*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
December 20, 2024

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

RE: CCN: 245461
Cycle Start Date: December 10, 2024

Dear Administrator:

On December 10, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS location may notify you of their determination regarding any imposed remedies.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies

(those preceded by a "F"and/or an "E" tag), i.e., the plan of correction should be directed to:

Annette Winters, Regional Supervisor Federal RR
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

**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

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

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December 20, 2024

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

Re: Event ID: E3CP11

Dear Administrator:

The above facility survey was completed on December 10, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any 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

*An equal opportunity employer*

| 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 12/10/2024 |

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| F 000 | INITIAL COMMENTS<br><br>On 12/9/24 through 12/10/24, a standard abbreviated 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, and Requirements for Long Term Care Facilities.<br><br>The following was reviewed: H54611900C (MN00108645) with a deficiency cited at F689 at Harm, Past Non-Compliance.<br><br>Although the provider had implemented corrective action prior to survey, harm was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents. | F 000 | | |
| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a safe transfer using a full body mechanical lift for 1 of 3 residents (R1) reviewed for accidents. This resulted in harm for R1 when she fell from the lift during a transfer, sustained a laceration to the back of her scalp and contusion (a bruise caused | F 689 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE 12/20/2024

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 689 | Continued From page 1<br>by blood vessels under the skin that break and bleed due to an injury such as a blow or impact) of the sacrum (a bone that connects the lumbar spine and the pelvis). R1 was sent to the emergency department (ED) and required four staples to the scalp. The facility implemented corrective action prior to the survey so the deficient practice was issued at past non-compliance.<br><br>Findings include:<br><br>Volaro Series 4 Lift Operators Manual dated 3/2019, identified the Volaro lift was designed for patient transfer only. Make sure all four loops from the sling are properly "nested" in the bottom of the hooks before lifting or transferring a resident and all four retainer springs are functioning correctly. Lift legs must be fully extended into the wide position when lifting a resident. Instructions provided identified when a resident was transferred from bed to chair: roll the person to their side and lay the folded sling behind them. Align the bottom of the back of the sling by the tailbone. Roll the person to their side and pull the rest of the sling through, straightening any wrinkles. Bring material under the legs the same way as if they were in the chair. Crisscross the inside flaps and thread the straps through the main loops. Bring the lift in, adjust the base to the widest position, and lower hanger near the center of the person being transferred. Keep the lift in the widest position possible at all times, especially when transferring a person who is uncooperative or combative. Bend the knees and hook up the color-coded loops that were previously used to bring them to a sitting position. Press the button to raise the lift just high enough to clear the bed and make sure the material | F 689 | | |

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| F 689 | Continued From page 2<br>under the leg stays straight toward the knee, keeping out as many wrinkles as possible. Note: Raise until there is tension on the straps and then double-check to make sure the loops are nested in the bottom of the hooks. If the base is in the narrow position, adjust it to the widest position once you are clear from the bed and always before turning the lift. Once the patient is over the chair, lower and guide them by the built-in handles on the sling to bring them back far into the chair. Note: Use only the lift handle bars to move the lift. Pulling or pushing on the person or the beam will cause the lift to be unstable.<br><br>R1's diagnoses list undated, identified dementia, recurrent dislocation left hip, history of repeated falls, difficulty in walking, osteoporosis, back pain, and personal history of other pathological fractures.<br><br>R1's fall risk assessment dated 11/8/24, identified poor recall, judgment, safety awareness. R1 required the use of assistive devices for mobility, no falls in the past three months. Fall risk score was nine and indicated at risk for falls.<br><br>R1's care plan dated 11/14/24, identified she had a potential for falls related to senile degeneration to the brain, weakness, different environment than home setting, and dementia. Staff were directed to monitor for changes in mobility and provide appropriate follow up, transfer with Volaro, and assist of two with medium Volaro sling. R1 was alert and oriented to self but did not typically talk or respond when asked questions. Staff were directed to have allowed R1 time to communicate, speak clearly and directly when spoken to, and use consistent approach that explained procedures in short, clear, and simple | F 689 | | |

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| F 689 | Continued From page 3<br>sentences. R1 had a self-care deficit and privacy for all cares was to be provided. Camera was placed in R1's room by family with dignity shield declined during cares.<br><br>R1's progress notes on 11/27/24, identified:<br><br>-At 9:23 a.m. writer arrived to R1's room around 8:05 a.m. and noted she was on the floor. Charge nurse was already present and applied pressure to head laceration. Emergency medical service (EMS) had just arrived, and report was given. Writer assisted with transfer to the stretcher. No obvious injuries except for head laceration. R1 was at her baseline cognition when EMS arrived. Vitals not obtained due to care needed for head laceration and assistance with transport to ED as soon as able. Writer spoke with daughter, updated, and had observed the fall. Root cause of fall was related to loop placement on the lift hook. Appropriate actions for follow up being completed. R1 will be monitored for pain, injury, or other concerns post fall. Will await return from ED.<br>-At 7:11 p.m. Fall: time of fall at 7:50 a.m. Description of event: two aids transferred her from bed to the wheelchair and she fell from the mechanical lift. Fall was witnessed and resident hit her head. Action Plan/Intervention: Recertification of mechanical lift usage. Practitioner notified at 7:59 a.m. and family.<br>-At 7:18 p.m. R1 came back from hospital with staples to her head to be removed in 7 to 10 days. Keep pressure on wound for 24 hours.<br><br>R1's ED visit on 11/27/24 at 9:07 a.m. identified R1 had significant dementia, previous lumbar fractures presented to ED for evaluation of possible injury sustained in a fall. R1 apparently | F 689 | | |

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| F 689 | Continued From page 4 | F 689 | | |

suffered a fall during a transfer with a mechanical lift. R1 struck the back of her head and had a lot of bleeding and no loss of consciousness. Physical assessment confirmed a 1.5-centimeter (cm) laceration cephalohematoma (blood collection underneath the scalp) to right occipital scalp and mental status at baseline. R1's laceration was repaired with four staples. Cat Scan (CT) (an imagining test that used x-rays and a computer to create detailed pictures of organs, bones, and tissues) completed and identified no acute fractures or dislocations, and an area of hematoma with no active bleeding. Clinical impressions included laceration of scalp and contusion of sacrum. R1's pelvic CT scan without contrast completed on 11/27/24 identified indication for scan was blunt polytrauma (injury to multiple body parts), evaluation for fractures. Findings: no pelvic fracture and high attenuation collection, superficial to the lower sacrum measuring 2.3 x 7.1 x 6.6 centimeters (cm), likely representing hematoma.

Facility investigation dated 11/27/24 at 10:59 a.m. identified incident description by charge nurse: R1 was being transferred from her bed to her wheelchair in a mechanical lift. Two staff present. R1 was on the floor lying with her feet toward the door and between the legs of the mechanical lift. There was blood on the floor under her head about the size of an 8-inch dinner plate. At 7:55 a.m. the charge nurse called the resident care manager (RCM). Upon entering R1's room she laid on her back with her hips and legs leaning to the left. R1 had been lifted up with assist of two and a mechanical lift. The mechanical lift sling was noted still hooked up to the mechanical lift machine with the right bottom strap dangling down towards the floor. Sling was later assessed,

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| F 689 | Continued From page 5<br>completely intact, no damage prior to being hooked up to mechanical lift. Nursing assistance (NA) knelt next to R1 and told RCM not sure what went wrong but indicated the strap fell off. R1 was non-verbal and did not move extremities well at baseline. Neuro check completed and normal. A puddle of blood was noted surrounding R1's head that came from the lower back side of her head. RCM held a clean towel against R1's and provided pressure to the laceration. R1 unable to provide description of incident. The two NAs involved in incident and all nursing staff in the building were immediately given mechanical lift competencies once resident left with EMS until all nursing had been signed off on their competencies. It appeared that the sling was not appropriately hooked up on the right lower side of the mechanical lift sling which caused R1 to slip out of the right side of the sling to the floor. Did someone say this, where did you get this statement from?<br><br>All nursing staff were sent out an email on 11/27/24 at 4:25 p.m. regarding R1's fall from the mechanical lift. All nursing staff were informed they were required to have completed a mechanical lift competency prior to their next shift worked. Attached to the email was a copy of the mechanical lift competency for all staff to use along with a picture of the sling positioned correctly and another picture of where the sling was positioned incorrectly. Nursing staff were reminded to check and double check the straps/loops are secure and all on. A little tug on the strap should be completed to help verify it is in place. When a second person came in to assist with the transfer all the straps are to be checked they are on and secure prior to the start of the transfer. | F 689 | | |

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| F 689 | Continued From page 6 | F 689 | | |

Mechanical lift audits had been started on 12/3/24 and continued through 12/6/24, a total of eight completed thus far and identified: Resident/staff, sling hooked up to mechanical lift correctly prior to transfer, staff double checked straps and looks to ensure they were nested into the loop, and signature/comments/education. No concerns were identified during the eight audits.

During an interview on 12/9/24 at 12:47 p.m. family member (FM) stated R1 had a camera in her room and recorded the fall on 11/27/24. FM stated she viewed the footage, and it showed NA was in room by herself with R1, placed the mechanical lift sling underneath her then hooked it up to the mechanical lift. FM stated another NA entered R1's room and the straps/loops were not checked. FM stated once the staff moved her off the bed to be transferred to the wheelchair she started to lean/fall on the right side, the lower right strap came off, NA attempted to hold R1's bottom, left leg was hooked, dangled in the air on the strap that remained attached to the lift, slid down out of the sling, was dropped onto the floor, and hit her head. FM stated additional staff entered the room and identified there was blood everywhere. FM stated another staff entered the room, knelt beside R1 and pressure was held to the back of her head. FM stated was very difficult for her to watch the video and was unable to view it again. FM stated the fall happened so fast, R1 was unable to verbalize much, knew what was going on, and was whimpering. FM stated CT was completed on R1's hips and back, had not received results. FM stated R1 was sent to ED, had a laceration to the back of her head and received four staples. FM stated the recorded fall was offered and viewed by the administrator and

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During an interview/observation 12/9/24 at 1:41 p.m. NA-C demonstrated how the mechanical lift should be attached to the straps/loops. NA-C stated for a safe transfer with the mechanical lift you must have all four straps/loops from the lift sling snapped into the hooks from the outside and around to ensure it stayed hooked on the mechanical lift. NA-C stated we were expected to double check prior to the start of the lift and again once the resident was lifted off the bed /chair, pause to make sure the loops were intact and stayed where they needed to be to prevent falls.

During an interview/observation 12/9/24 at 3:10 p.m. NA-A stated R1 had fallen from the mechanical lift on 11/27/24, during a transfer. NA-A demonstrated/reenacted R1's incident with the mechanical lift and lift sheet in an unoccupied bed/room. NA-A placed the lift sling on the bed and stated R1 laid on top of it. NA-A pushed the mechanical lift over to the bed and stated so that the swivel bar was over the resident. NA-A stated she was unaware the mechanical lift legs were to have been in the wide position when under the bed and while she hooked up resident to the mechanical lift. NA-A stated she thought it was only when the resident was moved in the lift then pointed out a sticker that had been placed on the mechanical lift and revealed: lift patient only with floor lift legs in wide position to prevent chance of tipping. NA-A stated she did not open the legs of the mechanical lift while she lifted R1 out of bed that day. NA-A stated would have been important because with the mechanical lift legs positioned wide resident's weight was dispersed more evenly and less risk of the resident being tipped over while in the lift. NA-A stated she hooked up

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| F 689 | Continued From page 8 the straps/loops from the lift sling to the two top hooks first on the mechanical lift. NA-A stated she pulled back the clasp and placed top loops into the mechanical lift hook and snapped the clasps in place. NA-A stated criss crossed the lower straps between R1's thighs and hooked straps/loops to the mechanical lift. NA-A stated she thought the clasps snapped closed and the lower loops freely hung in the loop on the mechanical lift but when reviewed what happened during the transfer the only explanation was the loop on the right side was not positioned fully in the mechanical lift hook and instead caught in between the clasp and the hook, which made the mechanical lift transfer unsafe and resulted in R1's fall. NA-A stated she sent a message via walkie for assistance to transfer R1 from the bed to the wheelchair. NA-A stated NA-B entered the room and stood by the bed on R1's right side located up by her head. NA-A stated the straps/loops were not double checked prior to the start of the transfer. NA-A stated R1 was lifted off the bed and mechanical lift legs remained in narrow position until she was high enough to clear the bed (approximately five feet). NA-A stated NA-B positioned the sling with R1 in it so that her legs were off the bed, and she faced the lift and herself. NA-A stated she pulled the mechanical lift backwards away from the bed approximately three feet, opened the legs of the mechanical lift so that the wheelchair could fit between them. NA-A stated she stood on left side of mechanical lift and NA-B stood on right side and with the weight of R1's legs suddenly her right leg dropped, right strap/loop fell from the mechanical lift hook, her upper body and head slipped out from her right side of the sling where it was detached from the mechanical lift. NA-A stated she placed her hand on R1's back, | F 689 | | |

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| F 689 | Continued From page 9 | F 689 | | |

stepped over the mechanical lift leg, and tried to grab her right leg. NA-A stated NA-B tried to brace R1 under the sling with her hands. NA-A stated she grabbed R1's head and that was when R1's body slide out of the sling, center backside of her head hit the ground first from approximately one foot off the ground. NA-A stated R1's feet partially rested on the metal base of the mechanical lift. NA-A stated NA-B sent a message on the walkies to alert staff nurse. NA-A stated R1 laid in a puddle of blood surrounding her head approximately eight inches in diameter and soaked her clothing on her back. NA-A stated R1's eyes started to water and visually looked like she started to cry. NA-A stated R1 was not knocked out when she hit the floor. NA-A stated staff nurse arrived in R1's room and placed a towel with pressure onto the back of her head to help control the bleeding. NA-A stated the fall was caused by her error, the one loop of the sling was not secured in the mechanical lift hook on the swivel bar, slipped out, should have been more careful, and rechecked them. NA-A stated she received education immediately regarding how to safely use a mechanical lift competency and demonstrate it back to show she had an understanding of the education.

During an interview on 12/9/24 at 4:20 p.m. licensed practical nurse (LPN)-A stated R1 was a mechanical lift transfer with assist of two staff. LPN-A stated worked on 11/27/24 and received a call on her walkie from NA-A that indicated assistance was needed in R1's room. LPN-A stated entered room and completed a quick assessment along with the floor manager and then called 911. LPN-A stated R1's eyes were wide open and pupils reactive and she laid in a pool of blood approximately eight inches in

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|---|---|---|---|
| | 245461 | A. BUILDING ______<br>B. WING ______ | C<br>12/10/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EVENTIDE LUTHERAN HOME | 1405 7TH STREET SOUTH<br>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 |
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| F 689 | Continued From page 10<br>diameter. LPN-A stated he saw three sling straps/loops that remained hooked on the mechanical lift, and one was not. LPN-A stated he was informed by NAs involved R1 had slipped out from the bottom of the sling, and they were unable to stop the fall. LPN-A stated unable to move or turn R1, waited for ambulance personnel to arrive in case she had more injuries.<br><br>During an interview on 12/10/24 at 11:15 a.m. NA-B stated on 11/27/25 received a message via walkie assistance was needed with R1. NA-B entered R1's room and noted she laid in bed already hooked up to the mechanical lift. NA-B placed R1's wheelchair closer to the bed, stood towards the end of the bed, and did not check the straps/loops prior to the transfer. NA-B stated she had not checked the straps/loops before when another NA had hooked them up and assumed it had been done properly and safely. NA-B stated unsure if the legs of the mechanical lift were opened when NA-A lifted R1 off the bed, NA-B lifted R1's feet off the bed. NA-B stated R1 was moved away from the bed in the mechanical lift approximately five feet and everything seemed normal. NA-B stated unsure if she continued to hold onto R1's feet when the leg strap (unsure of which one) on one side gave out, fell to the floor, unsure of what hit first but was not her head. NA-B stated R1 laid on the floor with blood around her head. NA-A stated the strap/loop was not hooked up properly and should have been checked again prior to the transfer. NA-A stated felt she was in shock when it happened, hard to remember all the details, and was the worst thing she had seen in her life, when a resident got hurt like that. NA-B stated she had received education right away after the fall on 11/27/24, the proper way to use the mechanical lift , placement of the | F 689 | | |

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mechanical lift sling and placement of the loops, when the mechanical lift wheels should be locked, and then demonstrated those steps back to show we knew how to do it.

During an interview on 12/10/24 at 1:55 p.m. DON stated on 11/27/24, NA-A lifted R1 up with the mechanical lift, there was tension on the sling and then as soon as R1's body was turned because the sling loop was not positioned on all the way and fell off the hook. DON stated R1's right side went down, and she fell to the floor. DON stated both NAs tried but were unable to stop R1 from falling gradually and it went fast once the loop let go. DON stated R1 fell approximately three feet, hit her upper back then her head. DON stated R1 sustained a laceration to back of her head, sent to ED, and treated. DON stated the fall could have been prevented if staff would have doubled checked the mechanical lift strap. DON stated immediately after the fall staff education and audits were initiated. DON stated all nursing staff were educated except for approximately five to seven staff employed as needed (PRN) and planned on education provided prior to their next shift.

During an interview on 12/10/24 at 4:20 p.m. medical doctor (MD)-A stated R1 was brought into ED due to a fall at the facility during a transfer with sustained a laceration to the back of her head, caused harm, and required treatment for it.

During an interview on 12/10/24 at 4:25 p.m. medical doctor/radiologist MD-B stated the CT of R1's pelvis completed on 11/27/24, findings identified high attenuation collection, superficial to the lower sacrum measuring 2.3 x 7.1 x 6.6 centimeters (cm), likely representing hematoma.

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acute or early subacute chronic. MD-B stated this could have resulted from the fall on 11/27/24.

Mechanical lift Sling Application and Lift Use Competency Evaluation and Education dated 12/2021, identified procedure/criteria for use of the lift machine:
-Select correct sling and size (per care plan and/or sling sizing chart).
-Slide sling down to seat of chair to tailbone area; do not place under resident's buttocks.
-Slide leg sections of sling along outer thighs, then tuck under thighs.
- Bring leg support straps up between legs, and cross to attach at opposite side of mechanical lift swivel bar.
-Attach sling straps to swivel bar (same length/loop on each side).
-Attach shoulder straps first, then leg straps to swivel bar.
-Ensure straps are secured before lifting resident. Lift resident high enough to cause tension on the straps. Then double check strap placement and security before continuing lift.
-Do no lock wheels (unless lifting from floor or sloped surface).
-Keep base at its widest setting.
-Keep resident at lowest height necessary.
-Always requires presence of two staff members (over age of 18).
-Mechanical lift lifts are for transfers only: never transport a resident in a lift. To prevent tipping. Do not push or pull-on mechanical lift beam or on resident.

Minnesota Department of Health

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| | 00072 | A. BUILDING: ______ B. WING ______ | C 12/10/2024 |

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

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| 2 000 | Initial Comments | 2 000 | | |

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/9/24 through 12/10/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaint was reviewed:

Minnesota Department of Health

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/20/24 |

Minnesota Department of Health

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| 2 000 | Continued From page 1<br><br>H54611900C (MN00108645). NO licensing orders were issued.<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.<br><br>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents. | 2 000 | | |