Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 8, 2025

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

RE: CCN: 245461
Cycle Start Date: April 2, 2025

Dear Administrator:

On April 29, 2025, 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,

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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May 8, 2025

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

Re: Reinspection Results
Event ID: BZXM12

Dear Administrator:

On April 29, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 2, 2025. At this time these correction orders were found corrected.

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
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Protecting, Maintaining and Improving the Health of All Minnesotans

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April 10, 2025

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

RE: CCN: 245461
Cycle Start Date: April 2, 2025

Dear Administrator:

On April 2, 2025, 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

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

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 July 2, 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 October 2, 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.

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

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Electronically delivered
April 10, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: BZXM11

Dear Administrator:

The above facility was surveyed on April 1, 2025 through April 2, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

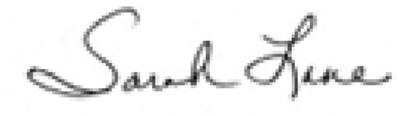
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

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

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

Please 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

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 04/02/2025

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
F 000	INITIAL COMMENTS On 4/1/25 through 4/2/25, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H54612289C (MN00111837) and H54612290C (MN00111840) with a deficiency issued at F880. 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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		4/24/25

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

Electronically Signed | 04/15/2025

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 880	Continued From page 1 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 2 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed during a high contact care activity for 2 of 3 residents (R1, R5) in enhanced barrier precautions (EBP) with an indwelling device. Findings include: Primary provider visit dated 2/4/25 at 8:00 p.m. identified assessment/plan: neurogenic bladder - continue with suprapubic catheter (a flexible tube placed through an incision in the abdomen instead of from the urethra to empty urine from the bladder into a collection bag) (SP), Mirabegron 25 milligrams (mg) (medication for bladder spasms). Nursing was responsible for catheter cares. No recent urinary tract infection (UTI) concerns. R1's annual Minimum Data Set (MDS) dated 3/15/25, identified intact cognition without behaviors. She had upper impairment on one	F 880	How corrective action will be accomplished for the resident(s) impacted: • Immediate education regarding enhanced barrier precautions and hand hygiene expectations was provided to the staff noted to have deficient practices when working with R1 and R5. • Education was provided to direct care staff working on all units on 4/2/25. How facility will identify other residents who have potential to be affected: • All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • All direct care staff will be educated on facility hand hygiene policy and transmission-based precautions policy, specifically regarding PPE use with enhanced barrier precautions on 4/22/25.	

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F 880	Continued From page 3 side, lower impairment on both sides and used a wheelchair for mobility. She required partial/moderate assistance with upper body dressing, personal hygiene, roll left and right, substantial/maximum assistance with toileting hygiene, shower/bathe, lower body dressing, and dependent upon staff for putting on and taking off footwear and all transfers. She had an indwelling urinary catheter and always incontinent of bowel. Medical diagnoses included congestive heart failure (CHF), neurogenic bladder, arthritis, osteoporosis, multiple sclerosis, anxiety, and depression. R1's current care plan identified R1 was at risk for infection related to SP catheter placement and chronic/long term use due to a neuromuscular dysfunction of the bladder. Staff were instructed to have provided EBP for all catheter cares and emptying, good hand hygiene, catheter cares per policy, monitor for signs/symptoms (s/sx) of UTI, encourage fluids, and position catheter bag and tubing below the level of the bladder. R5's significant change MDS dated 12/28/24, identified severely impaired cognition, altered level of consciousness and inattention (easily distractible or had difficulty keeping track of what was said) that fluctuated. She had behaviors symptoms every one to three days that included: physical directed toward others (hitting, kicking, pushing, scratching, grabbing), verbal directed towards others (threatening, screaming, cursing at others), and other symptoms not directed towards others (hitting or scratching self, disrobing in public, throwing or smearing food or body wastes, or verbal/vocal symptoms like screaming, disruptive sounds). She required substantial/maximal assistance with toileting	F 880	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 10 enhanced barrier precaution audits weekly for one month, then 5 audits per week for two months. •If concerns are identified, immediate corrective action and monitoring will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at each scheduled meeting.	

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F 880	Continued From page 4 hygiene, shower/bathe, upper and lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and all transfers. Used a manual wheelchair for mobility. She had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included CHF, neurogenic bladder, arthritis, osteoarthritis, and epilepsy (seizure disorder). R5's current care plan identified she was at risk for infection related to indwelling urinary catheter due to neurogenic bladder. She is on EBP. Staff were directed to use good hand hygiene, catheter cares per policy, observe for signs of catheter associated urinary tract infection (CAUTI), and encourage fluids. During an observation on 4/1/25 at 1:15 p.m. nursing assistant (NA)-A pushed R1 in her wheelchair from dining room back to her room. Located on the wall in the hallway on right side of R1's door was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room, and gown and gloves be placed on for all high-risk activities (dressing, bathing/showering, transferring in room or tub room, providing hygiene, changing briefs, and toileting, changing linens, device care and use of the urinary catheters, central lines, feeding tubes, and tracheostomies, wound care and dressing changes). NA-A walked back out into the hallway and grabbed the total lift machine, sanitized her hands, applied an isolation gown and gloves. She entered R1's bathroom and carried an empty graduate pitcher and alcohol swabs. She placed a paper towel onto the floor and the graduate pitcher on top. She removed the urinary catheter	F 880		

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F 880	Continued From page 5 collection bag from the privacy bag and hooked it on the lower bar of the lift machine. She pulled the end of the drainage tube out of the holder, wiped off the end of the tubing with the alcohol swab, unclamped the tubing and drained 400 milliliters (ml) of yellow urine with a strong odor into the collection container, and clamped the tubing. The end of the tubing was wiped with an alcohol swab and placed back into the holder. She emptied the urine into the toilet in the bathroom, rinsed out the container with water and placed it back into a clear bag that hung by the toilet on the wall. She removed her gloves and without sanitizing her hands placed a pair of clean gloves on. NA-A and NA-B connected he loops from the lift sheet onto the lift machine, transferred R1 back to bed, and removed the loops from the machine. Together they turned R1 over onto her side and removed the lift sheet from underneath her. NA-A used her gloved hands and lowered the head of the bed with the remote control, covered R1 with a blanket, and moved the bedside table over R1's abdomen. She removed her gown, placed it in the hamper located in R1's room, removed her gloves, exited the room, and sanitized her hands in the hallway. During an interview on 4/1/25 at 2:45 p.m. NA-B stated staff were expected to follow the facility policy EBP while they provided cares and worked with the urinary catheters to help prevent the spread of infection. Staff were expected to have applied a gown and gloves, removed gloves after completing cares, gloves became soiled, and/or emptying a urinary catheter, wash or sanitize their hands prior to the placement of a clean pair of gloves to help prevent infection. During an interview on 4/1/25 at 3:09 p.m. NA-A	F 880		

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F 880	Continued From page 6 stated R1 was placed in EBP because she had a urinary catheter. She had placed a gown and gloves on prior to entering the room and emptied urinary catheter while R1 sat in the wheelchair. There was 400 ml of yellow urine in the graduate pitcher, dumped the urine in the toilet and rinsed the container out. She removed her gloves and without sanitizing her hands placed a clean pair of gloves on. She left the bathroom and continued to work with the resident, then removed her gloves and gown, and sanitized her hands. She stated would have been really important to have washed her hands after she removed the dirty gloves and applied a clean pair to help prevent the spread of germs. She had forgotten to wash her hands. During an interview on 4/1/25 at 4:05 p.m. licensed practical nurse (LPN)-A stated staff were expected to have placed a gown and gloves on prior to entering an EBP room when planned to complete cares and emptying a urinary catheter. Staff would be expected to remove their gloves after working with a resident's catheter and urine, wash their hands, prior to when clean gloves were applied. Those steps were expected, especially when staff went from dirty to clean, would have helped prevent the transfer of bacteria and infection. During an observation on 4/2/25 at 9:57 a.m. NA-C entered R5's room. Located on the wall in the hallway on right side of R5's doorway was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room and placed gown and gloves on before all high-risk activities were completed. NA-C entered R5's room, gown and gloves were not applied. She explained the indwelling catheter would be emptied and applied a pair of clean	F 880		

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 04/02/2025

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
F 880	Continued From page 7 gloves. She placed a paper towel on the floor, graduate pitcher retrieved from the bathroom was placed on top of the paper towel and opened an alcohol swab. She removed end of the catheter tube from the holder and wiped off the end port with an alcohol swab. She unclicked the clamp on the tubing and emptied the urine from the collection bag into the graduate pitcher. She clicked the clamp closed, wiped off the end port with an alcohol swab, and placed the end in the holder located on the front of the collection bag. She emptied 400 ml of clear yellow urine into the toilet and without rinsing out the collection container placed it on the back side of the toilet. She removed her gloves and washed her hands with soap and water, flushed the toilet, grabbed a tied bag of garbage, and exited R5's room. During an interview on 4/2/25 at 10:05 a.m. NA-C stated R5 was placed in EBP due to her urinary catheter, infection, and helped prevent the spread of germs. Staff were expected to wear a gown and gloves when they provided any type of care, including emptying the urinary catheter to help prevent the spread of germs. She stated she did not wear an isolation gown while she worked with R5's urinary catheter and it was a mistake; she had forgotten to put on one. The graduate pitcher should have been rinsed out after the urine was dumped in the toilet to keep it clean, disinfected, and for infection control. She had gone back later and rinsed it. During an interview on 4/2/25 at 11:14 a.m. registered nurse (RN)-A director of quality and infection prevention stated residents with indwelling urinary catheters are placed in EBP to help prevent the spread of infection. Hand hygiene should be completed prior and after	F 880		

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F 880	Continued From page 8 resident contact, when hands were visibly soiled, before every clean procedure, before and after gloving, take off gloves appropriately without getting the hands solid, to help prevent the spread of infection. Staff would be expected to wear an isolation gown and gloves when entering a resident's room placed in enhanced barrier precautions when cares were to be completed and emptying the indwelling urinary catheter to help prevent the spread of infection. She would have promoted staff to have rinsed out the collection container once the urine was disposed of in the toilet to have helped prevent odor and hopefully inhibit the growth of bacteria. During an interview on 4/2/25 at 1:28 p.m. director of nursing (DON) stated EBP are used with those residents that had indwelling urinary catheters to prevent the spread of germs and multi-drug-resistant organisms (MDRO) (organisms that are resistant to typical antibiotic treatments and can cause infection). Staff would be expected to have completed hand hygiene prior to the application of the gloves and once they completed working with the indwelling urinary catheter gloves should have been removed, hand hygiene completed prior to a new application of clean gloves. This would have helped spread the germs and protected staff and residents. When a resident was placed in enhance barrier precautions staff were expected to wear a gown and gloves during prolonged exposure such as catheter cares and/or transfers of the resident to help prevent the spread of germs and MDROs. Facility policy Hand Hygiene dated 11/2024, identified proper hand hygiene will be followed before and after resident contact (before you	F 880		

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F 880	Continued From page 9 leave the room), before every clean procedure, after every dirty procedure, and as needed. Purpose: hand hygiene is a general term that applied to either hand washing or alcohol-based hand rub (ABHR). The purpose was to prevent the spread of infection.	F 880		

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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 4/1/25 through 4/2/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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

Electronically Signed | 04/15/25

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H54612289C (MN00111837), H54612290C (MN00111840) with a licensing order issued at 1390. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota	2 000		

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2 000	Continued From page 2 Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and	21390		4/24/25

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21390	Continued From page 3 l. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed during a high contact care activity for 2 of 3 residents (R1, R5) in enhanced barrier precautions (EBP) with an indwelling device. Findings include: Primary provider visit dated 2/4/25 at 8:00 p.m. identified assessment/plan: neurogenic bladder - continue with suprapubic catheter (a flexible tube placed through an incision in the abdomen instead of from the urethra to empty urine from the bladder into a collection bag) (SP), Mirabegron 25 milligrams (mg) (medication for bladder spasms). Nursing was responsible for catheter cares. No recent urinary tract infection (UTI) concerns. R1's annual Minimum Data Set (MDS) dated 3/15/25, identified intact cognition without behaviors. She had upper impairment on one side, lower impairment on both sides and used a wheelchair for mobility. She required partial/moderate assistance with upper body dressing, personal hygiene, roll left and right, substantial/maximum assistance with toileting hygiene, shower/bathe, lower body dressing, and dependent upon staff for putting on and taking off footwear and all transfers. She had an indwelling urinary catheter and always incontinent of bowel. Medical diagnoses included congestive heart	21390	Corrected	

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21390	Continued From page 4 failure (CHF), neurogenic bladder, arthritis, osteoporosis, multiple sclerosis, anxiety, and depression. R1's current care plan identified R1 was at risk for infection related to SP catheter placement and chronic/long term use due to a neuromuscular dysfunction of the bladder. Staff were instructed to have provided EBP for all catheter cares and emptying, good hand hygiene, catheter cares per policy, monitor for signs/symptoms (s/sx) of UTI, encourage fluids, and position catheter bag and tubing below the level of the bladder. R5's significant change MDS dated 12/28/24, identified severely impaired cognition, altered level of consciousness and inattention (easily distractible or had difficulty keeping track of what was said) that fluctuated. She had behaviors symptoms every one to three days that included: physical directed toward others (hitting, kicking, pushing, scratching, grabbing), verbal directed towards others (threatening, screaming, cursing at others), and other symptoms not directed towards others (hitting or scratching self, disrobing in public, throwing or smearing food or body wastes, or verbal/vocal symptoms like screaming, disruptive sounds). She required substantial/maximal assistance with toileting hygiene, shower/bathe, upper and lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and all transfers. Used a manual wheelchair for mobility. She had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included CHF, neurogenic bladder, arthritis, osteoarthritis, and epilepsy (seizure disorder). R5's current care plan identified she was at risk	21390		

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21390	Continued From page 5 for infection related to indwelling urinary catheter due to neurogenic bladder. She is on EBP. Staff were directed to use good hand hygiene, catheter cares per policy, observe for signs of catheter associated urinary tract infection (CAUTI), and encourage fluids. During an observation on 4/1/25 at 1:15 p.m. nursing assistant (NA)-A pushed R1 in her wheelchair from dining room back to her room. Located on the wall in the hallway on right side of R1's door was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room, and gown and gloves be placed on for all high-risk activities (dressing, bathing/showering, transferring in room or tub room, providing hygiene, changing briefs, and toileting, changing linens, device care and use of the urinary catheters, central lines, feeding tubes, and tracheostomies, wound care and dressing changes). NA-A walked back out into the hallway and grabbed the total lift machine, sanitized her hands, applied an isolation gown and gloves. She entered R1's bathroom and carried an empty graduate pitcher and alcohol swabs. She placed a paper towel onto the floor and the graduate pitcher on top. She removed the urinary catheter collection bag from the privacy bag and hooked it on the lower bar of the lift machine. She pulled the end of the drainage tube out of the holder, wiped off the end of the tubing with the alcohol swab, unclamped the tubing and drained 400 milliliters (ml) of yellow urine with a strong odor into the collection container, and clamped the tubing. The end of the tubing was wiped with an alcohol swab and placed back into the holder. She emptied the urine into the toilet in the bathroom, rinsed out the container with water and placed it back into a clear bag that hung by the	21390		

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21390	Continued From page 6 toilet on the wall. She removed her gloves and without sanitizing her hands placed a pair of clean gloves on. NA-A and NA-B connected he loops from the lift sheet onto the lift machine, transferred R1 back to bed, and removed the loops from the machine. Together they turned R1 over onto her side and removed the lift sheet from underneath her. NA-A used her gloved hands and lowered the head of the bed with the remote control, covered R1 with a blanket, and moved the bedside table over R1's abdomen. She removed her gown, placed it in the hamper located in R1's room, removed her gloves, exited the room, and sanitized her hands in the hallway. During an interview on 4/1/25 at 2:45 p.m. NA-B stated staff were expected to follow the facility policy EBP while they provided cares and worked with the urinary catheters to help prevent the spread of infection. Staff were expected to have applied a gown and gloves, removed gloves after completing cares, gloves became soiled, and/or emptying a urinary catheter, wash or sanitize their hands prior to the placement of a clean pair of gloves to help prevent infection. During an interview on 4/1/25 at 3:09 p.m. NA-A stated R1 was placed in EBP because she had a urinary catheter. She had placed a gown and gloves on prior to entering the room and emptied urinary catheter while R1 sat in the wheelchair. There was 400 ml of yellow urine in the graduate pitcher, dumped the urine in the toilet and rinsed the container out. She removed her gloves and without sanitizing her hands placed a clean pair of gloves on. She left the bathroom and continued to work with the resident, then removed her gloves and gown, and sanitized her hands. She stated would have been really important to have washed her hands after she removed the dirty gloves and	21390		

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21390	Continued From page 7 applied a clean pair to help prevent the spread of germs. She had forgotten to wash her hands. During an interview on 4/1/25 at 4:05 p.m. licensed practical nurse (LPN)-A stated staff were expected to have placed a gown and gloves on prior to entering an EBP room when planned to complete cares and emptying a urinary catheter. Staff would be expected to remove their gloves after working with a resident's catheter and urine, wash their hands, prior to when clean gloves were applied. Those steps were expected, especially when staff went from dirty to clean, would have helped prevent the transfer of bacteria and infection. During an observation on 4/2/25 at 9:57 a.m. NA-C entered R5's room. Located on the wall in the hallway on right side of R5's doorway was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room and placed gown and gloves on before all high-risk activities were completed. NA-C entered R5's room, gown and gloves were not applied. She explained the indwelling catheter would be emptied and applied a pair of clean gloves. She placed a paper towel on the floor, graduate pitcher retrieved from the bathroom was placed on top of the paper towel and opened an alcohol swab. She removed end of the catheter tube from the holder and wiped off the end port with an alcohol swab. She unclicked the clamp on the tubing and emptied the urine from the collection bag into the graduate pitcher. She clicked the clamp closed, wiped off the end port with an alcohol swab, and placed the end in the holder located on the front of the collection bag. She emptied 400 ml of clear yellow urine into the toilet and without rinsing out the collection container placed it on the back side of the toilet.	21390		

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21390	Continued From page 8 She removed her gloves and washed her hands with soap and water, flushed the toilet, grabbed a tied bag of garbage, and exited R5's room. During an interview on 4/2/25 at 10:05 a.m. NA-C stated R5 was placed in EBP due to her urinary catheter, infection, and helped prevent the spread of germs. Staff were expected to wear a gown and gloves when they provided any type of care, including emptying the urinary catheter to help prevent the spread of germs. She stated she did not wear an isolation gown while she worked with R5's urinary catheter and it was a mistake; she had forgotten to put on one. The graduate pitcher should have been rinsed out after the urine was dumped in the toilet to keep it clean, disinfected, and for infection control. She had gone back later and rinsed it. During an interview on 4/2/25 at 11:14 a.m. registered nurse (RN)-A director of quality and infection prevention stated residents with indwelling urinary catheters are placed in EBP to help prevent the spread of infection. Hand hygiene should be completed prior and after resident contact, when hands were visibly soiled, before every clean procedure, before and after gloving, take off gloves appropriately without getting the hands solid, to help prevent the spread of infection. Staff would be expected to wear an isolation gown and gloves when entering a resident's room placed in enhanced barrier precautions when cares were to be completed and emptying the indwelling urinary catheter to help prevent the spread of infection. She would have promoted staff to have rinsed out the collection container once the urine was disposed of in the toilet to have helped prevent odor and hopefully inhibit the growth of bacteria.	21390		

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21390	Continued From page 9 During an interview on 4/2/25 at 1:28 p.m. director of nursing (DON) stated EBP are used with those residents that had indwelling urinary catheters to prevent the spread of germs and multi-drug-resistant organisms (MDRO) (organisms that are resistant to typical antibiotic treatments and can cause infection). Staff would be expected to have completed hand hygiene prior to the application of the gloves and once they completed working with the indwelling urinary catheter gloves should have been removed, hand hygiene completed prior to a new application of clean gloves. This would have helped spread the germs and protected staff and residents. When a resident was placed in enhance barrier precautions staff were expected to wear a gown and gloves during prolonged exposure such as catheter cares and/or transfers of the resident to help prevent the spread of germs and MDROs. Facility policy Hand Hygiene dated 11/2024, identified proper hand hygiene will be followed before and after resident contact (before you leave the room), before every clean procedure, after every dirty procedure, and as needed. Purpose: hand hygiene is a general term that applied to either hand washing or alcohol-based hand rub (ABHR). The purpose was to prevent the spread of infection. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review and revise policies and procedures related to ensuring enhanced barrier precautions (EBP) were followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are following guidance with personal protection equipment and hand hygiene with identified EBP.	21390		

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21390	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21390		