	
	-R207 had a signifi	cant weight loss of 5.3% of her			nly and notify the provide	r.
		0 days. On 7/9/16 R207			ing and noting the provide	••
		on 8/9/16 R207 weighed 143#.			lents in facility were	
				reviewed and the	nose who met criteria for	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00072

PRINTED: 10/19/2016 FORM APPROVED OMB NO 0938-0391

TATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· ·		(X3) DAT	0938-039 E SURVEY
		BERTHIOL HOR HOMBER.	A. BUILDING	3		
		245461	B. WING			15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	MOORHEAD, MN 56560 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 157	On 9/15/16, at 9:06 Manager (CDM) co weight loss, she wa significant weight lo physician. R56's quarterly MD R56 had severe co extensive assistant significant weight lo Review of R56's we had a significant we 8/2/16. Record ider her body weight ov identified R56 weig weighed 105# on 8 On 9/15/16, at 7:17 stated she was una significant weight lo physician. She stat identify significant w update the physicia On 9/15/16, at 10:4 had completed a nu 6/11/16 and stated significant weight lo and had not update weight loss. On 9/15/16, at 2:51 stated she expecte	<ul> <li>a.m. Clinical Dietitian onfirmed R207 had significant as unaware R207 had any oss and did not update the</li> <li>NS dated, 5/26/16 identified gnitive impairment, required ce with eating and had oss.</li> <li>eight records identified R56 eight loss from 6/14/16 to ntified R207 had lost 9.5% of er 60 days. The record hed 116# on 6/14/16 and /2/16.</li> <li>Y a.m. Unit Manager (UM-A) aware of R207's and R56's oss, and did not update the ed she expected the CDM to weight loss for residents and an.</li> <li>A.m. CDM confirmed she utrition assessment for R56 on she was unaware of R56's</li> <li>p.m. director of nurses (DON) d the ified as soon as a significant entified.</li> </ul>	F 157	<ul> <li>significant weight loss had notif the provider by 9/30/2016. All or residents are in compliance with expectations.</li> <li>Nursing staff will be re-educated expectations on 10/6/2016. On education will be completed as with staff and chart audits will b completed with all new identification weight loss monthly and randor will be reported at quarterly QA</li> <li>Responsible Party: DON or Destination</li> </ul>	d on policy going needed ations of nly which meeting	

ALEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION (X	(3) DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
		245461	B. WING		09/15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EVENTIC	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 157	4/17/14 identified th assistant or nurse p	ne physician, physician's practitioner would be informed	F 15	7	
F 246 SS=D		ONABLE ACCOMMODATION	F 24	6	10/21/16
	services in the facil accommodations or preferences, excep	right to reside and receive ity with reasonable f individual needs and of when the health or safety of her residents would be			
	by:	NT is not met as evidenced			
	review the facility far residents physical e	tion, interview and document ailed to individualize the environment in accordance own needs for dining for 1 of 1		R56 care plan was reviewed for accommodation needs in the dining of Changes to care plan were made on 10/7/2016 to include bringing into the dining room right before serving the and removing immediately when mea	meal
	Alzheimer's disease	eport dated 9/15/16, included e, dementia with behavioral al disorder, major depressive ty disorder.		completed. Staff will sit near R56 throughout the meal to provide redire and assist as needed. Staff working the 2nd floor were re-educated by 10/10/2016 with changes to care plan R56.	on
	identified R56 had s severe depression, easily annoyed. MD	imum Data Set dated, 5/26/16 severe cognitive impairment, was short tempered and DS further identified R56 assistance with all activities of		Care plans were reviewed for all resi who have similar dining room enviror behaviors and updated to individualiz residents needs for accommodations Nursing staff were re-educated on	nment ze

Event ID: AUQH11

Facility ID: 00072

If continuation sheet Page 4 of 14

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	PLETED
		245461	B. WING		09/	15/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTI	DE LUTHERAN HOME	E		1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 246	identified R56 has had behaviors and anti-anxiety and an CAA further identifi successful in redire behaviors, and R56 The CAA also idem she slept all day, an call out with some in needed. The CAA anticipate all her ne understanding othe understanding othe understood. R56's Care Plan da hollered out, had an skills, periods of ind making herself und others, "Sundownir and behaviors)." Th R56's needs would The care plan furth assess and monito and determine con also identified R56 behaviors, and cha be reported to prace On 9/12/16, continu p.m. to 6:00 p.m. w R56 was observed table with R237, fa and R207 in the ba hollered out excess approximately 5:40 table and wheeled of the dining room.	severe cognitive impairment, I received antidepressant, ti-psychotic medication. The ed staff were not always ecting R56 when she had 5 would continue to call out. tified R56 had periods where nd when she woke up would need, then forget what she further identified staff were to eeds as R56 had difficulty ers and making herself ated 9/11/16, identified R56 gitation, poor decision making creased confusion, difficulty derstood and understanding ng (increased p.m. confusion ne care plan also identified l be met with staff assistance. Her identified staff were to r R56 for changes in mood tributing factors. The care plan may be hungry when she had unges in R56's mood were to etitioner and family.	F 24	<ul> <li>6 interventions to utilize in regards behaviors that are disruptive to tenvironment.</li> <li>Observation audits and ongoing will be completed as needed wit Audits will be completed weekly and then monthly x3 months and thereafter. Audits will be reported quarterly QA meeting.</li> <li>Responsible Party: DON or Des</li> </ul>	he dining education h staff. x 1 month d random ed at	

If continuation sheet Page 5 of 14

		AND HUMAN SERVICES				FORM	10/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245461	B. WING			09/	15/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME				405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 246	juice and immediate few sips and set the table in front of her help, help. An unide tables away stated, while the unidentifie tablemate stated to stated in reply, "She needs help with." A R284 who was sear rocked back and fo -6:00 p.m. An unide walked by R56 and help with?" R56 and help with?" R56 and help with?" R56 and help with?" R56 and then He asked R56 said "yes." The nurs food would be right away. R56 continue observed yelling ou anxious for the enti On 9/13/16, at 1:02 and repeatedly in th want water," in the seated at the same R56, "Be quiet," in a brow. On 9/14/16, during 5:29 p.m. to 6:04 p. in the back of the d Hurry up, I'm hungr -5:37 p.m. R56 was filled with juice, she on the edge of the o yelling out,	ely walked away. R56 took a e cup down on the edge of the and again started hollering entified resident seated a few "I wish they would help her," ed resident looked at R56. The the unidentified resident e doesn't know what she s R56 continued to yell out, ted next to her, groaned and rth in her chair. entified nursing staff person stated, "What do you need swered "I don't know" and 6 if she was hungry and she sing staff member told R56 her out and immediately walked ed to yell out. R56 was it and appeared agitated, re observation. f. p.m. R56 yelling out loudly he dining room, "I want water, I dining room. R20, who was table as R56, stated loudly to an angry voice and a furrowed continuous observation from .m. R56 was observed seated ining room continually yelling, y. " stantly hollering, "I want food, I	F2	246			

Facility ID: 00072

If continuation sheet Page 6 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/19/2016 APPROVED 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245461	B. WING	;		09/	15/2016
NAME OF PRC	VIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTIDE	LUTHERAN HOME				1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
go m (L ju av -5 R co yo ar -6 N. se w-6 N. R to O st o st o st st re ye co o ch it se ho th di O ho	arranging the facilealing during dining during during dining during during dining during duri	er as she became more and censed practical nurse asked her if she wanted more " LPN-A immediately walked 6 resumed yelling out "hurry ked her, "What's wrong" and at food." The CDM stated " It's , and when it comes I will help 56 juice, which R56 declined ely walked away from R56. ntinued to yell out repeatedly, her with a cup of coffee and ray table and immediately heal was brought to her and er to assist her with the meal. g out after NA-E sat down next a.m. unit manager (UM-A) ays called out in the dining ion (5 years earlier). She out was a behavior and was sure there's some lity could do to minimize R56's g. She stated the facility had R56 to the smaller dining the past, so it was less a stated the facility hadn't tried ed she was not involved in nts in the dining room, e hoped dietary would make tions and changes in the	F 2	246			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	10/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'	PLE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245461	B. WING		09/	15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 246	aware other resider out in the dining and the past. She stated R237 and R71 were out in the past and in the past because yelling. NA-B stated the dining room, dir yelling negatively af On 9/15/16, at 8:25 stated R56 always I room. She stated re it really bothered the someone sat with F she continued to he On 9/15/16, at 9:06 (CDM) stated she w dining on the 2nd fle complained about F the past. She stated out of the dining roo CDM confirmed the residents on the 2n stated they would lo they could do for R8	<ul> <li>a.m. clinical dietitian manager vas aware that R56 disrupted out in the dining esidents got, otherwise offected that R56 disrupted the esidents had R56 hollering during meals in disrupted residents had R56 hollering during meals in disrupted and bok into it and see what else 56.</li> </ul>	F 24	5		
F 325 SS=D	out of the dining roo disrupted. 483.25(i) MAINTAIN	vould expect staff to take R56 om if resident dining was being N NUTRITION STATUS DABLE	F 32	5		10/21/16
	Based on a residen assessment, the fac	t's comprehensive cility must ensure that a				

Facility ID: 00072

If continuation sheet Page 8 of 14

					FORM	APPROVED 0938-0391
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER         IDENTIFICATION         IDENTIFICATION         IDENTIFICATION         IDENTIFICATION         IDENTIFICATION         IDENTIFICATION          IDENTIFICATION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) E C			
		245461	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560		
PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	resident - (1) Maintains accep status, such as bod unless the resident' demonstrates that t (2) Receives a there	table parameters of nutritional y weight and protein levels, s clinical condition his is not possible; and apeutic diet when there is a	F 32	5		
	by: Based on observat review the facility fa reassess 1 of 4 resi significant weight loo Findings include: R207's diagnosis re R207 had diagnose brain injury, left side and right radius frac altered mental statu communication defi R207's quarterly Mi 6/25/16 identified R impairment and req The MDS further ide loose dentures, was weight loss. R207's Care Area A 4/1/16, identified R2 impairment, require ADLs, had increase	ion, interview and record iled to comprehensively idents (R207) reviewed with ss. eport dated 9/15/16, identified as which included: traumatic ed weakness , right humorous cture, depression, anxiety, is and cognitive		R207 comprehensive nutrition assessment was completed on 9/27 and notification to the provider on 9/27/2016 with increase in supplem and ongoing weight loss due to exp decline in condition. Provider had r further recommendations on 9/28/2 Family care conference completed 10/3/2016 with hospice in attendance Weight loss was reviewed with no changes made due to overall expect decline. Hospice provided educate family for end of life signs. Family on 10/10/16 the plan to not pursue for replacing ill-fitting dentures that w recommended in the dental assess All current residents in facility were reviewed and those who met criteria significant weight loss had notification the provider and comprehensively re-assessed by 9/30/2016. All curr residents are in compliance with pra- expectations Weight Changes Assessment and	eents bected to 2016. on ce. cted on to voiced fixing were ment. a for on to on to	

Facility ID: 00072

If continuation sheet Page 9 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES			ſ	-	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245461	B. WING			09/ <sup>,</sup>	15/2016
NAME OF F	PROVIDER OR SUPPLIER		· [	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
				14	405 7TH STREET SOUTH		
EVENIL	E LUTHERAN HOME			Μ	IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 325	intake. The CAA fur admitted to hospice goals were to slow complications and r R207's nutrition car identified R207's ca weight loss and hav care plan identified intake which did no potential for chewin weakness. The car received 4-ounces per day, a magic cu supplement) at noo portions, weight and problems were to b required feeding as Review of the 2nd F care sheet) dated 9 a regular diet and fe On 9/13/16, from 12 was observed seate dining room table in R207 appeared pal low. R207 took only (peanut butter cook mixed vegetables) her orange juice, m R207 used only her drinking, while her n NA-B passed by an to eat your cookie? NA-B left the area a a few minutes and table, out of the din	ther identified R207 was on 3/19/16 and R207's care or minimize decline, avoid	F 3	25	documentation policy was reviewer remains up to date. Clinical dietic manager was re-educated on the policy expectations on 9/19/2016. Change in process will include nur staff to notify clinical dietician whe change of weight is 5 pounds or g for review. Dietician will review all of residents monthly, make recommendations to maintain or in nutrition status with notification to provider if needed. Nutrition asse will be completed quarterly and as for residents who meet the criteria weight loss. Nursing staff will be re-educated of expectations by 10/6/2016. Ongo education will be completed as ne with staff and chart audits will be completed monthly with all new identifications of weight loss and r which will be reported at quarterly meeting.	an current sing n reater weights mprove the ssments needed for n policy ng eded andomly QA	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 10 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/19/2016 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED
		245461	B. WING	i		09/	15/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
EVENTI	DE LUTHERAN HOME				1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 325	magic cup was not or at her place setti Review of the Initial 3/316, identified R2 herself with reminde assistance with eati identified R207 did chewing problems, sided facial weakne identified R207's us 162-169# and R207 history of weight los identified 4-ounces supplement) would Review of quarterly 7/8/16 identified R2 fed herself with rem feeding assistance further identified R2 chewing problems, sided facial weakne identified R207 weigh no weight loss and per day. The asses weight loss of 9-167 weight. Review of R207's w identified: - R207 had a signiff weight loss is define greater over 30 day days, or 10% or greater of her body weight	observed to be administered ng during this time period. I Nutrition Assessment dated 07 received a regular diet, fed ers or required partial feeding ing. The assessment further not have any swallowing or had an upper partial and left ess. The assessment further sual body weight was between 7 had a fair appetite, with no as. The assessment also of Boost Plus (nutritional be added twice per day. nutritional assessment, dated 07 received a regular diet and ninders or required partial with eating. The assessment 207 had no swallowing or had upper partial and left ess. The assessment further ghed 153#, appetite was good, magic cup was added once sment failed to identify a # from admission/usual body weekly weight records cant weight loss (significant ed as a weight loss of 5% or rs, 7.5% or greater over 90 eater over 180 days) of 9.1% from 6/25/16 to 8/6/16 (42 R207 weighed 153.4# and on	F	325	5		

		AND HUMAN SERVICES				FORM	10/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245461	B. WING			09/	15/2016
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
EVENTID	E LUTHERAN HOME	1			405 7TH STREET SOUTH IOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	Continued From pa	ige 11	F 3	325			
	body weight over 30	cant weight loss of 5.3% of her 0 days. On 7/9/16 R207 on 8/9/16 R207 weighed 143#.					
		neal consumption from 7/16 to n average meal intake of less					
		Medication Administration 16 identified the following:					
	magic cup, of which refused her magic of and R207's consum	ties for R207 to receive the h R207 had consumed 25% or cup 11 days out of the month nption of the magic cup was total of 14 days out of the					
	Boost supplement, 50% boost plus sup	ies for R207 to receive the of which R207 consumed oplements 20 times out of the consumption was not recorded month.					
		Aedication Administration 2016 identified the following:					
	-R207 had consum magic cup once da	ed an average of 50% of her ily					
	R207 had taken the day a day consister	e boost supplement twice per ntly					
	Review of R207's p 9/15 identified:	progress notes from 7/8/16 to					
	-8/11/16, R207 had	lost 8# in 1 month, 10# in 3					

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		AND HUMAN SERVICES				FORM	D: 10/19/2016 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DA	TE SURVEY MPLETED
		245461	B. WING			09	/15/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTIC	E LUTHERAN HOME				1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 325	Continued From pa months.	ge 12	F	325			
	appetite was poor,	8# weight loss in 1 month, average meal intake was was stopped due to decrease d intake.					
	down 12-16# since since recent fall wit weeks R207 had be majority of meals. F supplement at lunc 4-ounces other nut	s been fairly stable, weight admission. Intake declined h fracture, for the past 2 een eating less than 50% at R207 received a nutritional h with variable intake and ritional supplement to help eights monitored and care					
	clinical record was Dietitian Manager ( had last been asset had been fairly stat R207 had a signific stated she was una weight loss. She sta R207 had she know loss. The CDM stat computer system to resident had signific received any alerts had received the sa supplements 3 time confirmed R207 wa her meals She state increased R207's n	6 a.m. a review of R207's conducted with Clinical CDM). She confirmed R207 ssed 7/8/16 and her weight ble at that time. She confirmed ant weight loss in August and ware of R207's significant ated she would have assessed vn about her significant weight ed she relied on the facility o give her alerts when a cant weight loss and had not for R207. She stated R207 ame diet and nutritional es per day since 3/3/16 and is eating only 50% or less of ed she probably would have utritional supplements if she 207's significant weight loss R207 drank good.					
	On 9/15/16, at 7:17	a.m. Unit Manager (UM-A)					

		AND HUMAN SERVICES				FORM	10/19/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		PLE CONSTRUCTION		E SURVEY IPLETED
		245461	B. WING	i		09/	15/2016
NAME OF	PROVIDER OR SUPPLIER		-		STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME				1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325	stated if a resident change an alert wor computer system a who logged in unde She stated she was significant weight lo dietitian manager w nutrition program for stated she would ex to be completed wit weight loss interver On 9/15/16, at 2:51 stated she expected to notify the nurse it loss from the previo weight accuracy. SI nutrition assessment a significant weight Review of the facilit Changes/Assessment 4/17/14 all residents change (5% over 1 or 10% over 6 mont assessed to promo	had a significant weight uld be generated by the facility nd could be viewed by all staff er resident weights and vitals. Is not aware of R207's bess and indicated the clinical vas responsible for the resident or the whole building. She expect a nutrition assessment th significant weight loss and ntions changed or added. p.m. director of nurses (DON) d the nursing assistants (NA's) f they entered a 3-5# weight bus weight, and to watch for he stated she expected a nt to be completed as soon as loss was identified. ty policy, Weight ent/Documentation dated, s who had a significant weight month, 7.5% over 3 months ths) would be monitored and te optimal health. The policy e dietitian was to review all	F	325			

Facility ID: 00072

If continuation sheet Page 14 of 14

		AND HUMAN SERVICES	Ŧ	allion	FORM	10/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE COMF	E SURVEY PLETED
		245461	B. WING		09/1	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 0	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.				
	Minnesota Departn Marshal Division. Eventide Lutheran not in substantial c requirements for pa Medicare/Medicaid 483.70(a), Life Saf edition of National	articipation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC),				
	DEFICIENCIES (K	R THE FIRE SAFETY -TAGS) TO:		FP	)(	
	Health Care Fire Ir State Fire Marshal 445 Minnesota Str St. Paul, MN 5510	Division eet, Suite 145				
	Or by email to:					
	y director's or provi hically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/10/2016

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.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION IG 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245461	B. WING		09	/14/2016
NAME OF I	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP C	ODE	
EVENTIC	DE LUTHERAN HOMI	E		007 TH STREET SOUTH		11
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
K 000	Continued From pa Marian.Whitney@s and Angela.Kappenma	state.mn.us	K 000			
		DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:				
	1. A description of to correct the defic	what has been, or will be, done siency.				
	2. The actual, or p	roposed, completion date.				
	responsible for co	or title of the person rrection and monitoring to rence of the deficiency				
	Eventide Lutheran a partial basemen at 4 different times constructed in 196	rveyed as two building: Home is a 3-story building with t. The building was constructed s. The original building was 51, is 1 story without a				
	II(222) constructio without a baseme original building, a Type II (222) cons	as determined to be of Type n. In 1977, a 3-story addition, nt, was constructed north of the nd was determined to be of truction. In 1978 an ce building that is one story with				
	a basement was o original building fo separated with a 2 have any resident	constructed to the east of the r administrative offices, is 2-hour fire barrier, does not use and is a business 92 an addition was constructed				
	to the north of the 3-stories, with a b a Type II (222) bu least a 2 hour fire	1977 building which is asement, was determined to be ilding and was separated with at barrier. The facility is divided e zones by 30 minute and 90				

		AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES			1	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245461	B. WING		09/	14/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	original building. It Type II (111). The building is fully accordance with N Installation of Sprin has a fire alarm syst detection and smol installed in accorda National Fire Alarm alarm system is mod department notification automatic fire dete system in accordant Fire Code 2007 ed The facility has a comparison	to the north west of the is 1-story , no basement and sprinkler protected in FPA 13 The Standard for the aklers 1999 edition. The facility stem with corridor smoke ke detection in common areas ance with NFPA 72 "The o Code" 1999 edition. The fire ponitored for automatic fire ation. Hazardous areas have ction that are on the fire alarm once with the Minnesota State	K 00	00		
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA Doors protecting c required enclosure hazardous areas s as those construct core wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist th no impediment to to open devices that pushed or pulled a provided with a me	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD orridor openings in other than is of vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least ance between bottom of door is not exceeding 1 inch. Doors smoke compartments are only he passage of smoke. There is the closing of the doors. Hold release when the door is is permitted. Doors shall be eash suitable for keeping the in doors meeting 19.3.6.3.6 are	KO	18		9/28/16

Facility ID: 00072

	terrana manten ser a contracteristica con service	AND HUMAN SERVICES		FOR	D: 10/12/201 MAPPROVE D. 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(		TE SURVEY
		245461	B. WING	0	9/14/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
K 018	made of steel or ot with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on observa facility failed to ma doors in the corrido (00) section 19.3.6 could affect the sai and an undetermin if smoke from a fire access corridors m Findings include: On the facility tour on 09-14-2016 obs revealed: 1. The door to resi tightly in the frame 2. The cabinet door	mes shall be labeled and her materials in compliance er latches are prohibited by a all health care facilities. is not met as evidenced by: tion and staff interview, the intain the smoke resistance of or according to NFPA 101 LSC .3.1. This deficient practice fety of 56 of the 190 residents led amount of staff and visitors, e were allowed to enter the exit haking it untenable. between 8:00 am to 3:00 pm servations and staff interview dent room 238 does not fit	K 018	<ul> <li>K18 Door not fitting tightly in frame, Room # 238: Facilities Director created work order 214666 to add smoke seal to door frame.</li> <li>Maintenance staff will continue to monito doors to ensure doors fit tightly in frame.</li> <li>K 18 Cabinet doors don I t latch in Heritage corridor: Facilities Director created work Order 214159 to install latching hardware on cabinet doors.</li> <li>Maintenance staff will monitor cabinets to ensure of positive latching.</li> </ul>	r
K 025 SS=E	Facility Administrat Facilities. NFPA 101 LIFE SA Smoke barriers sh least a one half ho constructed in acc barriers shall be pr atrium wall. Windo fire-rated glazing of	lition was confirmed by the tor and the Director of AFETY CODE STANDARD all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ows shall be protected by or by wired glass panels and	K 02	5	9/22/16
	steel frames. 8.3, 19.3.7.3, 19.3 This STANDARD 567(02-99) Previous Version	is not met as evidenced by:		Facility ID: 00072 If continuation	

If continuation sheet Page 4 of 8

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING	COMI	COMPLETED	
		B. WING		09/14/2016		
AME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE	
/ENTID	E LUTHERAN HOME	i i i i i i i i i i i i i i i i i i i		1405 7TH STREET SOUTH MOORHEAD, MN 56560		
X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR		(X5) COMPLETIC
RÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
K 025	Continued From pa	age 4	K 025			
		tion and staff interview, the		Facilities Director created w		
	facility failed to maintain proper construction of 3 of 9 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition,			214183, 214184, and 21418 penetrations on 1st, 2nd and	5 to fire caulk 3rd floors.	
		and 8.3. This deficient practice		Maintenance staff will contin	ue to monitor	
	could affect 48 of 1	90 residents and an		smoke barriers for penetration	ons.	
		unt of staff and visitors by propagate from one smoke				
	compartment to an					
	Findings include:					
	on 09-14-2016 obs revealed a penetra following locations.	between 8:00 am to 3:00 pm servations and staff interview tion in smoke barriers in the				
		ast corridor above the ceiling at				
	the cross corridor	doors. ast corridor above the ceiling at				
	the cross corridor (	doors.				
	3. The 1st floor sm	oke barrier by the atrium lobby.				
	Facility Administrat	lition was confirmed by the tor and the Director of				
K 024	Facilities.	AFETY CODE STANDARD	K 034	4		9/14/16
SS=E	I		K 034	*		0/11/10
		bkeproof enclosures used as ance with 7.2. 18.2.2.3, 19.2.2.4				
	This STANDARD	is not met as evidenced by:			اسم يامم	
		ations and staff interview, the o maintain 1 of 5 exit stairways		Facilities Director created w 214182 to remove chairs an		
	in accordance with	NFPA 101 Life Safety Code		materials from stairwell.		
	(2000) section 7.2	.2. This deficient practice could		Maintenance will monitor sta	ainwells for	
		ne use of the exit stairway used n undtermined amount of staff,		storage and remove items a		
		event of an emergency.				
			1			

Event ID: AUQH21

Facility ID: 00072

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE		ATE SURVEY	
D PLAN O	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 0	01 - MAIN BUILDING 01	COMPLETED	
		245461	B. WING	0	9/14/2016	
AME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
VENTID	E LUTHERAN HOME			05 7TH STREET SOUTH OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
K 034	Continued From pa	age 5	K 034			
K 056 SS=E	on 09-14-2016 obs revealed stair shaft was being used for was not properly la This deficient cond Facility Administrat Facilities. NFPA 101 LIFE SA Where required by facilities shall be p approved, supervis in accordance with systems are equip switches which are the building fire ala construction, altern shall be permitted	between 8:00 am to 3:00 pm servations and staff interview t 1C next to the atrium cafe r storage of chairs and the door ibeled as delayed egress. Ition was confirmed by the tor and the Director of AFETY CODE STANDARD r section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system a section 9.7. Required sprinkler ped with water flow and tamper e electrically interconnected to arm. In Type I and II native protection measures to be substituted for sprinkler	K 056		10/21/16	
	regulations prohibi NPFA 13 This STANDARD Based on observa facility failled to en sprinkler system is the NFPA 101 "The edition (LSC) secti "The Standard for Systems" 1999 ed deficient practice of due improper sprin	fic areas where State or local it sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: ations and staff interview, the sure that the automatic is installed in accordance with e Life Safety Code" 2000 ion 19.3.5.1 and the NFPA 13 the Installation of Sprinkler ition sections 5-4 and 5-5. This could allow for the spread of fire hkler coverage and affect 24 of and an undetermined amount s.	v	Facilities director contacted vendor to install additional sprinkler head/s in storage area of penthouse and in eleval shafts. He also contacted elevator servi representative.	tor ce	

Event ID: AUQH21

Facility ID: 00072

If continuation sheet Page 6 of 8

		E & MEDICAID SERVICES			O. 0938-039 ATE SURVEY
			. ,		OMPLETED
		245461	B. WING	0	9/14/2016
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	E LUTHERAN HOM	Ξ		1405 7TH STREET SOUTH MOORHEAD, MN 56560	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 056 K 062 SS=E	Continued From page 6 on 09-14-2016 observations and staff interview revealed: 1. The area where material is being stored in the penthouse was not adequately covered by a sprinkler head. 2. Two elevator shafts, one in the north wing that traveled to all floors and one in the admin area that traveled two floors, were not sprinkled. This deficient condition was confirmed by the Facility Administrator and the Director of Facilities. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested		K 056		9/20/16
	9.7.5 This STANDARD Based on observe the facility has fail maintain the autor accordance with N Section 19.7.6, an of Sprinkler Syste for the Inspection, Water Based Fire deficient practice sprinkler system v event of a fire and the 190 residents of staff and visito Findings include: On the facility tour on 09-14-2016 ob	7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by: ation and interview with staff, ed to properly inspect and matic sprinkler system in NFPA 101 Life Safety Code (00), id 4.6.12, NFPA 13 Installation ms (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This does not ensure that the fire vould function properly in the I could negatively affect all 28 of and an undetermined amount rs.		Facilities director created work order 214181 to replace broken tiles. Maintenance staff will do quarterly chec for broken/missing ceiling tiles.	ks

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/12/2016 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245461	B. WING			09/	14/2016
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
EVENTID	E LUTHERAN HOME				05 7TH STREET SOUTH OORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062	Continued From pa	age 7	ĸ	062			
K 147 SS=D	This deficient condition was confirmed by the Facility Administrator and the Director of Facilities. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility failed to provide for proper exiting from the electrical room in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect the safety of an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm on 09-14-2016 observations and staff interview revealed the electrical room in the penthouse exceeded 1200 amps and did not have panic hardware on the exit doors. This deficient condition was confirmed by the Facility Administrator and the Director of Facilities.		K	147	Facilities Director created Work or 214158 to install panic hardware of penthouse doors. Contacted vendor to obtain panic hardware for two penthouse doors.	n two	10/21/16
						_	

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5711,1020	FORM	10/12/2016 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 02 - PT/WELLNESS CENTER		E SURVEY IPLETED
		245461	B. WING		09/	14/2016
NAME OF F	PROVIDER OR SUPPLIER	il		STREET ADDRESS, CITY, STATE, ZIP CODE		
EVENTID	E LUTHERAN HOME			1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K 0	00		
	FIRE SAFETY					
	Minnesota Departm Fire Marshal Divisio Eventide Lutheran in substantial comp for participation in N Subpart 483.70(a), 2000 edition of Nat Association (NFPA)	Survey was conducted by the nent of Public Safety, State on. At the time of this survey Home Building 02 was found liance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection ) Standard 101, Life Safety er 18 New Health Care.				
	Eventide Lutheran a partial basement. at 4 different times constructed in 196 basement, and wa II(222) construction without a basemen original building, an Type II (222) constr administrative offic a basement was co original building for separated with a 2- have any resident u occupancy. In 199 to the north of the 3-stories, with a ba a Type II (222) build least a 2 hour fire b into sixteen smoke minute fire barriers	veyed as two building: Home is a 3-story building with The building was constructed The original building was 1, is 1 story without a s determined to be of Type a. In 1977, a 3-story addition, t, was constructed north of the ad was determined to be of ruction. In 1978 an e building that is one story with onstructed to the east of the administrative offices, is hour fire barrier, does not use and is a business 2 an addition was constructed 1977 building which is sement, was determined to be ding and was separated with at parrier. The facility is divided zones by 30 minute and 90 . In 2013 a PT/ Wellness I to the north west of the		EPO	C	
LABORATOR	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	nically Signed					10/10/2016

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.

THAND HUMAN SERVICES		APPROVED 0938-0391		
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	TE SURVEY MPLETED
245461	B, WING		09	/14/2016
R	-			
ΛE		MOORHEAD, MN 56560		
ICY MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE
It is 1-story , no basement and Ily sprinkler protected in NFPA 13 The Standard for the rinklers 1999 edition. The facility system with corridor smoke toke detection in common areas dance with NFPA 72 "The rm Code" 1999 edition. The fire monitored for automatic fire cation. Hazardous areas have tection that are on the fire alarm ance with the Minnesota State edition.	K			
	IDENTIFICATION NUMBER: 245461 R ME STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) page 1 It is 1-story , no basement and Illy sprinkler protected in NFPA 13 The Standard for the rinklers 1999 edition. The facility system with corridor smoke noke detection in common areas idance with NFPA 72 "The rm Code" 1999 edition. The fire monitored for automatic fire ication. Hazardous areas have tection that are on the fire alarm lance with the Minnesota State edition. a capacity of 195 beds and had a the time of the survey. at 42 CFR, Subpart 483.70(a) is	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MUL A. BUILD         245461       B. WING         SR       ME         STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)       ID PREFI TAG         page 1       K O         It is 1-story , no basement and NIPPA 13 The Standard for the rinklers 1999 edition. The facility system with corridor smoke hoke detection in common areas idance with NFPA 72 "The rm Code" 1999 edition. The fire monitored for automatic fire ication. Hazardous areas have tection that are on the fire alarm lance with the Minnesota State edition.         acapacity of 195 beds and had a the time of the survey.       is         at 42 CFR, Subpart 483.70(a) is       is	(x1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:       (x2) MULTIFLE CONSTRUCTION A BUILDING 02 - PT/WELLNESS CENTER         245461       B. WING         B. WING	(X1) PROVIDER/SUPPLER/CLA IDENTIFICATION NUMBER:     (X2) MULTIPLE CONSTRUCTION A BUILDING 02 - PTIWELLINESS CENTER     (X3) DA COL A BUILDING 02 - PTIWELLINESS CENTER       245461     B. WING     09       STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH MOORHEAD, MN 56560     09       STATEMENT OF DEFICIENCIES CONUST EE PROCEED BY FULL R LSC IDENTIFYING INFORMATION)     ID PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       page 1     K 000       It is 1-story, no basement and illy sprinkler protected in NFPA 13 The Standard for the rinklers 1999 edition. The facility system with corridor smoke tooke detection in common areas dance with NFPA 72 "The rm Code" 1999 edition. The fire monitored for automatic fire ication. Hazardous areas have tection that are on the fire alarm lance with the Minnesota State addition.       at 42 CFR, Subpart 483.70(a) is



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 30, 2016

Mr. Nathan Johnson, Administrator Eventide Lutheran Home 1405 7th Street South Moorhead, Minnesota 56560

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5461024

Dear Mr. Johnson:

The above facility was surveyed on September 12, 2016 through September 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

Eventide Lutheran Home September 30, 2016 Page 2

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and 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/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Minnesc	ota Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00072	B. WING		09/1	5/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVENTI	DE LUTHERAN HOME		STREET SC AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 10/10/16

Electronically Signed

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If continuation sheet 1 of 19

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00072	B. WING	B. WING		15/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, ST	ATE, ZIP CODE		
EVENTIC	E LUTHERAN HOME		I STREET SOL EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 000	you electronically. <i>A</i> is necessary for Sta enter the word "corr text. You must then State licensure proc completion date, the corrected prior to el Minnesota Departm On 9/12/16, 9/13/1 surveyors of this De above provider and orders are issued. electronic plan of cor reviewed these orde they will be complet Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "ID statute/rule out of cor "Summary Stateme and replaces the "To correction order. The findings which are in after the statement, evidence by." Follow are the Suggested I Time period for Cor PLEASE DISREGA	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. 6, 9/14/16 and 9/15/16 epartment's staff, visited the the following correction Please indicate in your prection that you have ers, and identify the date wher ted. the of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute "This Rule is not met as wing the surveyors findings Method of Correction and rection. RD THE HEADING OF THE		DEFICIENC	Τ)	

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED
		00072	0072 B. WING		09/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME		I STREET SOU EAD, MN 5656	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORRE	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 265	MN Rule 4658.008 Resident Health St	5 Notification of Chg in atus	2 265			10/21/1
	policies to guide sta physicians, physici practitioners, and it legal representative member of a reside accident, or death. nursing services, a attending physician development of the	ust develop and implement aff decisions to consult an assistants, and nurse f known, notify the resident's e or an interested family ent's acute illness, serious At a minimum, the director of nd the medical director or an n must be involved in the ese policies. The policies must address at least the ation times for:				
		involving the resident which d has the potential for requiring ion;				
	physical, mental, c example, a deterio	t change in the resident's or psychosocial status, for ration in health, mental, or s in either life-threatening al complications;				
	example, a need to	Iter treatment significantly, for discontinue an existing form adverse consequences, or to of treatment;				
	D. a decision resident from the n	to transfer or discharge the ursing home; or				

If continuation sheet 3 of 19

Minneso	ta Department of He	alth			i orani	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE COMPI	
		00072	B. WING		09/1	5/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
EVENTIC	E LUTHERAN HOME		STREET SC AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 3	2 265			
	E. expected an	d unexpected resident deaths.				
	by:	ent is not met as evidenced and record review the facility		Corrected		
	failed to promptly n	otify the physician for 2 of 4 R207) who experienced		Conecieu		
	Findings include:					
	6/25/16 identified R impairment and rec The MDS further id	nimum Data Set (MDS) dated 207 had moderate cognitive uired supervision with eating. entified R207 had broken or s on a regular diet, had no				
	Review of R207's w	eight records from identified:				
	weight loss is define greater over 30 day days, or 10% or gre of her body weight	cant weight loss (significant ed as a weight loss of 5% or rs, 7.5% or greater over 90 eater over 180 days) of 9.1% from 6/25/16 to 8/6/16 (42 R207 weighed 153.4# and on ed 139#.				
	body weight over 30	cant weight loss of 5.3% of her 0 days. On 7/9/16 R207 on 8/9/16 R207 weighed 143#.				
	Manager (CDM) co weight loss, she wa	a.m. Clinical Dietitian nfirmed R207 had significant s unaware R207 had any ss and did not update the				
/innesota D	epartment of Health			•		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00072	B. WING		09/	09/15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
EVENTI	DE LUTHERAN HOME		AD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 265	R56's quarterly MD R56 had severe con extensive assistance significant weight loc Review of R56's we had a significant we 8/2/16. Record ider her body weight over identified R56 weig weighed 105# on 8/ On 9/15/16, at 7:17 stated she was una significant weight loc physician. She state identify significant v update the physicia On 9/15/16, at 10:4 had completed a nu 6/11/16 and stated significant weight loc and had not update weight loss. On 9/15/16, at 2:51 stated she expecter physician to be noti weight loss was ide Review of the facilit Changes/Assessme 4/17/14 identified th	S dated, 5/26/16 identified gnitive impairment, required with eating and had oss. eight records identified R56 eight loss from 6/14/16 to ntified R207 had lost 9.5% of er 60 days. The record hed 116# on 6/14/16 and /2/16. a.m. Unit Manager (UM-A) ware of R207's and R56's oss, and did not update the ed she expected the CDM to veight loss for residents and n. 1 a.m. CDM confirmed she utrition assessment for R56 on she was unaware of R56's oss from June to September of the physician of R56's p.m. director of nurses (DON) d the fied as soon as a significant intified. ty policy, Weight ent/Documentation dated, he physician, physician's practitioner would be informed	2 265				

	alth				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		A. DOILDING.			
	00072	B. WING		09/1	5/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
EVENTIDE LUTHERAN HOME		STREET SC AD, MN 565			
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 265 Continued From pa	ge 5	2 265			
Director of Nursing could review the po- physician notification personnel in any ch- to monitor the proce- compliance. TIME PERIOD FOF (21) days. 2 965 MN Rule 4658.0600 -Nutritional Status Subpart. 2. Nutrition must ensure that a which supplies the determined by the of assessment. Subs	THOD OF CORRECTION: The and the Director of Nutrition licies and procedures for on, educate the appropriate hanges and appoint a designee edures to ensure ongoing R CORRECTION: twenty one O Subp. 2 Dietary Service anal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			10/21/16
by: Based on observati review the facility fa reassess 1 of 4 res significant weight lo Findings include:	ent is not met as evidenced on, interview and record illed to comprehensively idents (R207) reviewed with oss.		Corrected		
Ainnesota Department of Health					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00072	B. WING		09/	09/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE			
EVENTIC	DE LUTHERAN HOME		I STREET SOL EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	age 6	2 965				
	brain injury, left sid						
	6/25/16 identified F impairment and rec The MDS further id	inimum Data Set (MDS) dated 207 had moderate cognitive quired supervision with eating. entified R207 had broken or s on a regular diet, had no					
	4/1/16, identified R impairment, require ADLs, had increase dentures which put intake. The CAA fu admitted to hospice	Assessment (CAA) dated 207 had severe cognitive ed staff assistance with all ed confusion and had loose her at risk for decreased food rther identified R207 was e on 3/19/16 and R207's care or minimize decline, avoid minimize risks.					
	identified R207's ca weight loss and hav care plan identified intake which did no potential for chewir weakness. The car received 4-ounces per day, a magic cu supplement) at noc portions, weight an problems were to b	re plan dated 7/13/16, are plan goals were to prevent ve no chewing difficulties. The R207 had poor/fair food at meet her needs and had ng problems due to facial e plan further identified R207 nutritional supplement twice up ( ice-cream like nutritional on, regular diet with small d chewing/swallowing be monitored, and R207 ssistance as needed.					
	care sheet) dated 9	Floor Care Plan (nurse aid 9/14/16 identified R207 was on ed herself after set-up.					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00072	B. WING		09/15/2016		
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S				
EVENTI	DE LUTHERAN HOME		I STREET SOL EAD, MN 5656				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
2 965	Continued From pa	age 7	2 965				
	was observed seat dining room table in R207 appeared pa low. R207 took only (peanut butter cool mixed vegetables) her orange juice, m R207 used only he drinking, while her NA-B passed by ar to eat your cookie? NA-B left the area a few minutes and table, out of the dir R207 was not offer magic cup was not or at her place sett Review of the Initia 3/316, identified R2 herself with remind assistance with eat identified R207 did chewing problems, sided facial weakne identified R207's us 162-169# and R20 history of weight lo identified 4-ounces supplement) would Review of quarterly 7/8/16 identified R2 fed herself with rem feeding assistance further identified R2	2:30 p.m. to 1:02 p.m. R207 ted in her wheelchair at the in the back of the dining room. le and weak, her head hung y small bites of her meal kie, tator tot casserole and and very slowly. R207 drank hilk and took sips of her coffee. r left hand for eating and right arm laid limp on her lap. nd asked R207, "Are you going ?." R207 replied, "I suppose." and returned to the table within wheeled R207 away from the hing room and into the hallway. red assistance with eating, and observed to be administered ing during this time period. Al Nutrition Assessment dated 207 received a regular diet, fed lers or required partial feeding ting. The assessment further not have any swallowing or had an upper partial and left ess. The assessment also is of Boost Plus (nutritional I be added twice per day. y nutritional assessment, dated 207 received a regular diet and ninders or required partial with eating. The assessment 207 had no swallowing or had upper partial and left					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00072	B. WING		09/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME		STREET SOL AD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 965	Continued From pa	age 8	2 965			
	no weight loss and per day. The asses	ghed 153#, appetite was good, magic cup was added once sment failed to identify a # from admission/usual body				
	Review of R207's v identified:	veekly weight records				
	weight loss is defin greater over 30 day days, or 10% or gre of her body weight	icant weight loss (significant ed as a weight loss of 5% or ys, 7.5% or greater over 90 eater over 180 days) of 9.1% from 6/25/16 to 8/6/16 (42 R207 weighed 153.4# and on ed 139#.				
	body weight over 3	cant weight loss of 5.3% of her 0 days. On 7/9/16 R207 on 8/9/16 R207 weighed 143#.				
		neal consumption from 7/16 to n average meal intake of less				
		Medication Administration 16 identified the following:				
	magic cup, of whic refused her magic and R207's consur	ties for R207 to receive the h R207 had consumed 25% or cup 11 days out of the month nption of the magic cup was total of 14 days out of the				
	Boost supplement, 50% boost plus su	ies for R207 to receive the of which R207 consumed oplements 20 times out of the consumption was not recorded month.				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00072	B. WING	B. WING		09/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
EVENTIC	DE LUTHERAN HOME		I STREET SOL EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 965	Continued From pa	ige 9	2 965				
	-	Nedication Administration 2016 identified the following:					
	-R207 had consum magic cup once da	ed an average of 50% of her ily					
	R207 had taken th day a day consister	e boost supplement twice pen ntly	-				
	Review of R207's p 9/15 identified:	progress notes from 7/8/16 to					
	-8/11/16, R207 had months.	lost 8# in 1 month, 10# in 3					
	appetite was poor,	8# weight loss in 1 month, average meal intake was was stopped due to decrease d intake.					
	down 12-16# since since recent fall wit weeks R207 had be majority of meals. F supplement at lunc 4-ounces other nut	s been fairly stable, weight admission. Intake declined h fracture, for the past 2 een eating less than 50% at R207 received a nutritional h with variable intake and ritional supplement to help reights monitored and care					
	clinical record was Dietitian Manager ( had last been asses had been fairly stat R207 had a signific stated she was una	6 a.m. a review of R207's conducted with Clinical CDM). She confirmed R207 ssed 7/8/16 and her weight ole at that time. She confirmed cant weight loss in August and aware of R207's significant ated she would have assessed					

STATEME	Dta Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00072	B. WING		09/15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE	• • •	
EVENTIDE LUTHERAN HOME 1405 7TH STREET SOUTH MOORHEAD, MN 56560						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 965	R207 had she know loss. The CDM stat computer system to resident had signifi- received any alerts had received the sa supplements 3 time confirmed R207 wa her meals She stat increased R207's m had known about F because she knew On 9/15/16, at 7:17 stated if a resident change an alert wo computer system a who logged in unde She stated she was significant weight lo dietitian manager w nutrition program for stated she would et to be completed wir weight loss interver On 9/15/16, at 2:51 stated she expecter to notify the nurse i loss from the previo weight accuracy. S nutrition assessme a significant weight Review of the facilit Changes/Assessm 4/17/14 all resident change (5% over 1 or 10% over 6 mon	vn about her significant weight and she relied on the facility o give her alerts when a cant weight loss and had not for R207. She stated R207 ame diet and nutritional es per day since 3/3/16 and as eating only 50% or less of ed she probably would have nutritional supplements if she 2207's significant weight loss R207 drank good. T a.m. Unit Manager (UM-A) had a significant weight uld be generated by the facility nd could be viewed by all staff er resident weights and vitals. Is not aware of R207's pass and indicated the clinical vas responsible for the residen or the whole building. She expect a nutrition assessment th significant weight loss and ntions changed or added. p.m. director of nurses (DON) d the nursing assistants (NA's) f they entered a 3-5# weight ous weight, and to watch for he stated she expected a nt to be completed as soon as loss was identified.	t			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00072	B. WING		09/15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
EVENTI	DE LUTHERAN HOME		STREET SC AD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
2 965	Continued From pa	ge 11	2 965			
	further identified the weights at least mo	e dietitian was to review all nthly.				
	Director of Nutrition procedures for sign appropriate person	HOD OF CORRECTION: The could review the policies and ificant weigh loss, educate the nel in any changes and to monitor the procedures to npliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: twenty one				
2 995	MN Rule 4658.0610 Requirements -Gro	) Subp. 3 Dietary Staff oming.	2 995		9/21/16	
	clean outer garmer restraints must be v contamination of fo	g. Dietary staff must wear hts. Hairnets or other hair vorn to prevent the od, utensils, and equipment. acceptable hair restraint.				
	by: Based on observati review the facility fa hairnet or restraint food in the kitchene affect 54 of 54 resid	ent is not met as evidenced on, interview and document iled to ensure staff utilized a while preparing and serving itte. This had the potential to lent in the facility who were		Corrected		
	served food out of t Findings include:	he kitchenette.				
	at 5:59 p.m. severa tables in the main d	of the supper meal on 9/12/16 I residents were seated at the lining room on the first floor. g assistance (CNA's) would				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00072	B. WING	B. WING		15/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME		I STREET SOU EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 995	Continued From pa	ge 12 k the residents their	2 995			
	the kitchenette wind assistant (DA)-B sto proceeded to grab a then used various to scoopers, and spoo hotdog's on a bun o salad and baked be the menu slip. DA-E the steam table to the steam table to the o serving tray. DA-B o net that covered on head area with hair his head and had a approximately 3/4 o restrained. DA-B co residents in the ma in this fashion while	and bring the menu slips to dow on a serving tray. Dietary bod over the steam table and a plate with his gloved hands, ools such as: tongs, ice cream ons to serve the residents or BBQ chicken, potatoes eans while the CNA's read it of 3 would then lean forward over hand the plate across the CNA's to place the plate on the was observed to wear a hair ly the upper crown part of his exposed on the lower half of full facial beard which was of an inch long and was not ontinued to serve all the in dining room on the first floor e DA-B's hair and beard was ag the serving process.	f			
	confirmed she woul hair and indicated I nets properly, did n restrained and state not wear the hair ne has given DA-A edu has corrected this in missed it." DM indic employee that has not quite sure if he	B p.m. dietary manager (DM) Id expect staff to contain their DA-B does not wear the hair ot have hair and beard ed "I have noticed that he does et right." DM indicated that she ucation in regards to this and in the past and stated "I cated that this was her first had a full facial beard and was needed it restrained or not should be wearing a beard				
	Nutrition and Culina 4/17/16, indicated	olicy titled, Dress Code ary Services, revised on hairnets or chef's cap must be keep hair from food and food				

	TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00072	B. WING		09/15/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
EVENTI	DE LUTHERAN HOME		I STREET SO EAD, MN 565			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 995	Continued From pa	ge 13	2 995			
	expected and facial	lood grooming habits hair such as side burns, hes must be neatly trimmed.				
	dietary supervisor of hairnet requirement The result of the au	HOD OF CORRECTION: The ould educate staff on the and conduct random audits. dits could be reported to the ommittee for review.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21810	MN St. Statute 144 Residents of HC Fa	651 Subd. 6 Patients & c.Bill of Rights	21810			10/21/1
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	iate health care. Patients and the right to appropriate al care based on individual care for residents means table residents to achieve their sical and mental functioning. where the service is not blic or private resources.				
	by: Based on observati review the facility fa residents physical e	ent is not met as evidenced on, interview and document iled to individualize the environment in accordance own needs for dining for 1 of 1		Corrected		
	Findings include:					
		port dated 9/15/16, included , dementia with behavioral				

STATE FORM

AUQH11

If continuation sheet 14 of 19

TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00072	B. WING		09/15/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
EVENTIC	DE LUTHERAN HOME		I STREET SOL EAD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
21810	disturbance, menta disorder and anxiet R56's quarterly Min identified R56 had s severe depression, easily annoyed. MD required extensive daily living (ADLs). R56's Care Area As identified R56 has s had behaviors and anti-anxiety and an CAA further identifie successful in redire behaviors, and R56 The CAA also ident she slept all day, ar call out with some r needed. The CAA anticipate all her ne understanding othe understood. R56's Care Plan da hollered out, had ag skills, periods of inc	al disorder, major depressive				
	and behaviors)." Th R56's needs would The care plan furth assess and monitor and determine cont also identified R56	ng (increased p.m. confusion ne care plan also identified be met with staff assistance. er identified staff were to r R56 for changes in mood tributing factors. The care plan may be hungry when she had nges in R56's mood were to titioner and family				

TATEMENT OF DEFICIENCIE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00072	B. WING	B. WING		15/2016
AME OF PROVIDER OR SUP	PLIER STREET	ADDRESS, CITY, S	TATE, ZIP CODE		
VENTIDE LUTHERAN H	IOME	TH STREET SO HEAD, MN 5650			
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
R56 was obset table with R23 and R207 in th hollered out ex- approximately table and whe of the dining re -5:45 p.m. R50 nursing assist juice and imm few sips and s table in front of help, help. An tables away st while the unide tablemate stat stated in reply needs help wit R284 who was rocked back a -6:00 p.m. An walked by R56 help with?" R5 then He asked said "yes." The food would be away. R56 cor observed yellin anxious for the On 9/13/16, at and repeated!	m. were conducted. At 5:28 p.m. ryed seated at the dining room 7, family member (FM-B), R284 he back of the dining room. R56 kcessively help, help. At 5:40 p.m. FM-B stood up from eled R237 away from the table, o bom. 6 continued to call for help until ant (NA-H) handed her a glass of ediately walked away. R56 took a set the cup down on the edge of th f her and again started hollering unidentified resident seated a few tated, "I wish they would help her entified resident looked at R56. T ted to the unidentified resident , "She doesn't know what she th." As R56 continued to yell out, s seated next to her, groaned and nd forth in her chair. unidentified nursing staff person 6 and stated, "What do you need 66 answered "I don't know" and 1 R56 if she was hungry and she e nursing staff member told R56 I right out and immediately walked ntinued to yell out. R56 was ng out and appeared agitated, e entire observation.	he v ," he ner			

	TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED	
		00072			09/	15/2016
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
EVENTID	E LUTHERAN HOME		STREET SOU AD, MN 5656			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21810	Continued From page	ge 16	21810			
	in the back of the di Hurry up, I'm hungry -5:37 p.m. R56 cons want food, hurry up -5:43 p.m. R56 was filled with juice, she on the edge of the o yelling out, "C'mon for God's sa got louder and louder more frustrated. Lice (LPN-A) came and juice, R56 said, No. away from R56. R56 up, hurry up." -5:57 p.m. CDM ask R56 told her, "I wan coming in a little bit, you" and offered R and CDM immediat -6:03 p.m. R56 con NA-C approached h set it down on her tr walked away. -6:04 p.m. R56"s m NA-E sat next to he R56 stopped yelling to her. On 9/15/16, at 7:31 stated R56 had alwa room since admissi stated R56's yelling stated she felt she v rearranging the faci yelling during dining	ning room continually yelling, y. " stantly hollering, "I want food, I " handed a green nosey cup took a couple sips and placed dining room table. R56 started ake, hurry up," R56 continued er as she became more and censed practical nurse asked her if she wanted more " LPN-A immediately walked 6 resumed yelling out "hurry ked her, "What's wrong" and t food." The CDM stated " It's , and when it comes I will help 56 juice, which R56 declined ely walked away from R56. thinued to yell out repeatedly, her with a cup of coffee and ray table and immediately heal was brought to her and r to assist her with the meal. out after NA-E sat down next a.m. unit manager (UM-A) ays called out in the dining on (5 years earlier). She out was a behavior and was sure there's some lity could do to minimize R56's b. She stated the facility had				
	room on the unit in chaotic for R56, but	R56 to the smaller dining the past, so it was less stated the facility hadn't tried ed she was not involved in				

	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00072	B. WING		09/	09/15/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
EVENTIC	DE LUTHERAN HOME		I STREET SOU EAD, MN 5656				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21810	Continued From pa	ige 17	21810				
	however, stated she	nts in the dining room, e hoped dietary would make ations and changes in the st R56.					
	hollered out in the o staff started assistin usually stopped yel aware other resider out in the dining and the past. She stated R237 and R71 were out in the past and in the past because yelling. NA-B stated the dining room, dir yelling negatively at On 9/15/16, at 8:25	a.m. NA-B stated R56 always dining room. She stated once ng her with her meal, she ling. NA-A stated she was nts don't like it when she called d have told her to shut up in d she was aware R20, R195, e disturbed by R56's calling R71 had not been nice to R56 e she was frustrated with R56's d sometimes it is really bad in ning was disrupted, and R56's ffected the other residents.					
	room. She stated re it really bothered th	esidents got upset with her and em. DA-A stated when R56 she was good, otherwise	8				
	(CDM) stated she v dining on the 2nd fl complained about F the past. She stated out of the dining roo CDM confirmed the residents on the 2n	a.m. clinical dietitian manager was aware that R56 disrupted oor, and stated residents had R56 hollering during meals in d nursing typically took R56 om when she was disruptive. e dining experience for d floor was disrupted and ook into it and see what else 56.					
	(DON) stated she v	p.m. Director of nursing vould expect staff to take R56 om if resident dining was being					

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SUR COMPLETE		
	00072		B. WING		09/15/2	016
NAME OF PROVIDER OR SUPP	LIER STREET A	OVIDER OR SUPPLIER	DRESS, CITY, S	TATE, ZIP CODE		
EVENTIDE LUTHERAN H		LUTHERAN HOME	STREET SO AD, MN 565			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	(EACH DEFICIENC)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE CO	(X5) DMPLETE DATE
21810 Continued Fro disrupted. SUGGESTED Director of Nur procedures for needs, educate changes and a procedures to	n page 18 METHOD OF CORRECTION: The sing could review the policies and accommodation of resident the appropriate personnel in any ppoint a designee to monitor the ensure ongoing compliance. FOR CORRECTION: twenty one	UGGESTED MET pirector of Nursing rocedures for acc eeds, educate the hanges and appoi rocedures to ensu	21810	DEFICIENCY)		
Minnesota Department of Health		artment of Health				