Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 1, 2025

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

RE: CCN: 245461
Cycle Start Date: June 25, 2025

Dear Administrator:

On June 25, 2025, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), 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, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
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 September 25, 2025 (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 December 25, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

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 _____	06/25/2025

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 6/23/25 to 6/25/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance. 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/23/25 to 6/25/25, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your 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. 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 substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		7/18/25

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

Electronically Signed | 07/09/2025

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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F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this	F 550		

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F 550	Continued From page 2 subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R4) who received assistance with eating in the dining room. Findings include: R4's quarterly Minimum Data Set (MDS) dated 5/14/25, identified R4 had severe cognitive impairment and had diagnoses which included: hypertension (elevated blood pressure), dementia, and anemia. Identified R4 required staff assistance to eat. R4's care plan dated 11/9/22, identified R4 had self-care performance deficit related to weakness and dementia. R4's interventions included assistance with hygiene, bathing and dressing. Identified R4 required total staff assistance with eating. Identified R4 had a terminal prognosis and received hospice care. During an observation on 6/24/25 at 12:35 p.m., R4 sat in a reclining wheelchair in the dining room at a table. Hospice registered nurse (H-RN) stood near R4's right side, and provided R4 with food from a spoon. -at 12:43 H-RN continued to stand near R4's side while assisting R4 to eat from a spoon. During a phone interview on 6/24/25 at 12:50 p.m., family member (FM)-A stated she did not feel it was a dignified practice for staff to stand while feeding R4. FM-A stated she would have	F 550	How corrective action will be accomplished for the resident(s) impacted: •Immediate education was provided to the hospice staff member assisting R4 regarding being seated while assisting residents with eating to ensure a dignified dining experience. •Education was provided to nursing staff on the date the deficient practice was noted regarding being seated while assisting residents with eating to ensure a dignified dining experience. •R4s chair height was assessed to verify staff can be seated while assisting R4 with eating How facility will identify other residents who have potential to be affected: •All residents in the facility who require assistance while eating 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: •Nursing staff and contracted hospice agency will be provided education on 7/14/2025 on the facility policy Standards of Care, specifically regarding providing a dignified dining experience for all residents and the expectation of being seated while assisting residents with eating.	

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F 550	Continued From page 3 expected staff to sit while assisting R4 to eat. During an interview on 6/24/25 at 12:56 p.m., H-RN verified he had stood up while assisting R4 to eat. H-RN stated R4's chair was big and it was not convenient for him to sit so he stood to assist R4 with her meal. RN-A further stated it was not a dignified practice to stand while assisting residents to eat. During an interview on 6/24/25 at 1:08 p.m., RN-A verified H-RN stood while assisting R4 to eat. RN-A stated her expectation was H-RN would have sat down while feeding R4 to maintain dignity. During an interview on 6/25/25 at 9:18 a.m., director of nursing (DON) stated staff were expected to be seated by residents while assisting with eating as it was important to maintain dignity and promote safety. Review of a facility policy titled Standards of Care revised 8/24, identified standards of care were followed when providing care to all residents. Identified all residents would receive safe, dignified care.	F 550	How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: •The DON or designee will audit dignity during dining experiences weekly for one month, then every other week for 3 months, and then monthly for three months. •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nebulizer	F 554	How corrective action will be accomplished for the resident(s)	7/18/25

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F 554	Continued From page 4 medications were administered safely for 1 of 1 residents (R5) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications. Findings include: R5's admission Minimum Data Set (MDS) dated 6/6/25, indicated R5 was cognitively intact and had diagnoses which included pneumonia, hip fracture, and respiratory failure. R5 was dependent on staff for transfers and toileting hygiene. R5's care plan dated 5/30/25, identified R5 as having an activity of daily living (ADL) self-care performance deficit related to a fracture of the right ankle. R5's care plan interventions included assistance with dressing and grooming and being able to feed self after staff assisted with tray set up. Review of the care plan dated 5/30/25, lacked information regarding the self-administration of medications. Review of R5' s electronic health record (EHR) revealed Formoterol Fumarate inhalation nebulization solution (a medication prescribed for asthma) 20 micrograms (mcg)/2 milliliters (ml) two times a day for asthma, Ipratropium-Albuterol inhale orally every six hours as needed for shortness of breath. EHR lacked information regarding the self-administration of medications. Review of R5's Order summary Report Dated 6/4/24 directed staff to administer Formoterol Fumarate inhalation nebulization solution 20mcg/2ml two times a day for asthma,	F 554	impacted: •The nursing staff caring for R5 during the survey were educated on the facility policy Medications- Self Administration of Medications and process for residents self-administering nebulizers. •R5 was assessed for the ability to self-administer nebulizers and R5's plan of care was updated with the assessment How facility will identify other residents who have potential to be affected: •All residents in the facility who receive nebulizer treatments 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: •Nursing staff were educated during shift change reports regarding staying with residents during a nebulizer treatment unless the resident has been assessed as appropriate to be left alone during nebulizer administration •Nursing staff will be provided education on 7/14/25 on facility policy Medications-Self Administration of Medications, specifically regarding safe administration of nebulizer medications. •All residents who receive nebulizers were assessed to ensure safe administration of nebulizer medications. How the facility will monitor its corrective actions to ensure that the deficient	

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F 554	Continued From page 5 Ipratropium-Albuterol inhale orally every six hours as needed for shortness of breath. The order summary report lacked an order to self-administer medications. Review of assessments located in the assessment tab of the EHR lacked an assessment of self-medication assessment. During an observation on 6/23/25 at 12:15 p.m., R5 was sitting in a wheelchair next to the bed with a nebulizer mask on her and a nebulizer machine turned on. No staff were present in the room or outside of the room. During an observation on 6/24/25 at 9:41 a.m., R5 was sitting in a wheelchair next to the bed with a nebulizer mask on her face and the nebulizer machine on. No staff were present in the room or outside of the room. During an interview on 6/24/25 at 11:09, licensed practical nurse (LPN) indicated self-administration assessment of medication were charted under the administration tab in the EHR. LPN looked and was unable to find a self-administration of medication assessment. LPN located an assessment for brief interview for mental status (BIMS). LPN indicated if a resident had a high BIMS score that indicated the resident as cognitively intact. LPN indicated the procedure for a resident to self-administer medications was to ensure a resident was cognitively intact and the resident could demonstrate they could self-administrate medication safely. LPN did not believe the facility needed to obtain a physician order for self-administration of medications. LPN verified that R5 administered her nebulizer independently after being set up by staff.	F 554	practice is corrected and will not recur: •The DON or designee will complete nebulizer administration audits weekly for one month, then every other week for 3 months, then monthly for 3 months •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 554	Continued From page 6 During an interview on 6/25/25 at 7:42 a.m., resident care manager (RCM) indicated the nurses would do an assessment for the self-administration of medication, the facility would obtain a physician order, and would place the self-administration of medication in the care plan. RCM verified that R5 did not have a self-administration medication assessment. RCM also verified that R5 did not have self-administration of medications care planned. During an interview on 6/25/25 at 12:00 p.m., director of nursing (DON) indicated the facility had a self medication policy. The nurse would complete a BIMS assessment of the resident throughout the day. The nurse would assess the resident's performance with holding or keeping the mask on during the nebulizer treatment, if the resident could shut off the nebulizer appropriately, and discuss with the provider. The facility would review self-administrations quarterly or as needed. The DON would expect nurses to follow the policy on self-medication administration to ensure a resident could safely administer the medications. Review of a facility policy titled Medications Self-Administration of Medications dated 3/25, identified if deemed appropriate the resident may participate in the self-administration of medication process. A provider's order was required. The standing order may be utilized but the resident's primary provider must be informed. Medication administration will be monitored and the resident's ability to self-administer medications would be reviewed quarterly, prior to discharging home, and with a significant change in condition or as needed. Procedure: 1. The resident will be	F 554		

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F 554	Continued From page 7 asked if they would like to self-administer medications. 2. If the resident declined, documentation would be made in the resident's medical record. 3. If the resident wanted to self-administer medications, the nurse would complete the Self-Administration of Medication Assessment to determine appropriateness. Inhalants or inhalers: The resident must demonstrate competency of use(timing of breathing, depressing the atomizer, position of the mouth for medication administration, length of time to wait between doses, etc.)	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R95) had adequate hydration within reach reviewed for reasonable accommodations. Findings include: R95's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R95 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. R95 required partial assistance with eating and extensive assistance with dressing and personal hygiene. R95 had a diagnosis of cerebral infection (stroke), hemiparesis (weakness of one side of the body),	F 558	How corrective action will be accomplished for the resident(s) impacted: •R95's water mug was placed within reach on her right side. •Staff caring for R95 during the time the deficient practice was noted received education regarding keeping water mugs within reach of residents. •Education was provided at shift changes to all staff working on the unit caring for R95 regarding keeping the water mug on R95's right side and within reach.	7/18/25

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F 558	Continued From page 8 anxiety, and depression. R95's care plan was revised on 3/12/25, indicating that R95 could feed herself after staff assisted with tray setup. Staff to encourage R95 to use her right hand to feed herself, and place the tray in the far-right visual felid. Dysphasia mechanically altered with nectar thick liquids, on 4/3/25 per speech therapy changed to pureed with nectar thick liquids with hopes of improving intakes. Dislikes strawberries. The family prefers that R95 be given cranberry juice to drink instead of any other flavored juices or milk. No water mug with thin liquids. R95's physician order dated 6/10/25, indicated R95 had a Dysphasia mechanically altered texture and nectar thick consistency. During an interview on 6/23/25 at 11:56 a.m., a family member indicated that R95's water mug had been across the room multiple times when visiting. The family member indicated that R95 could not move her wheelchair across the room to get her water mug. If the water mug was beside R95, then she would have been able to take a drink independently. During an observation on 6/24/25 at 9:43 a.m., R95 was sitting in a wheelchair looking out the window. The side table with the water mug was behind R95 next to the bed, out of reach. During an observation/interview on 6/25/25 at 7:28 a.m., R95 was in bed wake, and R95's nightstand was across the room next to the wall out of reach. NA-E verified that R95 was unable to reach the water mug. NA-E indicated staff's normal practice was to keep the water mug next	F 558	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: •Nursing staff will be provided with education on resident's rights to receive services with reasonable accommodation, including keeping adequate hydration/water mugs within reach on 7/14/2025. •Residents who have weakness to affected limb(s) were assessed to determine appropriate water mug placement and care plans were updated to reflect this need. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: •The DON or designee will complete audits regarding adequate hydration/water mugs within reach weekly for one month, then every other week for 3 months, then monthly for 3 months •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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	245461	A. BUILDING _____ B. WING _____	06/25/2025

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F 558	Continued From page 9	F 558		

to her. NA-E indicated R95 was able to drink fluids independently, but at times did need assistance.

During an observation/interview on 6/25/25 at 11:11 a.m., R95 was in her wheelchair next to the bed and the side table with the water mug was against the wall on the left side about three feet away. NA-C confirmed R95 could not reach her side table and water mug on the left side. NA-C confirmed R95 had left-sided weakness from a stroke. R95 confirmed she was unable to reach the water mug. The water mug was moved to the right side of the wheelchair and R95 was able to demonstrate she could pick up the water mug and bring it to her mouth.

During an interview on 6/25/25 at 10:11 a.m., R95 indicated staff did not always leave the water mug within reach. R95 indicated she would get thirsty and would be unable to reach her water mug.

During an interview on 6/24/25 at 6:47 p.m., NA-D indicated R95 was able to drink water independently depending on R95's mood that day.

During an interview on 6/24/25 at 7:13 p.m., trained medical assistant (TMA)-A indicated R95 could hold her water mug when in reach.

During an interview on 6/25/25 at 7:51 a.m., resident care manager (RCM)-A indicated R95 was able to drink independently if the water mug was placed on her right side.

During an interview on 6/25/25 at 12:07 p.m., director of nursing (DON) indicated her expectations would have been for staff to place

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F 558	Continued From page 10 the water within reach to prevent dehydration. Review of the policy titled: Standards of Care dated 8/2024, directed staff to offer fluids when completing scheduled cares (toileting, turning, etc.) Policy lacked information of having water within reach when appropriate.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.	F 561		7/18/25

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F 561	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation, the facility failed to honor a resident's right to make choices about food choices at meals for 1 of 1 residents (R95) reviewed for choices. Findings include: R95's quarterly Minimum Data Set (MDS) dated 4/3/25, indicated R95 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. R95 required partial assistance with eating and extensive assistance with dressing and personal hygiene. R95 had diagnoses of cerebral infection (stroke), hemiparesis (weakness of one side of the body), anxiety, and depression. R95's care plan revised on 3/12/25, indicated R95 could feed herself after staff assisted with tray setup. Staff to encourage R95 to use her right hand to feed herself and place the tray in the far-right visual felid. R95's diet was changed on 4/3/25, per speech therapy to pureed (smooth blended foods) with nectar thick liquids with hopes of improving intakes. The family preferred that R95 be given cranberry juice to drink instead of any other flavored juices or milk. No water mug with thin liquids. R95's physician order dated 6/10/25, indicated R95 had a Dysphagia (difficulty swallowing) mechanically altered texture and nectar thick consistency. During an interview on 5/23/25 at 11:55 a.m., family member (FM)-A indicated staff would ask	F 561	How corrective action will be accomplished for the resident(s) impacted: •Food choices at meals are now being provided to R95. R95 was assessed to determine food preferences and care plan was updated. •Education was provided to nursing staff caring for R95 regarding food choices and her food preferences, offering alternative choices if she is not eating what is served. 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: •Menus have been reviewed and updated to ensure all residents have food choices and alternative food options available at meals. •All staff will be provided education on updated menus, ensuring residents have food choices including alternative food options at meals on 7/14/2025 How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: •The DON or designee will complete	

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F 561	Continued From page 12 other residents what they wanted for the meal but would not ask R95 what she wanted for her meal; staff would not give her options. During an interview/observation on 6/23/25 at 3:10 p.m., nursing assistant (NA)-C went to each resident's room and asked residents which meal choice for supper they wanted however, did not provide R95 options for supper. NA-C indicated there was only one choice for mechanical soft diets and pureed diets. During an interview on 6/25/25 at 7:28 a.m., NA-E indicated all the mechanical soft diets and pureed diets get the same meal and because of this staff did not ask R95 what she wanted to eat each meal. NA-E indicated that R95 was able to verbalize what she liked to eat. During an interview on 6/24/25 at 6:47 p.m., NA-D indicated the kitchen chose what meal option R95 would receive. NA-D indicated the kitchen staff would puree the food in the kitchen before it was brought up to the dining room to be served. During an interview on 6/25/25 at 7:51 a.m., resident care manager (RCM)-A stated an expectation would be for staff to give all residents options for meals. During an interview on 6/25/25 at 10:11 a.m., R95 verified staff did not ask her what she wanted for meals. R95 indicated she normally did not like what was for lunch. At times some staff would make her something else to eat, however, not consistently. During an interview on 6/25/25 at 10:15 a.m.,	F 561	audits regarding residents being provided food choices at meals weekly for one month, then every other week for 3 months, then monthly for 3 months •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 561	Continued From page 13 NA-F indicated residents on a dysphasia mechanical diet or food that needed to be ground up, were not provided meal options. NA-F indicated staff had not been asking R95 what she wanted to eat for meals as the kitchen would bring the food already ground up. During an interview on 6/25/25 at 10:29 a.m., DA-A indicated the food was blended in the kitchen and then brought up to the kitchenette for the residents who received a pureed diet. Residents who did not have mechanically altered diets would have two meal choices. Which meal choice was blended was predetermined by the cook. During an interview on 6/24/25 at 5:25 p.m., Cook-B indicated residents who received a pureed or mechanical soft diet would receive the first option on the menu. During an interview on 6/25/25 at 10:37 a.m., Cook-A indicated staff would puree the first meal choice, otherwise the facility was wasting a lot of food. A lot of residents who received a pureed diet were incapable of making a meal choice. Cook-A indicated the normal process was to puree the first meal choice. During an interview on 6/25/25 at 10:38 a.m., dietary manager (DM) indicated if a resident was able to express preferences the facility would try to honor their preferences. The kitchen would keep a record of foods a resident did not like if they were able to verbalize that. If a resident could not verbalize what they did not like the staff would watch for symptoms such as turning the head away when being fed. DM verified that residents who received a pureed diet did not	F 561		

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F 561	Continued From page 14 receive meal choice options. During an interview on 6/25/25 at 12:07 a.m., director of nursing (DON) indicated her expectation would be for staff to offer an alternative food option if a resident was not eating their meal. Having choices would be important for nutritional intake and the prevention of dehydration. A policy titled Liberal Geriatric Diets, textures and Consistencies dated 8/24, indicated Eventide uses non-therapeutic (regular) diets to enhance the quality of life for our residents. All therapeutic diet orders such as general adult, diabetic, salt restrictions, heart-healthy, renal, etc. will be changed to a regular diet upon admission, Diets may be adjusted by a registered dietician based on the resident's individual needs and preferences. All orders for high-calorie/high-protein nutritional supplements, snacks, and calorie counts will be discontinued upon admission. The registered dietitian would implement high-calorie/high-portion nutritional supplements and snacks based on the resident individual needs and preferences. Eventide follows texture/liquid modifications as ordered. Texture modifications/liquid consistencies may be downgraded by the dietician and/or nursing as needed. The policy lacked information regarding meal choices.	F 561		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For	F 637		7/18/25

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F 637	Continued From page 15 purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) using the Resident Assessment Instrument (RAI) process, following the initiation of hospice services for 1 of 1 resident (R117) reviewed for hospice. Findings include: R117's quarterly Minimum Data Set (MDS) dated 2/28/25, identified R117 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and traumatic brain injury. Identified R117 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. R117's progress notes dated 3/31/25 to 5/19/25, identified R117 was admitted to Ethos Hospice on 4/28/25. R117's electronic medical record (EMR) identified a quarterly MDS was completed on 2/28/25, and a death MDS was completed on 5/19/25. R117 EMR lacked a significant changed MDS was completed when R117 was admitted to hospice.	F 637	How corrective action will be accomplished for the resident(s) impacted: •A significant change MDS was completed and submitted for R117. How facility will identify other residents who have potential to be affected: •All residents who admit to hospice services 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: •The facility will ensure staff will complete a significant change in status assessment after initiation of hospice services and MDS coded accordingly as indicated in the long-term care facility RAI 3.0 user's manual. •All staff were educated on completing a significant change assessment after initiation of hospice services as indicated in the long-term care facility RAI 3.0 manual on 7/14/2025	

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F 637	Continued From page 16 During an interview on 6/25/25 at 11:11 a.m., MDS coordinator confirmed R117 passed away on 5/19/25. MDS coordinator further indicated the significant MDS was missed because the MDS coordinator counted the days wrong. During an interview on 6/25/25 at 11:54 a.m., director of nursing (DON) confirmed the above findings. DON stated that her expectations were to have MDS's completed timely. Review of facility policy titled Resident Assessment Instrument (RAI) process - MDS 3.0 revised 2/25, The RAI was a method for assessing functional capacity and needs, identify problems, needs, and strengths developing intervention. If the interdisciplinary team determined there was a significant change in condition, the MDS Coordinator would notify all disciplines and initiate the significant change in status.	F 637	How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: •The DON or designee will complete audits regarding the completion of significant change in status assessments after initiation of hospice services weekly for one month, then every other week for 3 months, then monthly for 3 months •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 686		7/18/25

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F 686	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a pressure relieving device was implemented to prevent skin breakdown for 1 of 3 residents (R22) reviewed for pressure ulcers. Findings include: R22's quarterly Minimum Data Set (MDS) dated 4/17/25, identified R22 had severe cognitive impairment and diagnoses which included hemiplegia (paralysis on one side of the body), aphasia (disorder that affects the ability to communicate), and Parkinson's Disease. Identified R22 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R22 was at risk for pressure ulcers. R22's annual Care Area Assessment (CAA) dated 10/19/24, identified R22 required total assistance from staff with repositioning and was at risk for skin breakdown. Identified R22 was incontinent of bowel and bladder. R22's care plan dated 10/14/2016, identified R22 had self care deficits and was at risk for skin breakdown related to stroke and right sided hemiparesis and dependence on staff for repositioning in bed and wheelchair. Identified R22 was to wear Prevalon boots when in bed. R22's Braden Scale for Predicting Pressure Ulcer Risk dated 4/12/25, identified R22 was at moderate risk of developing a pressure ulcer. R22's treatment administration record (TAR) for	F 686	How corrective action will be accomplished for the resident(s) impacted: •The intervention of applying prevalon boots to R22's feet for pressure ulcer prevention was immediately applied when deficient practice was noted. •Immediate education regarding implementing pressure ulcer prevention measures was completed with staff caring for R22 at the time the deficient practice was observed. •R22's pressure ulcer prevention measures were educated to nursing staff through shift report on the unit R22 resides How facility will identify other residents who have potential to be affected: •All residents with care planned pressure relieving devices to prevent skin breakdown 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 residents with care planned pressure relieving devices to prevent skin breakdown were assessed to verify interventions are implemented. •Nursing staff will be provided education on facility policy Skin Assessment, specifically regarding the expectation that care planned pressure relieving devices	

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F 686	Continued From page 18 the month of June 2025, identified R22 was to have Prevalon boots when in bed on every shift. Third floor nursing assistant (NA) care sheet undated, identified R22 was to have Prevalon boots on while in bed. During an observation on 6/23/25 at 12:29 p.m., R22 was lying in bed on her back wearing gripper socks on her feet. Blue Prevalon boots were on a bedside table across the room. During an observation on 6/24/25 at 1:22 p.m., nursing assistant (NA)-A and NA-B sanitized hands and applied gloves, hooked R22 up to the hoyer lift and lifted R22 into bed. NA-A and NA-B rolled R22 onto her side and pulled her pants down to check her incontinent product then turned R22 onto her left side. Blue Prevalon boots continued to be on the bedside table across the room. NA-A- and NA-B removed gloves sanitized hands, and exited R22's room. At no time did NA-A or NA-B offer to place the blue Prevalon boots onto R22's feet. During a joint interview on 6/24/25 at 1:34 p.m., NA-A and NA-B stated they had not offered to put the blue Prevalon boots on R22's feet because R22 only required the blue Prevalon boots on her feet when she went to bed at night. During an interview on 6/24/25 at 1:40 p.m., registered nurse (RN)-A verified R22 was at risk for developing pressure ulcers. RN-A stated R22 was to have blue Prevalon boots at all times while she is in bed per the care plan. RN-A placed the blue Prevalon boots on R22's feet and stated her expectation was the staff placed the blue Prevalon boots on any time R22 was in bed to	F 686	are implemented to prevent skin breakdown, ensuring residents receive necessary treatment and services consistent with professional standards of care to prevent pressure ulcers on 7/14/2025 How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: •The DON or designee will complete audits regarding ensuring residents are being offered pressure relieving devices weekly for one month, then every other week for 3 months, then monthly for 3 months •If concerns are identified, immediate corrective action will be implemented. The IP or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 686	Continued From page 19 prevent skin breakdown. During an interview on 6/25/25 at 9:16 a.m., director of nursing (DON) verified R22 was at risk for skin breakdown. DON stated her expectation was that staff would have applied the blue Prevalon boots on R22's feet when in bed per the care plan to prevent skin breakdown. Review of a facility policy titled Skin Assessment revised 12/23, identified the purpose of the skin assessment was to identify current and potential problems. Identified a resident admitted to the facility was to receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers, Further identified the goal was that residents who entered the facility without pressure ulcers do not develop pressure ulcers unless their clinical condition demonstrates the pressure ulcer was unavoidable.	F 686		

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 _____	**06/24/2025**

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 An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/24/2025. 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 | 07/09/2025

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 115 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353		6/24/25

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K 353	Continued From page 3 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.1.2(3) and (5). These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 06/24/2025 at 11:30 AM, it was revealed by observation that a sprinkler head escutcheon plate was missing from a sprinkler located in the Activities Storage Closet. 2. On 06/24/2025 at 11:41 AM, it was revealed by observation that sprinkler heads in the 3rd Floor	K 353	A detailed description of the corrective action taken or planned to correct the deficiency: •The sprinkler head escutcheon missing in the Activities Storage Closet was replaced. •Sprinkler heads in the 3rd floor east shower room and laundry room were cleaned to remove lint and debris. Address the measures that will be put into place to ensure the deficiency does not reoccur: •Sprinkler heads are inspected annually. Sprinkler heads in locations throughout the facility with higher lint and humidity	

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K 353	Continued From page 4 East Shower Room were covered in a layer of lint and debris. 3. On 06/24/2025 at 12:29 PM, it was revealed by observation that sprinkler heads in the Basement Laundry Room were covered in a layer of lint and debris. An interview with Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 353	factors will be inspected quarterly. Indicate how the facility plans to monitor future performance to ensure solutions are sustained: •Sprinkler head cleanliness and escutcheon placement has been added to monthly environmental rounding checklists. Identify who is responsible for the corrective actions and monitoring of compliance. •The Director of Facilities and Maintenance or designee will audit sprinkler escutcheon placement and sprinkler head cleanliness monthly for one year.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 15, 2025

Administrator
Eventide Lutheran Home
1405 7TH STREET SOUTH
MOORHEAD, MN 56560

RE: CCN: 245461
Cycle Start Date: June 25, 2025

Dear Administrator:

On July 30, 2025, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

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