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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: AUQH
Facility ID: 00072

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **11/10/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, HFE NEII 11/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/29/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **10/28/2016** (L33)

DETERMINATION APPROVAL

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, 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

An equal opportunity employer.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245461	A. Building B. Wing	11/10/2016

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 Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0157 Reg. # 483.10(b)(11) LSC	Correction Completed 10/21/2016	ID Prefix F0246 Reg. # 483.15(e)(1) LSC	Correction Completed 10/21/2016	ID Prefix F0325 Reg. # 483.25(i) LSC	Correction Completed 10/21/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	**REVIEWED BY (INITIALS)** GA/mm	**DATE** 11/21/2016	**SIGNATURE OF SURVEYOR** 28034	**DATE** 11/10/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 9/15/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245461	A. Building 01 - MAIN BUILDING 01 B. Wing	10/24/2016

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 Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 09/28/2016	ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 09/22/2016	ID Prefix Reg. # NFPA 101 LSC K0034	Correction Completed 09/14/2016
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 10/21/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/20/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 10/21/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	11/21/2016	36536	10/24/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
9/14/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: AUQH
Facility ID: 00072

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **09/15/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **195** (L18)
13. Total Certified Beds **195** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Sherri Softing, HFE NEII 10/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - 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;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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 Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING ______ B. WING ______	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		10/21/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING ______ B. WING ______	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to promptly notify the physician for 2 of 4 residents (R56 and R207) who experienced significant weight loss. Findings include: R207's quarterly Minimum Data Set (MDS) dated 6/25/16 identified R207 had moderate cognitive impairment and required supervision with eating. The MDS further identified R207 had broken or loose dentures, was on a regular diet, had no weight loss. Review of R207's weight records from identified: - R207 had a significant weight loss (significant weight loss is defined as a weight loss of 5% or greater over 30 days, 7.5% or greater over 90 days, or 10% or greater over 180 days) of 9.1% of her body weight from 6/25/16 to 8/6/16 (42 days). On 6/25/16 R207 weighed 153.4# and on 8/6/16 R207 weighed 139#. -R207 had a significant weight loss of 5.3% of her body weight over 30 days. On 7/9/16 R207 weighed 151# and on 8/9/16 R207 weighed 143#.	F 157	This plan of correction is submitted solely to comply with all applicable state and federal regulatory requirements. These written responses do not constitute an admission of non-compliance with any requirements nor an agreement with any findings. Notification to the provider was completed for R207 on 9/27/2016 and R56 had a recent dietary consult ordered on 9/2 with follow up notification to provider on 9/16/2016 of consult. Clinical Dietician Manager was re-educated on the expectations of following the weight changes assessment policy in regards to notification to provider on 9/19/2016. Weight Changes Assessment policy was reviewed and remains up to date. Change in process will include nursing staff to notify clinical dietician when change of weight is 5 pounds for review. Dietician will review all weights of residents monthly and notify the provider. All current residents in facility were reviewed and those who met criteria for	

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F 157	Continued From page 2 On 9/15/16, at 9:06 a.m. Clinical Dietitian Manager (CDM) confirmed R207 had significant weight loss, she was unaware R207 had any significant weight loss and did not update the physician. R56's quarterly MDS dated, 5/26/16 identified R56 had severe cognitive impairment, required extensive assistance with eating and had significant weight loss. Review of R56's weight records identified R56 had a significant weight loss from 6/14/16 to 8/2/16. Record identified R207 had lost 9.5% of her body weight over 60 days. The record identified R56 weighed 116# on 6/14/16 and weighed 105# on 8/2/16. On 9/15/16, at 7:17 a.m. Unit Manager (UM-A) stated she was unaware of R207's and R56's significant weight loss, and did not update the physician. She stated she expected the CDM to identify significant weight loss for residents and update the physician. On 9/15/16, at 10:41 a.m. CDM confirmed she had completed a nutrition assessment for R56 on 6/11/16 and stated she was unaware of R56's significant weight loss from June to September and had not updated the physician of R56's weight loss. On 9/15/16, at 2:51 p.m. director of nurses (DON) stated she expected the physician to be notified as soon as a significant weight loss was identified. Review of the facility policy, Weight Changes/Assessment/Documentation dated,	F 157	significant weight loss had notification to the provider by 9/30/2016. All current residents are in compliance with practice expectations. Nursing staff will be re-educated on policy expectations on 10/6/2016. Ongoing education will be completed as needed with staff and chart audits will be completed with all new identifications of weight loss monthly and randomly which will be reported at quarterly QA meeting Responsible Party: DON or Designee	

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F 157	Continued From page 3 4/17/14 identified the physician, physician's assistant or nurse practitioner would be informed of a resident significant weight loss.	F 157		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to individualize the residents physical environment in accordance with the resident's own needs for dining for 1 of 1 residents (R56). Findings include: R56's Diagnosis Report dated 9/15/16, included Alzheimer's disease, dementia with behavioral disturbance, mental disorder, major depressive disorder and anxiety disorder. R56's quarterly Minimum Data Set dated, 5/26/16 identified R56 had severe cognitive impairment, severe depression, was short tempered and easily annoyed. MDS further identified R56 required extensive assistance with all activities of daily living (ADLs). R56's Care Area Assessment dated 2/29/16,	F 246	R56 care plan was reviewed for accommodation needs in the dining room. Changes to care plan were made on 10/7/2016 to include bringing into the dining room right before serving the meal and removing immediately when meal is completed. Staff will sit near R56 throughout the meal to provide redirection and assist as needed. Staff working on the 2nd floor were re-educated by 10/10/2016 with changes to care plan for R56. Care plans were reviewed for all residents who have similar dining room environment behaviors and updated to individualize residents needs for accommodations. Nursing staff were re-educated on 10/6/2016 with the dining room expectations and provided a list of	10/21/16

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F 246	Continued From page 4 identified R56 has severe cognitive impairment, had behaviors and received antidepressant, anti-anxiety and anti-psychotic medication. The CAA further identified staff were not always successful in redirecting R56 when she had behaviors, and R56 would continue to call out. The CAA also identified R56 had periods where she slept all day, and when she woke up would call out with some need, then forget what she needed. The CAA further identified staff were to anticipate all her needs as R56 had difficulty understanding others and making herself understood. R56's Care Plan dated 9/11/16, identified R56 hollered out, had agitation, poor decision making skills, periods of increased confusion, difficulty making herself understood and understanding others, "Sundowning (increased p.m. confusion and behaviors)." The care plan also identified R56's needs would be met with staff assistance. The care plan further identified staff were to assess and monitor R56 for changes in mood and determine contributing factors. The care plan also identified R56 may be hungry when she had behaviors, and changes in R56's mood were to be reported to practitioner and family. On 9/12/16, continuous observation from 5:28 p.m. to 6:00 p.m. were conducted. At 5:28 p.m. R56 was observed seated at the dining room table with R237, family member (FM-B), R284 and R207 in the back of the dining room. R56 hollered out excessively help, help. At approximately 5:40 p.m. FM-B stood up from table and wheeled R237 away from the table, out of the dining room. -5:45 p.m. R56 continued to call for help until nursing assistant (NA-H) handed her a glass of	F 246	interventions to utilize in regards to behaviors that are disruptive to the dining environment. Observation audits and ongoing education will be completed as needed with staff. Audits will be completed weekly x 1 month and then monthly x3 months and random thereafter. Audits will be reported at quarterly QA meeting. Responsible Party: DON or Designee	

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F 246	Continued From page 5	F 246		

juice and immediately walked away. R56 took a few sips and set the cup down on the edge of the table in front of her and again started hollering help, help. An unidentified resident seated a few tables away stated, "I wish they would help her," while the unidentified resident looked at R56. The tablemate stated to the unidentified resident stated in reply, "She doesn't know what she needs help with." As R56 continued to yell out, R284 who was seated next to her, groaned and rocked back and forth in her chair.
-6:00 p.m. An unidentified nursing staff person walked by R56 and stated, "What do you need help with?" R56 answered "I don't know" and then He asked R56 if she was hungry and she said "yes." The nursing staff member told R56 her food would be right out and immediately walked away. R56 continued to yell out. R56 was observed yelling out and appeared agitated, anxious for the entire observation.

On 9/13/16, at 1:02 p.m. R56 yelling out loudly and repeatedly in the dining room, "I want water, I want water," in the dining room. R20, who was seated at the same table as R56, stated loudly to R56, "Be quiet," in an angry voice and a furrowed brow.

On 9/14/16, during continuous observation from 5:29 p.m. to 6:04 p.m. R56 was observed seated in the back of the dining room continually yelling, Hurry up, I'm hungry. "
-5:37 p.m. R56 constantly hollering, "I want food, I want food, hurry up."
-5:43 p.m. R56 was handed a green nosey cup filled with juice, she took a couple sips and placed on the edge of the dining room table. R56 started yelling out,
"C'mon for God's sake, hurry up," R56 continued

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F 246	Continued From page 6 got louder and louder as she became more and more frustrated. Licensed practical nurse (LPN-A) came and asked her if she wanted more juice, R56 said, No." LPN-A immediately walked away from R56. R56 resumed yelling out "hurry up, hurry up." -5:57 p.m. CDM asked her, "What's wrong" and R56 told her, "I want food." The CDM stated " It's coming in a little bit, and when it comes I will help you" and offered R56 juice, which R56 declined and CDM immediately walked away from R56. -6:03 p.m. R56 continued to yell out repeatedly, NA-C approached her with a cup of coffee and set it down on her tray table and immediately walked away. -6:04 p.m. R56"s meal was brought to her and NA-E sat next to her to assist her with the meal. R56 stopped yelling out after NA-E sat down next to her. On 9/15/16, at 7:31 a.m. unit manager (UM-A) stated R56 had always called out in the dining room since admission (5 years earlier). She stated R56's yelling out was a behavior and stated she felt she was sure there's some rearranging the facility could do to minimize R56's yelling during dining. She stated the facility had considered moving R56 to the smaller dining room on the unit in the past, so it was less chaotic for R56, but stated the facility hadn't tried it yet. UM-A indicated she was not involved in seating arrangements in the dining room, however, stated she hoped dietary would make those recommendations and changes in the dining room to assist R56. On 9/15/16, at 8:11 a.m. NA-B stated R56 always hollered out in the dining room. She stated once staff started assisting her with her meal, she	F 246		

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F 246	Continued From page 7 usually stopped yelling. NA-A stated she was aware other residents don't like it when she called out in the dining and have told her to shut up in the past. She stated she was aware R20, R195, R237 and R71 were disturbed by R56's calling out in the past and R71 had not been nice to R56 in the past because she was frustrated with R56's yelling. NA-B stated sometimes it is really bad in the dining room, dining was disrupted, and R56's yelling negatively affected the other residents. On 9/15/16, at 8:25 a.m. dietary associate (DA-A) stated R56 always hollered out in the dining room. She stated residents got upset with her and it really bothered them. DA-A stated when someone sat with R56 she was good, otherwise she continued to holler out. On 9/15/16, at 9:06 a.m. clinical dietitian manager (CDM) stated she was aware that R56 disrupted dining on the 2nd floor, and stated residents had complained about R56 hollering during meals in the past. She stated nursing typically took R56 out of the dining room when she was disruptive. CDM confirmed the dining experience for residents on the 2nd floor was disrupted and stated they would look into it and see what else they could do for R56. On 9/15/16, at 2:51 p.m. Director of nursing (DON) stated she would expect staff to take R56 out of the dining room if resident dining was being disrupted.	F 246		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a	F 325		10/21/16

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F 325	Continued From page 8 resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively reassess 1 of 4 residents (R207) reviewed with significant weight loss. Findings include: R207's diagnosis report dated 9/15/16, identified R207 had diagnoses which included: traumatic brain injury, left sided weakness , right humorous and right radius fracture, depression, anxiety, altered mental status and cognitive communication deficit. R207's quarterly Minimum Data Set (MDS) dated 6/25/16 identified R207 had moderate cognitive impairment and required supervision with eating. The MDS further identified R207 had broken or loose dentures, was on a regular diet, had no weight loss. R207's Care Area Assessment (CAA) dated 4/1/16, identified R207 had severe cognitive impairment, required staff assistance with all ADLs, had increased confusion and had loose dentures which put her at risk for decreased food	F 325	R207 comprehensive nutrition assessment was completed on 9/27/2016 and notification to the provider on 9/27/2016 with increase in supplements and ongoing weight loss due to expected decline in condition. Provider had no further recommendations on 9/28/2016. Family care conference completed on 10/3/2016 with hospice in attendance. Weight loss was reviewed with no changes made due to overall expected decline. Hospice provided education to family for end of life signs. Family voiced on 10/10/16 the plan to not pursue fixing or replacing ill-fitting dentures that were recommended in the dental assessment. All current residents in facility were reviewed and those who met criteria for significant weight loss had notification to the provider and comprehensively re-assessed by 9/30/2016. All current residents are in compliance with practice expectations Weight Changes Assessment and	

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F 325	Continued From page 9 intake. The CAA further identified R207 was admitted to hospice on 3/19/16 and R207's care goals were to slow or minimize decline, avoid complications and minimize risks. R207's nutrition care plan dated 7/13/16, identified R207's care plan goals were to prevent weight loss and have no chewing difficulties. The care plan identified R207 had poor/fair food intake which did not meet her needs and had potential for chewing problems due to facial weakness. The care plan further identified R207 received 4-ounces nutritional supplement twice per day, a magic cup (ice-cream like nutritional supplement) at noon, regular diet with small portions, weight and chewing/swallowing problems were to be monitored, and R207 required feeding assistance as needed. Review of the 2nd Floor Care Plan (nurse aid care sheet) dated 9/14/16 identified R207 was on a regular diet and fed herself after set-up. On 9/13/16, from 12:30 p.m. to 1:02 p.m. R207 was observed seated in her wheelchair at the dining room table in the back of the dining room. R207 appeared pale and weak, her head hung low. R207 took only small bites of her meal (peanut butter cookie, tator tot casserole and mixed vegetables) and very slowly. R207 drank her orange juice, milk and took sips of her coffee. R207 used only her left hand for eating and drinking, while her right arm laid limp on her lap. NA-B passed by and asked R207, "Are you going to eat your cookie?." R207 replied, "I suppose." NA-B left the area and returned to the table within a few minutes and wheeled R207 away from the table, out of the dining room and into the hallway. R207 was not offered assistance with eating, and	F 325	documentation policy was reviewed and remains up to date. Clinical dietician manager was re-educated on the current policy expectations on 9/19/2016. Change in process will include nursing staff to notify clinical dietician when change of weight is 5 pounds or greater for review. Dietician will review all weights of residents monthly, make recommendations to maintain or improve nutrition status with notification to the provider if needed. Nutrition assessments will be completed quarterly and as needed for residents who meet the criteria for weight loss. Nursing staff will be re-educated on policy expectations by 10/6/2016. Ongoing education will be completed as needed with staff and chart audits will be completed monthly with all new identifications of weight loss and randomly which will be reported at quarterly QA meeting. . Responsible Party: DON or Designee	

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F 325	Continued From page 10	F 325		

magic cup was not observed to be administered or at her place setting during this time period.

Review of the Initial Nutrition Assessment dated 3/316, identified R207 received a regular diet, fed herself with reminders or required partial feeding assistance with eating. The assessment further identified R207 did not have any swallowing or chewing problems, had an upper partial and left sided facial weakness. The assessment further identified R207's usual body weight was between 162-169# and R207 had a fair appetite, with no history of weight loss. The assessment also identified 4-ounces of Boost Plus (nutritional supplement) would be added twice per day.

Review of quarterly nutritional assessment, dated 7/8/16 identified R207 received a regular diet and fed herself with reminders or required partial feeding assistance with eating. The assessment further identified R207 had no swallowing or chewing problems, had upper partial and left sided facial weakness. The assessment further identified R207 weighed 153#, appetite was good, no weight loss and magic cup was added once per day. The assessment failed to identify a weight loss of 9-16# from admission/usual body weight.

Review of R207's weekly weight records identified:

- R207 had a significant weight loss (significant weight loss is defined as a weight loss of 5% or greater over 30 days, 7.5% or greater over 90 days, or 10% or greater over 180 days) of 9.1% of her body weight from 6/25/16 to 8/6/16 (42 days). On 6/25/16 R207 weighed 153.4# and on 8/6/16 R207 weighed 139#.

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F 325	Continued From page 11	F 325		

-R207 had a significant weight loss of 5.3% of her body weight over 30 days. On 7/9/16 R207 weighed 151# and on 8/9/16 R207 weighed 143#.

Review of R207's meal consumption from 7/16 to 9/11/16 identified an average meal intake of less than 50%.

Review of R207's Medication Administration record from July 2016 identified the following:

- 31 total opportunities for R207 to receive the magic cup, of which R207 had consumed 25% or refused her magic cup 11 days out of the month and R207's consumption of the magic cup was not recorded for a total of 14 days out of the month.

-62 total opportunities for R207 to receive the Boost supplement, of which R207 consumed 50% boost plus supplements 20 times out of the month and R207's consumption was not recorded 21 times out of the month.

Review of R207's Medication Administration record from August 2016 identified the following:

-R207 had consumed an average of 50% of her magic cup once daily

R207 had taken the boost supplement twice per day a day consistently

Review of R207's progress notes from 7/8/16 to 9/15 identified:

-8/11/16, R207 had lost 8# in 1 month, 10# in 3

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F 325	Continued From page 12 months. -7/26/16, R207 had 8# weight loss in 1 month, appetite was poor, average meal intake was 25-50%, metformin was stopped due to decrease in appetite and food intake. -7/11/16, weight has been fairly stable, weight down 12-16# since admission. Intake declined since recent fall with fracture, for the past 2 weeks R207 had been eating less than 50% at majority of meals. R207 received a nutritional supplement at lunch with variable intake and 4-ounces other nutritional supplement to help meet her needs. Weights monitored and care plan followed. On 9/15/16, at 9:06 a.m. a review of R207's clinical record was conducted with Clinical Dietitian Manager (CDM). She confirmed R207 had last been assessed 7/8/16 and her weight had been fairly stable at that time. She confirmed R207 had a significant weight loss in August and stated she was unaware of R207's significant weight loss. She stated she would have assessed R207 had she known about her significant weight loss. The CDM stated she relied on the facility computer system to give her alerts when a resident had significant weight loss and had not received any alerts for R207. She stated R207 had received the same diet and nutritional supplements 3 times per day since 3/3/16 and confirmed R207 was eating only 50% or less of her meals She stated she probably would have increased R207's nutritional supplements if she had known about R207's significant weight loss because she knew R207 drank good. On 9/15/16, at 7:17 a.m. Unit Manager (UM-A)	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING ______ B. WING ______	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 13 stated if a resident had a significant weight change an alert would be generated by the facility computer system and could be viewed by all staff who logged in under resident weights and vitals. She stated she was not aware of R207's significant weight loss and indicated the clinical dietitian manager was responsible for the resident nutrition program for the whole building. She stated she would expect a nutrition assessment to be completed with significant weight loss and weight loss interventions changed or added. On 9/15/16, at 2:51 p.m. director of nurses (DON) stated she expected the nursing assistants (NA's) to notify the nurse if they entered a 3-5# weight loss from the previous weight, and to watch for weight accuracy. She stated she expected a nutrition assessment to be completed as soon as a significant weight loss was identified. Review of the facility policy, Weight Changes/Assessment/Documentation dated, 4/17/14 all residents who had a significant weight change (5% over 1 month, 7.5% over 3 months or 10% over 6 months) would be monitored and assessed to promote optimal health. The policy further identified the dietitian was to review all weights at least monthly.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey Eventide Lutheran Home Building 01 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by email to:	K 000	 	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _______	**09/14/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was surveyed as two building: Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961, is 1 story without a basement, and was determined to be of Type II(222) construction. In 1977, a 3-story addition, without a basement, was constructed north of the original building, and was determined to be of Type II (222) construction. In 1978 an administrative office building that is one story with a basement was constructed to the east of the original building for administrative offices, is separated with a 2-hour fire barrier, does not have any resident use and is a business occupancy. In 1992 an addition was constructed to the north of the 1977 building which is 3-stories, with a basement, was determined to be a Type II (222) building and was separated with at least a 2 hour fire barrier. The facility is divided into sixteen smoke zones by 30 minute and 90 minute fire barriers. In 2013 a PT/ Wellness	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 building was added to the north west of the original building. It is 1-story , no basement and Type II (111). The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinklers 1999 edition. The facility has a fire alarm system with corridor smoke detection and smoke detection in common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 195 beds and had a census of 190 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are	K 018		9/28/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	09/14/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of doors in the corridor according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 56 of the 190 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:00 am to 3:00 pm on 09-14-2016 observations and staff interview revealed: 1. The door to resident room 238 does not fit tightly in the frame 2. The cabinet doors to clean linen storage in the heritage wing corridor do not positively latch. This deficient condition was confirmed by the Facility Administrator and the Director of Facilities.	K 018	K18 Door not fitting tightly in frame, Room # 238: Facilities Director created work order 214666 to add smoke seal to door frame. Maintenance staff will continue to monitor doors to ensure doors fit tightly in frame. K 18 Cabinet doors don't latch in Heritage corridor: Facilities Director created work Order 214159 to install latching hardware on cabinet doors. Maintenance staff will monitor cabinets to ensure of positive latching.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by:	K 025		9/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

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K 025	Continued From page 4 Based on observation and staff interview, the facility failed to maintain proper construction of 3 of 9 smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 48 of 190 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 8:00 am to 3:00 pm on 09-14-2016 observations and staff interview revealed a penetration in smoke barriers in the following locations. 1. The 3rd floor, east corridor above the ceiling at the cross corridor doors. 2. The 2nd floor, east corridor above the ceiling at the cross corridor doors. 3. The 1st floor smoke barrier by the atrium lobby. This deficient condition was confirmed by the Facility Administrator and the Director of Facilities.	K 025	Facilities Director created work Orders 214183, 214184, and 214185 to fire caulk penetrations on 1st, 2nd and 3rd floors. Maintenance staff will continue to monitor smoke barriers for penetrations.	
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain 1 of 5 exit stairways in accordance with NFPA 101 Life Safety Code (2000) section 7.2.2. This deficient practice could negatively affect the use of the exit stairway used by patients, and an undtermined amount of staff, and visitors in the event of an emergency. Findings include:	K 034	Facilities Director created work order 214182 to remove chairs and building materials from stairwell. Maintenance will monitor stairwells for storage and remove items as needed.	9/14/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

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K 034	Continued From page 5 On the facility tour between 8:00 am to 3:00 pm on 09-14-2016 observations and staff interview revealed stair shaft 1C next to the atrium cafe was being used for storage of chairs and the door was not properly labeled as delayed egress. This deficient condition was confirmed by the Facility Administrator and the Director of Facilities.	K 034		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NFPA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failled to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. This deficient practice could allow for the spread of fire due improper sprinkler coverage and affect 24 of the 190 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm	K 056	Facilities director contacted vendor to install additional sprinkler head/s in storage area of penthouse and in elevator shafts. He also contacted elevator service representative.	10/21/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

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K 056	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.	K 056		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system would function properly in the event of a fire and could negatively affect all 28 of the 190 residents and 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 missing and broken ceiling tiles in storage room 2-052.	K 062	Facilities director created work order 214181 to replace broken tiles. Maintenance staff will do quarterly checks for broken/missing ceiling tiles.	9/20/16

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	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/14/2016**

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

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K 062	Continued From page 7 This deficient condition was confirmed by the Facility Administrator and the Director of Facilities.	K 062		
K 147 SS=D	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 order 214158 to install panic hardware on two penthouse doors. Contacted vendor to obtain panic hardware for two penthouse doors.	10/21/16

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **02 - PT/WELLNESS CENTER** B. WING	**09/14/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Eventide Lutheran Home Building 02 was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was surveyed as two building: Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1961, is 1 story without a basement, and was determined to be of Type II(222) construction. In 1977, a 3-story addition, without a basement, was constructed north of the original building, and was determined to be of Type II (222) construction. In 1978 an administrative office building that is one story with a basement was constructed to the east of the original building for administrative offices, is separated with a 2-hour fire barrier, does not have any resident use and is a business occupancy. In 1992 an addition was constructed to the north of the 1977 building which is 3-stories, with a basement, was determined to be a Type II (222) building and was separated with at least a 2 hour fire barrier. The facility is divided into sixteen smoke zones by 30 minute and 90 minute fire barriers. In 2013 a PT/ Wellness building was added to the north west of the	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **02 - PT/WELLNESS CENTER** B. WING ______	**09/14/2016**

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

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K 000	Continued From page 1 original building. It is 1-story , no basement and Type II (111). The building is fully sprinkler protected in accordance with NFPA 13 The Standard for the Installation of Sprinklers 1999 edition. The facility has a fire alarm system with corridor smoke detection and smoke detection in common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 195 beds and had a census of 190 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

"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, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: ______ B. WING ______	09/15/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 9/12/16, 9/13/16, 9/14/16 and 9/15/16 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or	2 265		10/21/16

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2 265	Continued From page 3 E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to promptly notify the physician for 2 of 4 residents (R56 and R207) who experienced significant weight loss. Findings include: R207's quarterly Minimum Data Set (MDS) dated 6/25/16 identified R207 had moderate cognitive impairment and required supervision with eating. The MDS further identified R207 had broken or loose dentures, was on a regular diet, had no weight loss. Review of R207's weight records from identified: - R207 had a significant weight loss (significant weight loss is defined as a weight loss of 5% or greater over 30 days, 7.5% or greater over 90 days, or 10% or greater over 180 days) of 9.1% of her body weight from 6/25/16 to 8/6/16 (42 days). On 6/25/16 R207 weighed 153.4# and on 8/6/16 R207 weighed 139#. -R207 had a significant weight loss of 5.3% of her body weight over 30 days. On 7/9/16 R207 weighed 151# and on 8/9/16 R207 weighed 143#. On 9/15/16, at 9:06 a.m. Clinical Dietitian Manager (CDM) confirmed R207 had significant weight loss, she was unaware R207 had any significant weight loss and did not update the physician.	2 265	Corrected	

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2 265	Continued From page 4 R56's quarterly MDS dated, 5/26/16 identified R56 had severe cognitive impairment, required extensive assistance with eating and had significant weight loss. Review of R56's weight records identified R56 had a significant weight loss from 6/14/16 to 8/2/16. Record identified R207 had lost 9.5% of her body weight over 60 days. The record identified R56 weighed 116# on 6/14/16 and weighed 105# on 8/2/16. On 9/15/16, at 7:17 a.m. Unit Manager (UM-A) stated she was unaware of R207's and R56's significant weight loss, and did not update the physician. She stated she expected the CDM to identify significant weight loss for residents and update the physician. On 9/15/16, at 10:41 a.m. CDM confirmed she had completed a nutrition assessment for R56 on 6/11/16 and stated she was unaware of R56's significant weight loss from June to September and had not updated the physician of R56's weight loss. On 9/15/16, at 2:51 p.m. director of nurses (DON) stated she expected the physician to be notified as soon as a significant weight loss was identified. Review of the facility policy, Weight Changes/Assessment/Documentation dated, 4/17/14 identified the physician, physician's assistant or nurse practitioner would be informed of a resident significant weight loss.	2 265		

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2 265	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The Director of Nursing and the Director of Nutrition could review the policies and procedures for physician notification, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: twenty one (21) days.	2 265		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively reassess 1 of 4 residents (R207) reviewed with significant weight loss. Findings include: R207's diagnosis report dated 9/15/16, identified	2 965	Corrected	10/21/16

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2 965	Continued From page 6 R207 had diagnoses which included: traumatic brain injury, left sided weakness , right humorous and right radius fracture, depression, anxiety, altered mental status and cognitive communication deficit. R207's quarterly Minimum Data Set (MDS) dated 6/25/16 identified R207 had moderate cognitive impairment and required supervision with eating. The MDS further identified R207 had broken or loose dentures, was on a regular diet, had no weight loss. R207's Care Area Assessment (CAA) dated 4/1/16, identified R207 had severe cognitive impairment, required staff assistance with all ADLs, had increased confusion and had loose dentures which put her at risk for decreased food intake. The CAA further identified R207 was admitted to hospice on 3/19/16 and R207's care goals were to slow or minimize decline, avoid complications and minimize risks. R207's nutrition care plan dated 7/13/16, identified R207's care plan goals were to prevent weight loss and have no chewing difficulties. The care plan identified R207 had poor/fair food intake which did not meet her needs and had potential for chewing problems due to facial weakness. The care plan further identified R207 received 4-ounces nutritional supplement twice per day, a magic cup (ice-cream like nutritional supplement) at noon, regular diet with small portions, weight and chewing/swallowing problems were to be monitored, and R207 required feeding assistance as needed. Review of the 2nd Floor Care Plan (nurse aid care sheet) dated 9/14/16 identified R207 was on a regular diet and fed herself after set-up.	2 965		

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2 965	Continued From page 7 On 9/13/16, from 12:30 p.m. to 1:02 p.m. R207 was observed seated in her wheelchair at the dining room table in the back of the dining room. R207 appeared pale and weak, her head hung low. R207 took only small bites of her meal (peanut butter cookie, tator tot casserole and mixed vegetables) and very slowly. R207 drank her orange juice, milk and took sips of her coffee. R207 used only her left hand for eating and drinking, while her right arm laid limp on her lap. NA-B passed by and asked R207, "Are you going to eat your cookie?." R207 replied, "I suppose." NA-B left the area and returned to the table within a few minutes and wheeled R207 away from the table, out of the dining room and into the hallway. R207 was not offered assistance with eating, and magic cup was not observed to be administered or at her place setting during this time period. Review of the Initial Nutrition Assessment dated 3/316, identified R207 received a regular diet, fed herself with reminders or required partial feeding assistance with eating. The assessment further identified R207 did not have any swallowing or chewing problems, had an upper partial and left sided facial weakness. The assessment further identified R207's usual body weight was between 162-169# and R207 had a fair appetite, with no history of weight loss. The assessment also identified 4-ounces of Boost Plus (nutritional supplement) would be added twice per day. Review of quarterly nutritional assessment, dated 7/8/16 identified R207 received a regular diet and fed herself with reminders or required partial feeding assistance with eating. The assessment further identified R207 had no swallowing or chewing problems, had upper partial and left sided facial weakness. The assessment further	2 965		

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2 965	Continued From page 8	2 965		

identified R207 weighed 153#, appetite was good, no weight loss and magic cup was added once per day. The assessment failed to identify a weight loss of 9-16# from admission/usual body weight.

Review of R207's weekly weight records identified:

- R207 had a significant weight loss (significant weight loss is defined as a weight loss of 5% or greater over 30 days, 7.5% or greater over 90 days, or 10% or greater over 180 days) of 9.1% of her body weight from 6/25/16 to 8/6/16 (42 days). On 6/25/16 R207 weighed 153.4# and on 8/6/16 R207 weighed 139#.

-R207 had a significant weight loss of 5.3% of her body weight over 30 days. On 7/9/16 R207 weighed 151# and on 8/9/16 R207 weighed 143#.

Review of R207's meal consumption from 7/16 to 9/11/16 identified an average meal intake of less than 50%.

Review of R207's Medication Administration record from July 2016 identified the following:

- 31 total opportunities for R207 to receive the magic cup, of which R207 had consumed 25% or refused her magic cup 11 days out of the month and R207's consumption of the magic cup was not recorded for a total of 14 days out of the month.

-62 total opportunities for R207 to receive the Boost supplement, of which R207 consumed 50% boost plus supplements 20 times out of the month and R207's consumption was not recorded 21 times out of the month.

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2 965	Continued From page 9 Review of R207's Medication Administration record from August 2016 identified the following: -R207 had consumed an average of 50% of her magic cup once daily R207 had taken the boost supplement twice per day a day consistently Review of R207's progress notes from 7/8/16 to 9/15 identified: -8/11/16, R207 had lost 8# in 1 month, 10# in 3 months. -7/26/16, R207 had 8# weight loss in 1 month, appetite was poor, average meal intake was 25-50%, metformin was stopped due to decrease in appetite and food intake. -7/11/16, weight has been fairly stable, weight down 12-16# since admission. Intake declined since recent fall with fracture, for the past 2 weeks R207 had been eating less than 50% at majority of meals. R207 received a nutritional supplement at lunch with variable intake and 4-ounces other nutritional supplement to help meet her needs. Weights monitored and care plan followed. On 9/15/16, at 9:06 a.m. a review of R207's clinical record was conducted with Clinical Dietitian Manager (CDM). She confirmed R207 had last been assessed 7/8/16 and her weight had been fairly stable at that time. She confirmed R207 had a significant weight loss in August and stated she was unaware of R207's significant weight loss. She stated she would have assessed	2 965		

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2 965	Continued From page 10	2 965		

R207 had she known about her significant weight loss. The CDM stated she relied on the facility computer system to give her alerts when a resident had significant weight loss and had not received any alerts for R207. She stated R207 had received the same diet and nutritional supplements 3 times per day since 3/3/16 and confirmed R207 was eating only 50% or less of her meals She stated she probably would have increased R207's nutritional supplements if she had known about R207's significant weight loss because she knew R207 drank good.

On 9/15/16, at 7:17 a.m. Unit Manager (UM-A) stated if a resident had a significant weight change an alert would be generated by the facility computer system and could be viewed by all staff who logged in under resident weights and vitals. She stated she was not aware of R207's significant weight loss and indicated the clinical dietitian manager was responsible for the resident nutrition program for the whole building. She stated she would expect a nutrition assessment to be completed with significant weight loss and weight loss interventions changed or added.

On 9/15/16, at 2:51 p.m. director of nurses (DON) stated she expected the nursing assistants (NA's) to notify the nurse if they entered a 3-5# weight loss from the previous weight, and to watch for weight accuracy. She stated she expected a nutrition assessment to be completed as soon as a significant weight loss was identified.

Review of the facility policy, Weight Changes/Assessment/Documentation dated, 4/17/14 all residents who had a significant weight change (5% over 1 month, 7.5% over 3 months or 10% over 6 months) would be monitored and assessed to promote optimal health. The policy

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2 965	Continued From page 11 further identified the dietitian was to review all weights at least monthly. SUGGESTED METHOD OF CORRECTION: The Director of Nutrition could review the policies and procedures for significant weigh loss, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: twenty one (21) days.	2 965		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff utilized a hairnet or restraint while preparing and serving food in the kitchenette. This had the potential to affect 54 of 54 resident in the facility who were served food out of the kitchenette. Findings include: During observation of the supper meal on 9/12/16 at 5:59 p.m. several residents were seated at the tables in the main dining room on the first floor. The certified nursing assistance (CNA's) would	2 995	Corrected	9/21/16

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2 995	Continued From page 12 go to the tables, ask the residents their preference of food and bring the menu slips to the kitchenette window on a serving tray. Dietary assistant (DA)-B stood over the steam table and proceeded to grab a plate with his gloved hands, then used various tools such as: tongs, ice cream scoopers, and spoons to serve the residents hotdog's on a bun or BBQ chicken, potatoes salad and baked beans while the CNA's read it off the menu slip. DA-B would then lean forward over the steam table to hand the plate across the steam table to the CNA's to place the plate on the serving tray. DA-B was observed to wear a hair net that covered only the upper crown part of his head area with hair exposed on the lower half of his head and had a full facial beard which was approximately 3/4 of an inch long and was not restrained. DA-B continued to serve all the residents in the main dining room on the first floor in this fashion while DA-B's hair and beard was not restrained during the serving process. On 9/15/16 at 12:53 p.m. dietary manager (DM) confirmed she would expect staff to contain their hair and indicated DA-B does not wear the hair nets properly, did not have hair and beard restrained and stated "I have noticed that he does not wear the hair net right." DM indicated that she has given DA-A education in regards to this and has corrected this in the past and stated "I missed it." DM indicated that this was her first employee that has had a full facial beard and was not quite sure if he needed it restrained or not and stated "yes he should be wearing a beard net." Review of facility policy titled, Dress Code Nutrition and Culinary Services, revised on 4/17/16, indicated hairnets or chef's cap must be worn at all times to keep hair from food and food	2 995		

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	00072	A. BUILDING: ______ B. WING ______	09/15/2016

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

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2 995	Continued From page 13 contact surfaces, good grooming habits expected and facial hair such as side burns, beards and mustaches must be neatly trimmed. SUGGESTED METHOD OF CORRECTION: The dietary supervisor could educate staff on the hairnet requirement and conduct random audits. The result of the audits could be reported to the quality assurance committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 995		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to individualize the residents physical environment in accordance with the resident's own needs for dining for 1 of 1 residents (R56). Findings include: R56's Diagnosis Report dated 9/15/16, included Alzheimer's disease, dementia with behavioral	21810	Corrected	10/21/16

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21810		21810		

Continued From page 14

disturbance, mental disorder, major depressive disorder and anxiety disorder.

R56's quarterly Minimum Data Set dated, 5/26/16 identified R56 had severe cognitive impairment, severe depression, was short tempered and easily annoyed. MDS further identified R56 required extensive assistance with all activities of daily living (ADLs).

R56's Care Area Assessment dated 2/29/16, identified R56 has severe cognitive impairment, had behaviors and received antidepressant, anti-anxiety and anti-psychotic medication. The CAA further identified staff were not always successful in redirecting R56 when she had behaviors, and R56 would continue to call out. The CAA also identified R56 had periods where she slept all day, and when she woke up would call out with some need, then forget what she needed. The CAA further identified staff were to anticipate all her needs as R56 had difficulty understanding others and making herself understood.

R56's Care Plan dated 9/11/16, identified R56 hollered out, had agitation, poor decision making skills, periods of increased confusion, difficulty making herself understood and understanding others, "Sundowning (increased p.m. confusion and behaviors)." The care plan also identified R56's needs would be met with staff assistance. The care plan further identified staff were to assess and monitor R56 for changes in mood and determine contributing factors. The care plan also identified R56 may be hungry when she had behaviors, and changes in R56's mood were to be reported to practitioner and family.

On 9/12/16, continuous observation from 5:28

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21810	Continued From page 15 p.m. to 6:00 p.m. were conducted. At 5:28 p.m. R56 was observed seated at the dining room table with R237, family member (FM-B), R284 and R207 in the back of the dining room. R56 hollered out excessively help, help. At approximately 5:40 p.m. FM-B stood up from table and wheeled R237 away from the table, out of the dining room. -5:45 p.m. R56 continued to call for help until nursing assistant (NA-H) handed her a glass of juice and immediately walked away. R56 took a few sips and set the cup down on the edge of the table in front of her and again started hollering help, help. An unidentified resident seated a few tables away stated, "I wish they would help her," while the unidentified resident looked at R56. The tablemate stated to the unidentified resident stated in reply, "She doesn't know what she needs help with." As R56 continued to yell out, R284 who was seated next to her, groaned and rocked back and forth in her chair. -6:00 p.m. An unidentified nursing staff person walked by R56 and stated, "What do you need help with?" R56 answered "I don't know" and then He asked R56 if she was hungry and she said "yes." The nursing staff member told R56 her food would be right out and immediately walked away. R56 continued to yell out. R56 was observed yelling out and appeared agitated, anxious for the entire observation. On 9/13/16, at 1:02 p.m. R56 yelling out loudly and repeatedly in the dining room, "I want water, I want water," in the dining room. R20, who was seated at the same table as R56, stated loudly to R56, "Be quiet," in an angry voice and a furrowed brow. On 9/14/16, during continuous observation from 5:29 p.m. to 6:04 p.m. R56 was observed seated	21810		

Minnesota Department of Health

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21810	Continued From page 16	21810		

in the back of the dining room continually yelling, Hurry up, I'm hungry. "
-5:37 p.m. R56 constantly hollering, "I want food, I want food, hurry up."
-5:43 p.m. R56 was handed a green nosey cup filled with juice, she took a couple sips and placed on the edge of the dining room table. R56 started yelling out,
"C'mon for God's sake, hurry up," R56 continued got louder and louder as she became more and more frustrated. Licensed practical nurse (LPN-A) came and asked her if she wanted more juice, R56 said, No." LPN-A immediately walked away from R56. R56 resumed yelling out "hurry up, hurry up."
-5:57 p.m. CDM asked her, "What's wrong" and R56 told her, "I want food." The CDM stated " It's coming in a little bit, and when it comes I will help you" and offered R56 juice, which R56 declined and CDM immediately walked away from R56.
-6:03 p.m. R56 continued to yell out repeatedly, NA-C approached her with a cup of coffee and set it down on her tray table and immediately walked away.
-6:04 p.m. R56"s meal was brought to her and NA-E sat next to her to assist her with the meal. R56 stopped yelling out after NA-E sat down next to her.

On 9/15/16, at 7:31 a.m. unit manager (UM-A) stated R56 had always called out in the dining room since admission (5 years earlier). She stated R56's yelling out was a behavior and stated she felt she was sure there's some rearranging the facility could do to minimize R56's yelling during dining. She stated the facility had considered moving R56 to the smaller dining room on the unit in the past, so it was less chaotic for R56, but stated the facility hadn't tried it yet. UM-A indicated she was not involved in

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21810	Continued From page 17 seating arrangements in the dining room, however, stated she hoped dietary would make those recommendations and changes in the dining room to assist R56. On 9/15/16, at 8:11 a.m. NA-B stated R56 always hollered out in the dining room. She stated once staff started assisting her with her meal, she usually stopped yelling. NA-A stated she was aware other residents don't like it when she called out in the dining and have told her to shut up in the past. She stated she was aware R20, R195, R237 and R71 were disturbed by R56's calling out in the past and R71 had not been nice to R56 in the past because she was frustrated with R56's yelling. NA-B stated sometimes it is really bad in the dining room, dining was disrupted, and R56's yelling negatively affected the other residents. On 9/15/16, at 8:25 a.m. dietary associate (DA-A) stated R56 always hollered out in the dining room. She stated residents got upset with her and it really bothered them. DA-A stated when someone sat with R56 she was good, otherwise she continued to holler out. On 9/15/16, at 9:06 a.m. clinical dietitian manager (CDM) stated she was aware that R56 disrupted dining on the 2nd floor, and stated residents had complained about R56 hollering during meals in the past. She stated nursing typically took R56 out of the dining room when she was disruptive. CDM confirmed the dining experience for residents on the 2nd floor was disrupted and stated they would look into it and see what else they could do for R56. On 9/15/16, at 2:51 p.m. Director of nursing (DON) stated she would expect staff to take R56 out of the dining room if resident dining was being	21810		

Minnesota Department of Health

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21810	Continued From page 18	21810		

disrupted.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review the policies and procedures for accommodation of resident needs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: twenty one (21) days.