



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 18, 2022

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

RE: CCN: 245461
Cycle Start Date: June 15, 2022

Dear Administrator:

On July 12, 2022, the Minnesota Department of Health, 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,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 07/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2022	
NAME OF PROVIDER OR SUPPLIER EVENTIDE LUTHERAN HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH MOORHEAD, MN 56560			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 6/14/22, to 6/15/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED, and related deficiencies were cited. H54612287C (MN00084193), with a deficiency cited at (F886). 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 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on			F 886			7/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/30/2022

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 886	Continued From page 1 parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.	F 886			

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F 886	Continued From page 2 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure routine COVID-19 testing occurred for unvaccinated staff according to the community positivity rates identified in CMS (Centers for Medicare and Medicaid Services) guidelines. This deficient practice had the potential to affect all 124 residents currently residing in the facility. Findings include: CMS's Quality, Safety and Oversight Group (QSO) memo 20-38 for nursing homes dated 3/10/22, identified the long term care (LTC) facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. The memo indicated the facility must have procedures for addressing staff, including individuals providing services under arrangement and volunteers, who refuse testing or were unable to be tested. The QSO memo identified "Facility staff" included employees, consultants, contractors, volunteers, and caregivers who provided care and services to residents on behalf of the facility, and students in	F 886	How corrective action will be accomplished for the resident(s) impacted: - The facility is unable to go back and collect specimens from unvaccinated employees to test according to community transmission rates. Once this practice was noticed, the unvaccinated staff were pulled from the floor and tested prior to their next shift. We screened all residents in the facility for signs and symptoms of COVID-19. How facility will identify other residents who have potential to be affected: - All residents in the facility who the unvaccinated staff worked with had 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 process for tracking COVID-19 vaccination and testing of new employees has been improved; one person oversees		

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F 886	Continued From page 3 the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing services under arrangement and volunteers," facilities should prioritize those individuals who were regularly in the facility (e.g., weekly) and had contact with residents. The memo instructed facilities to use their community transmission level as the trigger for staff testing frequency. The facility was expected to test all staff, who were not up-to-date, at the frequency prescribed in the Routine Testing table based on the level of community transmission. The Center for Disease Control and Prevention (CDC) identified the Clay county community transmission rate was substantial from 5/24/22, to 5/29/22. Review of the employee Care Center Covid and Flu Vaccination tracking form undated, identified the facility had a total of 231 staff. Two of the 231 staff were partially vaccinated and three staff had religious exemptions. Review of nursing assistant (NA)-A Employee Summary dated 6/15/22, indicated NA-A was hired on 5/24/22. Review of NA-A's Department of Health Immunizations undated, identified NA-A had received one dose of Moderna Covid-19 vaccine on 5/16/22. The immunization record lacked any further documentation NA-A had received any further doses of COVID-19 vaccine. Review of the facility schedules from 5/24/22, to 6/15/22 revealed the following: NA-A had worked at the facility on 5/30/22,	F 886	the process for new hires and verifies that they have the COVID-19 vaccine and/or are testing according to CMS QSO 20-38. - All new hires will have a deadline to obtain the COVID-19 vaccine or apply for a religious or medical exemption, if eligible. - The leadership team will be educated on the proper process for ensuring unvaccinated staff are in compliance with CMS QSO 20-38. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: - The administrator or designee will audit all new hires' vaccination compliance for one month, 10 new hires' vaccination compliance each month for 3 months, and 5 new hires' vaccination compliance each month for 8 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The administrator or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.		

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F 886	Continued From page 4 5/31/22, 6/1/22, 6/4/22, 6/5/22, 6/7/22, 6/10/22, 6/13/22 and 6/15/22. Review of NA-A's Point of Care Testing Results from 5/24/22, to 6/15/22 revealed the following: NA-A had tested on 6/15/22, showing a negative result while being employed by the facility. The testing logs lacked identification NA-A was being tested prior to working when scheduled or dates for routine testing based on the community transmission level. During an interview on 6/14/22, at 1:01 p.m. the administrator verified the above findings and indicated the facility was testing for COVID-19 on Mondays and Thursdays due to the community transmission level being substantial. The administrator indicated if staff were to miss the testing dates, staff would be removed from the schedule and would not be allowed to work until they tested. During a follow up interview on 6/15/22, at 9:57 a.m. the administrator confirmed NA-A was hired on 5/24/22, had received one dose of COVID-19 vaccine and was not eligible for her second dose until 6/16/22. The administrator confirmed NA-A was currently working in the facility and had not been testing two times a week according to the facility's community transmission rate (substantial) for staff who were not fully vaccinated. The administrator indicated she would expect staff to follow the facility policy for testing. On 6/15/22, at 10:06 a.m. attempted to contact NA-A via telephone with no response and no return call.	F 886			

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F 886	Continued From page 5 During an interview on 6/15/22, at 10:14 a.m. the infection preventionist (IP) confirmed the above findings and indicated NA-A had not been added to the tracking spread sheet for COVID-19 testing. The IP verified NA-A missed her testing dates due to the error and indicated staff were to test according to the facility's community transmission rate (substantial) for staff who were not fully vaccinated. The IP indicated she would expect staff to follow the facility policy for testing and to test two times a week according to the community transmission rate. Review of the facility policy titled, Covid-19 Vaccine Employee revised on 5/2022, indicated if an employee refused the vaccine they would be required to complete the medical or religious exception form. Employees approved for a medical or religious exception would be required to test according to the community transmission rate and wear a N95 and eye protection for the duration of the COVID-19 public health emergency. Review of facility policy titled, Eventide Covid-19 revised on 9/2021, indicated if an employee was unable to report to the facility wide testing dates, this would be communicated to the manager in advance to ensure testing was completed as soon as possible and as required by the Minnesota/North Dakota Department of Health and Centers for Medicare & Medicaid Services.	F 886			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 28, 2022

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

RE: CCN: 245461
Cycle Start Date: June 15, 2022

Dear Administrator:

On June 15, 2022, 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 Huseeth, 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.huseeth@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 15, 2022 (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 15, 2022 (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/ltr_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.

Eventide Lutheran Home

June 28, 2022

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst

Minnesota Department of Health

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 28, 2022

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

Re: Event ID: JS5N11

Dear Administrator:

The above facility survey was completed on June 15, 2022 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,

A handwritten signature in blue ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2022
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/14/22 and 6/15/22, 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 found to be		2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

06/30/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/15/2022
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2 000	Continued From page 1 SUBSTANTIATED: H54612287C (MN00084193) however no licensing orders were issued. The 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. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			