Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 6, 2023

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

RE: CCN: 245461
Cycle Start Date: August 16, 2023

Dear Administrator:

On August 16, 2023, a 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by November 16, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by February 16, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/14/23 to 8/16/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1)	E 041		9/18/23

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

Electronically Signed | 09/11/2023

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

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E 041	Continued From page 1 Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may	E 041		

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E 041	Continued From page 2 inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by:	E 041		

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E 041	Continued From page 3 Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the 122 residents within the facility. Findings include: On 8/15/23 at 12:30 p.m., it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month four-hour generator load bank test. An interview with the Administrator on 8/15/23, verified this deficient finding at the time of discovery.	E 041	How corrective action will be accomplished for the resident(s) impacted: - The Director of Facilities and Maintenance has scheduled a 4-hour load bank test for 9/12/2023, which will be conducted and documented in accordance with NFPA 110, Health Care Facilities Code, and Life Safety Code guidelines. How facility will identify other residents who have potential to be affected: - All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - All staff will be educated on the requirement for 4-hour, 36-month load bank testing on 9/13/23. - A recurring preventive maintenance service reminder will be added to our automated work order generation system to include a 36-month, 4-hour load bank test. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: - The Director of Facilities and Maintenance and Administrator or designee(s) will audit the Life Safety compliance documentation binder, including generator testing documentation, monthly for twelve months with additional audits as recommended by the QA committee. If concerns are	

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E 041	Continued From page 4	E 041	identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 000	INITIAL COMMENTS On 8/14/23 to 8/16/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiencies cited. H54613609C (MN00085543), H54614148C (MN00092601), H54614150C (MN00086630). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii)	F 575		9/18/23

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F 575	Continued From page 5 §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post accessible contact information of all pertinent State agencies or ombudsman information for 4 of 4 residents (R4, R32, R33, R92), who routinely attended resident council. This had the potential to affect all 122 residents who resided in the facility. Findings include: During the resident council meeting held on 8/15/23 at 1:11 p.m., with state surveyors. R4, R32, R33, and R92 were in attendance. Upon asking, R4, R32, R33 and R92 indicated they did	F 575	How corrective action will be accomplished for the resident(s) impacted: - The Resident Bill of Rights and the regional ombudsman's contact information is currently posted inside the nursing home entrance to the left of the double doors on the wall. The posting is located approximately 3 1/2 feet off the ground in a black frame. An additional posting has been placed near the Main Street reception desk. - The regional ombudsman attended resident council on 9/12/23 and a	

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F 575	Continued From page 6 not know where the ombudsman information was located or posted within the building. During observations on 8/14/23 and 8/15/23, the Bill Of Rights (BOR) posting was located outside the nursing home entrance on the first floor to the right of the double doors above a shelf. The posting was located approximately seven feet high off the ground and in black frame hanging on the wall above the shelf. No other postings of contact information for the State agencies or ombudsman information were noted within the facility or on the additional floors of the nursing home and was not accessible to the residents to view or read. During an interview on 8/16/23 at 1:54 p.m., the director of social services (DSS) confirmed the above finding and indicated R4, R32, R33, R92 regularly attend the resident council meetings. The DSS indicated she had not reviewed or identified the location of the ombudsman contact information at the resident council meetings. The DSS further indicated she would expect the ombudsman information to be reviewed at the meetings so the residents would know where the information was located within the nursing home. During an interview on 8/16/23 at 12:21 p.m., the administrator confirmed the above finding and indicated she would expect staff to share the information in the resident council meeting of where the ombudsman information was located within the building. On 8/15/23, a policy regarding ombudsman information was requested and one was not provided.	F 575	reminder was provided to residents present of her role and where to find her contact information. - An informational memo will be distributed to all residents with information on the location of resident rights and ombudsman information in the facility. The regional ombudsman contact information will be reviewed routinely at resident council meetings. How facility will identify other residents who have potential to be affected: - All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Education will be provided to all staff on 9/13/23 about the location of the required postings in the building. - The Resident Bill of Rights and ombudsman information will be posted in one additional area of the building. The regional ombudsman contact information will be reviewed routinely at resident council meetings. - The Director of Social Services and Admissions or designee will discuss the location of resident rights and ombudsman contact information postings in the building during future resident council meetings. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: - The Director of Social Services and Admissions or designee will audit resident	

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F 575	Continued From page 7	F 575	council meeting notes quarterly for one year to monitor for inclusion of information of the location of resident rights and ombudsman information in the building. - If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents.	F 577		9/18/23

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F 577	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 4 of 4 residents (R4, R32, R33, R92), who routinely attended resident council, were made aware of the state agency (SA) survey results. This had the potential to affect all 122 residents who resided in the facility. Findings include: During the resident council meeting held on 8/15/23 at 1:11 p.m., with state surveyors. R4, R32, R33, and R92 were in attendance. Upon asking, R4, R32, R33 and R92 indicated they did not know where the SA survey results were located within the building. During observations on 8/14/23 and 8/15/23, near the main entrance of the nursing home; a black frame was noted on a shelf in the corner to the right of the nursing home entrance double doors. The frame was located approximately seven feet high off the ground and inside the frame was a posting which identified where the facility's survey results were located: (state survey results can be found in the main atrium lounge across from the Grill near the administration offices.) The posting of the SA survey results was not visible or accessible to a resident seated in a wheel chair or within the resident care areas or additional floors of the nursing home. In addition, the posting and did not indicate exactly where the location of the survey results would be located once you got to the main atrium lounge. During an interview on 8/16/23 at 12:06 p.m., the director of social services (DSS) confirmed the	F 577	How corrective action will be accomplished for the resident(s) impacted: - The facility survey results are posted in a binder on a table across from the grill in the atrium of the facility for resident and public access. A sign indicating the location of the binder is available in the entrance to the nursing home. An additional posting will be placed near the Main Street reception desk. - An informational memo will be distributed to all residents with information on the location of survey results in the facility. Rights to survey results information and posting location will be reviewed routinely at resident council meetings. How facility will identify other residents who have potential to be affected: - All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: - Education will be provided to all staff on 9/13/23 about the location of survey results in the building. - An additional posting of the location of survey results will be placed near the Main Street reception desk. - The Director of Social Services and Admissions or designee will routinely discuss the recent survey results and the location of a copy of survey results in the	

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F 577	Continued From page 9 above findings and indicated R4, R32, R33, R92 regularly attended the resident council meetings. Indicated she had not reviewed the SA survey results or identified the location of them at the resident council meetings. Stated she would expect the SA survey results to be reviewed at the meetings so the residents would know where the information was located within the facility. During an interview on 8/16/23 at 12:21 p.m., the administrator confirmed the above finding and indicated she would expect staff to share the information in the resident council meeting of where the SA survey results were located within the building. On 8/15/23, a policy regarding survey results was requested and one was not provided.	F 577	building during future resident council meetings. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: - The Director of Social Services and Admissions or designee will audit resident council meeting agendas quarterly for one year to monitor for inclusion of a reminder of the location of state survey results information in the building. - If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		9/18/23

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F 584	Continued From page 10 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide housekeeping services to ensure a clean environment for 2 of 2 residents (R65, R69) who had pervasive urine odors in the room. Findings include: R65 During observations on 8/14/23 at 1:43 p.m., R65 was laying on her back and was covered with a blanket sleeping. R65 had a catheter, which was placed in a privacy bag laying on the floor by the foot of her bed on the left side. R65's room had a	F 584	How corrective action will be accomplished for the resident(s) impacted: • The source of odor was identified for R65 and R69 and interventions have been implemented to assist in eliminating odors. How facility will identify other residents who have potential to be affected: • All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that	

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F 584	Continued From page 11 strong urine odor which permeated out of her room and into the hallway. - at 1:58 R65 remained in the same position and the strong urine odor continued to permeate out of her room and into the hallway of the south wing on the first floor. During observations on 8/15/23 at 8:45 a.m., R65 was seated in her geri chair, call light in reach, the catheter was present in a privacy bag and hooked to her geri chair. R65 indicated she did not know how long she had her catheter in place and stated she has had infections in the past. R65's room continued to have a strong urine odor which permeated out of her room and into the hallway. - at 3:15 p.m., R65 was lying in bed resting and continued to have strong urine odor which permeated out of her room and into the hallway. - at 3:32 p.m., R65's room remained the same and housekeeping staff were observed to exit another resident's room and wheeled her cleaning cart into the soiled utility room. The staff were not observed to enter R65's room. - at 3:59 p.m., R65's room remained the same. - at 4:35 p.m., R65's was seated in her geri chair watching TV, with catheter in privacy bag hooked to her chair and the urine odor remained the same. During observations on 8/16/23 at 7:22 a.m., R65 was seated in her geri chair resting with her eyes closed, call light in reach, her catheter was placed in a privacy bag and hooked to her geri chair. R65's room continued to have a strong urine smell which permeated out into the hallway. - at 7:39 a.m., R65's and her room remained the same. - at 7:53 a.m. R65's and her room remained the	F 584	the deficient practice will not recur: • Education will be provided to all staff on 9/13/23 regarding the requirement for cleanliness in resident rooms, potential sources of odors, and interventions to use for room odors. • Environmental rounds will be conducted quarterly for all residents and interventions will be implemented as needed to eliminate odor. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: • The Support Services Coordinator and DON or designee will perform 10 audits a month for three months and 5 audits a month for three months to monitor for room odors with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 584	Continued From page 12 same. During an interview on 8/16/23 at 7:42 a.m., house keeper (HK)-A indicated housekeeping staff cleaned resident rooms on a daily basis during the week and on the weekends the rooms were only cleaned when there was a spill or when something needed to be cleaned. HK-A indicated she only worked on the south wing of the first floor. In a follow up interview at 12:28 p.m., HK-A confirmed R65's room smelled of strong urine odor and indicated R65 had a catheter bag. HK-A stated when nursing staff emptied or changed the bag, it leaked onto the floor. HK-A indicated house keeping staff attempted to remove the urine smell by cleaning and it would go away at times. HK-A stated she had used an air freshener in the past and indicated she had not been directed on what else to do to remove the pervasive odor. During an interview on 8/16/23 at 12:36 p.m., licensed practical nurse (LPN)-A confirmed R65's room did smell of urine at times due to her having a supra-pubic catheter and having a very strong urine smell. LPN-A indicated at times staff would use a spray to assist with the odor removal in R65's room and indicated some days were worse than others. During an interview on 8/16/23 at 12:49 p.m. the administrator indicated her expectation of staff would be to minimize odors due to dignity issues. The administrator stated she would expect staff to try various things to minimize the odors in resident rooms such as air fresheners, cleaning rooms more, changing of linens, clothes, and to	F 584		

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F 584	Continued From page 13 find out what the source of odor was and to fix it. Review of facility policy titled, Proper Cleaning of a Room revised on 4/2017, indicated the facility would ensure that all room were infection free and would clean all surfaces and floors in rooms. R69 Findings include: During observations on 8/15/23, at 9:05 a.m., R69 was seated in his recliner chair listening to music while looking out the window. R69's room had a strong urine/foul odor which permeated throughout the room and bathroom. - at 10:17 a.m. continued to have the same strong urine/foul odor and resident assumed the same position. - at 3:35 p.m. R69's room had finished being cleaned by housekeeping and R69's room continued to have the same strong urine/foul odor. - at 4:45 p.m. continued to have the same strong urine/foul odor and resident assumed the same position. During an interveiw and observation on 8/16/23, at 1:44 p.m. house keeper (HK)-A stated residents' rooms were cleaned on a daily basis during the week and only when needed on the weekends. HK-A confirmed R69's room had a strong urine/foul odor on 8/14/23 and 8/16/23. HK-A stated R69's room had a strong urine/foul odor in the past and had a couple air fresheners placed under his dresser to help eliminate the strong urine/foul odor. HK-A stated R69 did not leave his room often however when HK-A was	F 584		

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F 584	Continued From page 14 working and R69 left his room, she would attempt to deep clean R69's room to help reduce the strong urine/foul odor. HK-A indicated maintenance had not been contacted about R69's strong urine/foul odor. During an interview on 8/16/23, at 1:54 p.m. the administrator and vice president of clinical services indicated her expectations were for house keeping staff to clean each resident's room daily to ensure they were clean and to minimize odors due to dignity issues. The administrator stated she would expect nursing staff to work with house keeping and the house keeping supervisor to locate the source of the odor and to remove it. Review of facility policy titled, Proper Cleaning of a Room revised on 4/2017, indicated the facility would ensure that all rooms were infection free and staff would clean all surfaces and floors in rooms.	F 584		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely incontinence care for 1 of 3 residents (R64) who was dependent upon staff for assistance with activities of daily living. Findings include:	F 677	How corrective action will be accomplished for the resident(s) impacted: • The facility cannot correct that they were late to offer R64 toileting on 8/16/2023. R64's careplan related to toileting was reviewed and revised to meet toileting needs. Education regarding	9/18/23

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F 677	Continued From page 15 R64's quarterly Minimum Data Set (MDS), dated 4/29/23, identified R64 was cognitively impaired and had diagnoses which included Alzheimer, dementia and anxiety. Indicated R64 required staff assistance for all activities of daily living (ADL)'s, was frequently incontinent of bowel and bladder and and was not on a bowel or bladder toileting program. R64's annual Care Area Assessment (CAA) dated 1/28/23, indicated R64 was cognitively impaired due to dementia, was frequently incontinent and required staff assistance with toileting. R64's Bowel and Bladder assessments dated 7/22/23, indicated R64 was incontinent of bowel and bladder, unaware of the need to toilet, due to impaired mobility and severe cognition. R64 was dependent on staff for to be toileted every two hours and as needed and to check her brief with toileting and change as needed. R64's care plan revised on 8/11/23, identified R64 had potential for changes in bowel and bladder function related to weakness, urge incontinence of bowel and bladder. The care plan listed various interventions which directed staff to assist R64 with toileting every two hours and to check and change brief as needed with toileting. R 64's nursing assistant care plan dated 8/16/23, indicated R 64 was incontinent of bowel and bladder and required staff assistance with toileting and to be checked and changed as needed. The care plan lacked how often staff were to toilet and check and change R64. During observations on 8/16/23 at 7:08 a.m., R64 was lying in bed on her back covered with the	F 677	this update has been provided to staff. • Immediate education regarding the importance of following toileting plans was given to the employee responsible for R64's care on 8/16/2023. Education regarding R64's toileting was discussed at shift changes on the unit. How facility will identify other residents who have potential to be affected: • All residents in the facility who require assistance with toileting needs have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education will be provided to all staff on 9/13/23 regarding the importance of following each resident's toileting plan of care. • All toileting routines in resident careplans were reviewed for accuracy and updates were made if indicated. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: • DON or designee will perform 10 audits a month for three months and 5 audits a month for 9 months on appropriate ADL cares as it relates to checking and changing residents with incontinence with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results	

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F 677	Continued From page 16 head of the bed slightly elevated, call light within reach, and sleeping. - at 7:36 a.m. R64 remained in bed lying on her back sleeping. - at 7:44 a.m. R64 remained in bed lying on her back sleeping. - at 7:57 a.m. R64 remained in bed lying on her back sleeping. - at 8:09 a.m. R64 remained in bed lying on her back and was awake. - at 8:37 a.m. R64 remained in bed lying on her back and was awake watching TV. - at 8:50 a.m. R64 remained in bed lying on her back and was awake watching TV. - at 8:52 a.m. nursing assistant (NA)-B entered R64's room with her breakfast tray, set the tray down on the bedside table and assisted R64 to set up on the edge of her bed. NA-B placed the bed side table in front of R64 and she began to eat her breakfast independently. NA-B indicated the night staff had gotten R64 up this morning and dressed for the day. NA-B sanitized her hands, left R64 room and was not observed to offer or provide toileting. - at 9:03 a.m. R64 continued to eat her breakfast. - at 9:19 a.m. R64 was done eating her breakfast and laid back down on the bed. - at 9:37 a.m. R64 remained lying on her bed. - at 9:39 a.m. NA-B walked by R64's room, while activity staff entered her room and asked if she would like to attend church that morning and left. R64 remained the same. - at 9:40 a.m. NA-B, NA- A and registered nurse (RN)-A walked by R64's room while they passed room trays to other residents. - at 9:42 a.m. NA-B and RN-A walked by R64's room and other staff in the dining room area assisting residents to eat. - at 9:44 a.m. NA-C walked by R64's room and	F 677	to the QA committee at the quarterly meeting.	

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F 677	Continued From page 17 she yelled out to her. NA-C entered R64's asking her what she needed, R64 began talking to NA-C about her shoes and left R64's room. NA-C was not observed to offer or provided toileting. -at 9:47 a.m. RN-A was passing room trays, NA-A and NA-C were assisting resident with eating in the dining room, NA-B was answering call lights and licensed practical nurse (LPN)-A was providing care to other residents. R64 remained the same and staff members were not observed to offer or provided toileting to R64. - at 9:52 a.m. R64 remained lying on her bed, when NA-B entered her room, asked if she needed to use the bathroom and R64 declined. NA-B lowered the head of R64's bed, assisted her to stand with her walker and had her move closer to the head of her bed. NA-B assisted R64 to lay back down in bed, raised the bed to a working level, gloved her hands and gathered an incontinent brief and wipes. - at 9:56 a.m. NA-B removed R64's pants, unhooked her incontinent brief and noted her incontinent brief was moderately saturated with urine. R64's peri area had no open areas, was pink/red in color and slightly wrinkled. NA-B threw the soiled brief in the garbage, cleaned R64's peri area with wipes and removed her gloves. NA-B re-gloved her hands, placed a clean incontinent brief on R64, removed her gloves and pulled R64's pants up. NA-B made R64 comfortable, placed call light within reach, washed her hands and left the room. R64 was not provided or offered incontinent cares from 7:08 a.m. to 9:56 a.m. for a total of two hours and 48 minutes. During an interview on 8/16/23 at 10:02 a.m. NA-B indicated R64 required staff assistance with toileting and indicated R64 had not been toileted or checked and changed since the night shift staff	F 677		

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F 677	Continued From page 18	F 677		

had gotten her up around 6:30 a.m. NA-B confirmed R64 was incontinent of bowel/bladder and was to be checked and changed every two hours.

During an interview on 8/16/23 at 10:07 a.m. NA-A indicated R64 was incontinent of bowel/bladder and required staff assistance every two hours to be toileted and check/changed. NA-A indicated she did not know the last time R64 had been toileted and indicated she had not worked with R64 this morning.

During an interview on 8/16/23 at 10:09 a.m. NA-C indicated R64 required staff assistance with toileting every two hours and was incontinent of bowel/bladder. NA-C indicated the night shift staff normally got R64 up and was not sure the last time she had been toileted and indicated she had not worked with her that morning.

During an interview on 8/16/23 at 12:57 p.m. RN-A confirmed R64's care and indicated R64 required staff assistance with toileting and her ADL's. RN-A indicated R64 was incontinent of bowel/bladder, wore an incontinent brief and was to be checked and changed every two hours. RN-A indicated his expectation of staff was to follow the resident's care plan.

During an interview on 8/16/23 at 3:06 p.m., the director of nursing (DON) confirmed R64's care plan and indicated she required staff assistance with toileting and was to be checked and changed every two hours and as needed. The DON indicated her expectation was for staff to be following the resident's care plan as written.

Review of facility policy titled, Standards of Care

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F 677	Continued From page 19 revised on 3/22, indicated the standards would guide the staff at the facility in providing quality, safe care to our residents. The care plan indicated each staff member providing direct nursing care would have in their possession throughout their shift the written plan of care for each resident and to perform specific cares according to the form.	F 677		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		9/18/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 08/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 20 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This deficient practice had the potential to affect all 122 residents who resided in the facility and/or any visitors who may have wished to view the information. Findings include: Review of the Daily Staffing Report (located in a clear plastic sleeve on the wall of the main nurses' station) on 8/14/23 at 2:31 p.m., revealed the following: The report was dated for 7/18/23, and identified a census of 120 when the current census was 122. -at 6:26 p.m. the staff posting remained the same. During an observation on 8/15/23 at 8:30 a.m. the facility's Daily Staffing Report continued to be dated 7/18/23, and identified a census of 120. During an interview on 8/15/23 at 3:32 p.m., staffing coordinator (SC) confirmed the above findings and stated she was not certain whose responsibility it was to ensure the staff posting	F 732	How corrective action will be accomplished for the resident(s) impacted: • We are unable to correct historical lack of staffing information postings. How facility will identify other residents who have potential to be affected: • All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education has been provided to the Staffing Coordinator and will be provided to all staff on 9/13/23 on the requirement and expectation for posting staffing information daily. The Staffing Coordinator or designee will post this information each day and update as needed. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: • DON or designee will perform 2 audits each week for one month and 5 audits each month for 3 months to ensure	

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F 732	Continued From page 21 was updated on a daily basis. SC stated she would expect the staff posting to be updated daily and as needed to reflect the changes with staffing and census. During an interview on 8/15/23 at 4:59 p.m., director of nursing (DON) confirmed the above findings and stated it was the responsibility of the SC to ensure the staff posting was updated Monday-Friday and nursing staff were responsible to post the report on the weekends. DON indicated her expectation of staff was the staff posting was posted daily to reflect the current staffing and census. On 8/16/23, a policy regarding staff posting was requested however, one was not provided. .	F 732	staffing information is posted appropriately with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 812 SS=E	. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		9/18/23

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F 812	Continued From page 22 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure foods were properly stored for 1 of 2 dry storage areas and 1 of 3 walk in freezers. This had the potential to affect 121 of the 122 residents that received food from the kitchen. Findings include: On 8/14/23 at 11:31 a.m., during an initial tour of the facility with dietary manager (DM) the following concerns were identified in the dry storage area and the walk in freezers: - four large boxes of ice cream bars had been placed on the middle of the floor of the walk in freezer which was attached to the walk in meat cooler. Basement dry Storage: The following items had been placed on the floor of the dry storage area: - four cases of lemon lime pop. - two cases of diet coke. - five large cans of baked beans. - two cases of oreo cookies. - one case of smucker's jelly jams.	F 812	How corrective action will be accomplished for the resident(s) impacted: • Items improperly stored on the floor were immediately moved to proper storage areas. How facility will identify other residents who have potential to be affected: • All residents in the facility who consume food provided by the facility's food service have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Immediate education was provided to the culinary department on proper food storage. • Education will be provided to all staff on 9/13/23 regarding appropriate food storage requirements. • Food storage locations were assessed to ensure adequate storage that meets requirements is available. How the facility will monitor its corrective	

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F 812	Continued From page 23 - one case of cake mix. - two cases of tomato soup. The culinary coordinator (CC) confirmed the above findings and indicated the facility had received their shipment of supplies last Friday. Basement walk in freezer: The following items had been placed on the floor of the walk in freezer: - had a case of jimmy dean sausage. - had a case of wild fish. - had a case of biscuits. - had a case of broccoli. - had a case of strawberries. - had a case of carrots. - had a case of tater tots - had a case of scrabbled eggs. - had a case of crab meat, - had several cases of waffles. - had a case of coffee. - had a whole kernel corn. - had cases of shredded hash browns. - had a case of whip topping. The DM confirmed the above findings and indicated the facility had received their shipment of supplies last Friday. During an interview on 8/16/23 at 11:47 a.m., DM confirmed the above findings and indicated the facility received shipments every Tuesday and Friday. The DM indicated food should not be stored on the floor and dietary staff should be putting it away as soon as possible. The DM stated when food was not stored properly, there was a potential for food borne illness related to possible leaks on the floor, not a clean environment, rodents chewing and getting into	F 812	actions to ensure that the deficient practice is corrected and will not recur: • Director of Nutrition and Culinary Services or designee will perform 2 audits each week for one month and 5 audits each month for 3 months to ensure food is stored appropriately with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 812	Continued From page 24 the food and possible contamination of the food. During an interview on 8/16/23 at 11:55 a.m. the CC indicated the facility received shipments of food on Tuesdays and Fridays and usually dietary staff would put the food items away when they were delivered. The CC stated dietary staff should be putting the food items away as soon as possible due to infection control concerns, water on the floor and rodents. The CC indicated food being left on the floor could become contaminated and could cause a food borne illness. Review of facility policy titled, Cold Storage revised on 1/18, indicated all foods were to be stored at least six inches off the floor.	F 812		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following:	F 883		9/18/23

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F 883	Continued From page 25 (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 residents (R49, R1, R9, R10, and R111) were offered or received	F 883	How corrective action will be accomplished for the resident(s) impacted:	

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F 883	Continued From page 26 pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: Review of the Pneumococcal Vaccine Timing for Adults, dated 3/15/2023, from the CDC identified adults 65 years of age or older who had previously received the Pneumococcal Polysaccharide Vaccine 23 (PPSV23) should receive one dose of 20-valent Pneumococcal Conjugate Vaccine (PCV20) or one dose of 15-valent Pneumococcal Conjugate Vaccine (PCV15). The dose of PCV20 or PCV15 should be administered at least one year after the most recent dose of PPSV23. Adults 65 years of age or older who had previously received the Pneumococcal 13-valent Conjugate Vaccine (PCV13) should receive one dose PCV20 or PPSV23. The dose of PCV20 or PPSV23 should be administered at lease one year after the most recent PCV13 dose. Adults 65 years of age or older who had previously received the PCV13 and one or more doses of the PPSV23 should receive one dose of PCV20. The dose of PCV20 should be administered at least one year after the most recent dose of PPSV23. Review of R49's Minnesota Immunization Information Connection (MIIC) identified R49 had received the PPSV23 vaccination on 6/11/2018. R49's medical record lacked documentation R49 had been offered or received PCV20 or PCV15 vaccinations. Review of R1's MIIC identified R1 had received the PCV13 vaccination on 9/16/21. R1's medical record lacked documentation R1 had been	F 883	• All 5 residents impacted will be provided education and offered the pneumococcal vaccine. How facility will identify other residents who have potential to be affected: • All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education will be provided to all staff on 9/13/23 regarding the process for educating and offering residents the pneumococcal vaccine per CDC guidelines. • Vaccine records for all residents currently residing and all new admissions in the facility are being reviewed and education on the pneumococcal vaccine will be offered to all eligible residents. • Eventide's policy titled Pneumococcal Vaccine was reviewed and meets the current CDC recommendations related to the pneumococcal vaccine. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: • DON or designee will perform audits on all new admissions for one month and 5 audits each month for 3 months to ensure staffing information is posted appropriately with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will	

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F 883	Continued From page 27 offered or received the PCV20 or PPSV23 vaccinations. Review of R9's MIIC identified R9 had received the PVC13 on 12/8/15 and the PPSV23 on 10/31/94, 10/9/09, and 12/20/16. R9's medical record lacked documentation R9 had been offered or received the PCV20. Review of R10's MIIC identified R10 had received the PVC13 on 3/3/15, and the PPSV23 on 1/4/02. R10's medical record lacked documentation R10 had been offered or received the PCV20. Review of R111's Certification of Immunization identified R111 had received the PCV13 on 4/15/19, and the PPSV23 on 4/19/22. R111's medical record lacked documentation R111 had been offered or received the PCV20. During an interview on 8/16/23, at 3:59 p.m. the director of nursing (DON), interim infection preventionist (IIP), and vice president of clinical services(VPCS) confirmed the updated pneumococcal guidelines issued by the CDC on 3/15/23. VPCS and DON reviewed residents' immunization records and confirmed the medical records lacked documentation of PVC15, PVC20, and PPSV23 vaccinations. The DON stated her expectation was residents would be offered or receive pneumococcal vaccinations according to CDC guidelines. Review of facility policy titled, Pneumococcal Vaccinations updated 9/22, identified all residents would be offered pneumococcal vaccinations to aid in prevention of pneumococcal infections. Upon admission, residents would be provided information on the pneumococcal vaccinations	F 883	submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 883	Continued From page 28 and would be offered pneumococcal vaccinations after reviewing the residents pneumococcal vaccination history. Administration of pneumococcal vaccinations or revaccination would be made in accordance to CDC recommendations at time of the vaccination.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/15/2023**

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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/15/2023. At the time of this survey, Eventide Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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 FORM 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/11/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as one building, with all construction being a type II. Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at four different times. The original building was constructed in 1961, is one-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	K 000		

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K 000	Continued From page 2 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 northwest of the original building. It is 1-story, has no basement, and is Type II (111). The building is fully sprinkler protected in accordance with NFPA 13, The Standard for the Installation of Sprinklers. 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 and Signaling Code. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility has a capacity of 145 beds and had a census of 122 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		9/18/23

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	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/15/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 321	Continued From page 3 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include:	K 321	A detailed description of the corrective action taken or planned to correct the deficiency. • Room 322 was labeled as storage and an automatic door closure was added on 9/7/2023. Address the measures that will be put into place to ensure the deficiency does not	

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K 321	Continued From page 4 On 08/15/2023 at 2:00 PM, it was revealed by observation that resident room 322 did not have door closers and were being used as combustible storage rooms. An interview with the Administrator verified this deficient finding at the time of discovery.	K 321	reoccur. • Education will be provided to all staff on 9/13/23 on the requirements for storage of combustible materials. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. • Monitoring for storage of combustible materials in rooms designated as resident rooms will be added to monthly environmental rounding checklists going forward.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor.	K 324		9/18/23

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K 324	Continued From page 5 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to maintain cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1 and 19.3.2.5.3 (9). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/15/2023 between 11:45 AM and 2:00 PM, it was revealed by observation that the stove in the physical therapy room did not have a lockout switch with a timer not exceeding 120 minutes. An interview with the Administrator verified this deficient finding at the time of discovery.	K 324	A detailed description of the corrective action taken or planned to correct the deficiency. • A switch with an automatic, 120-minute shutoff timer will be added to the stove/oven in the therapy gym on 9/14/2023 by an electrical contractor. Address the measures that will be put into place to ensure the deficiency does not reoccur. • To utilize the stove/oven in the future, the switch will need to be activated and the 120-minute timer will be engaged. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. • The Director of Facilities and Maintenance or designee will audit the switch function on the stove/oven in the therapy gym once a month for one year to ensure proper function.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm	K 712		9/18/23

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K 712	Continued From page 6 signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 at 11:00 AM, it was revealed by a review of available documentation that the facility did not perform a fire drill during the third shift of the 1st and 2nd quarters of 2023. An interview with the Administrator verified this deficient finding at the time of discovery.	K 712	A detailed description of the corrective action taken or planned to correct the deficiency. • We are unable to correct the timing of historically conducted fire drills. Address the measures that will be put into place to ensure the deficiency does not reoccur. • Completed review of fire drill documentation and process requirements with Director of Facilities and Maintenance on 9/7/23. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. • The Director of Facilities and Maintenance and Administrator or designee(s) will audit the Life Safety compliance documentation binder, including fire drill documentation, monthly for twelve months. If concerns are identified, immediate intervention will occur as indicated.	

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K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the fire door inspections per NFPA 101 (2012 edition), Life Safety Code, sections 8.3.3.1, 19.7.6, and NFPA 80 (2010 edition) Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023, at 11:30 AM, it was revealed by a review of available fire door test and inspection documentation and an interview with the Administrator that the facility provided documentation verifying the annual fire door inspection was last completed on 04/12/2022. An interview with the Administrator verified this	K 761	A detailed description of the corrective action taken or planned to correct the deficiency. • Annual fire door inspections were completed using a 13-point inspection process on 8/28/2023. Address the measures that will be put into place to ensure the deficiency does not reoccur. • Education has been provided to maintenance staff regarding timely completion of the fire door inspection preventive maintenance work order utilizing a 13-point inspection. This has been rescheduled for June 2024. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible	9/18/23

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K 761	Continued From page 8 deficient finding at the time of discovery.	K 761	for the corrective actions and monitoring of compliance. • The Director of Facilities and Maintenance and Administrator or designee(s) will audit the Life Safety compliance documentation binder, including fire door inspection documentation, monthly for twelve months. If concerns are identified, immediate intervention will occur as indicated.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		9/18/23

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K 914	Continued From page 9 Based on a review of available documentation and staff interview, the facility failed to conduct the electrical testing and maintenance per NFPA 99 Standards for Health Care Facilities 2012 edition, sections 6.3.3.2 , 6.3.4.1.3, and 6.3.4.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 between 10:15 AM and 02:30 PM, it was revealed by a review of available documentation that the electrical receptacle inspection form that the facility provided did not include physical integrity, continuity of grounding, polarity, and retention force. Documentation provided was last completed on 06/06/2022. An interview with the Administrator verified this deficient finding at the time of discovery.	K 914	A detailed description of the corrective action taken or planned to correct the deficiency. • Receptacle testing was completed on 5/3/2023. During this testing, concerns were identified. On 9/6/23, a work order was reissued to follow up on those concerns. On 9/8/2023, all concerns were resolved from the initial inspection. Address the measures that will be put into place to ensure the deficiency does not reoccur. • Education has been provided to maintenance staff regarding proper documentation and timely repair follow-up for receptacle testing. Documentation template has been updated to include more detailed information about specific resident rooms and receptacle issues. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. • The Director of Facilities and Maintenance and Administrator or designee(s) will audit the Life Safety compliance documentation binder, including receptacle testing documentation, monthly for twelve months. If concerns are identified, immediate intervention will occur as indicated.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K 918		9/18/23

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K 918	Continued From page 10 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health	K 918	A detailed description of the corrective action taken or planned to correct the deficiency.	

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K 918	Continued From page 11 Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, sections 4.2, 8.4.9, 8.4.9.1 and 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/15/2023 at 12:30 PM, it was revealed by a review of available documentation that the facility failed to provide documentation of a 36-Month 4-hour generator load bank test. An interview with the Administrator verified this deficient finding at the time of discovery.	K 918	• The Director of Facilities and Maintenance has scheduled a 4-hour load bank test for 9/12/2023, which will be conducted and documented in accordance with NFPA 110, Health Care Facilities Code, and Life Safety Code guidelines. Address the measures that will be put into place to ensure the deficiency does not reoccur. • A recurring preventive maintenance service reminder will be added to our automated work order generation system to include a 36-month, 4-hour load bank test. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. • The Director of Facilities and Maintenance and Administrator or designee(s) will audit the Life Safety compliance documentation binder, including generator testing documentation, monthly for twelve months. If concerns are identified, immediate intervention will occur as indicated.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

RE: CCN: 245461
Cycle Start Date: August 16, 2023

Dear Administrator:

On September 27, 2023, we notified you a remedy was imposed. On October 18, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 4, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 12, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 27, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 4, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us