Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 25, 2023

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

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

Dear Administrator:

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

As authorized by CMS the remedy of:

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

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 Therefore, the NATCEP prohibition is rescinded.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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 25, 2023

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

Re: Reinspection Results
Event ID: DH8212

Dear Administrator:

On October 18, 2023 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 August 16, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 27, 2023

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

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

Dear Administrator:

On September 6, 2023, we informed you that we may impose enforcement remedies.

On September 15, 2023, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 12, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 12, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 12, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

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 $11,995, 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.

If you have not achieved substantial compliance by October 12, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Eventide Lutheran Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 16, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

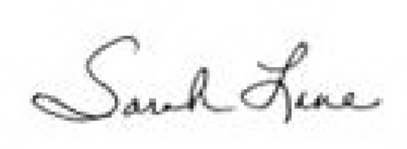
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: DH8211

Dear Administrator:

The above facility was surveyed on September 13, 2023 through September 15, 2023 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.

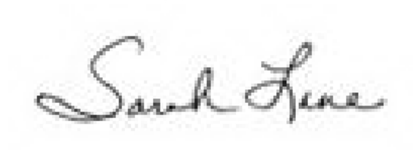
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/13/23, through 9/15/23, 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. H54615335C (MN00096740) H54615522C (MN00096685) with a deficiency issued at F689. 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 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		10/4/23

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

Electronically Signed | 09/29/2023

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

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the fall risk for 1 of 3 residents (R2) reviewed for accidents. This deficient practice caused actual harm when R2 fell and sustained a left fractured patella (knee cap). Findings include: R2's quarterly Minimum Data Set (MDS) dated 8/17/23, identified intact cognition with no behaviors, extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. R2 was not on a toileting program, had frequent bladder incontinence and continent of bowel. R2 received anticoagulants and antidepressants 7 out of the 7 days during the look back period. R2 had three falls since admission, one without injury and two with minor injuries. R2's diagnoses dated 9/15/23, identified spinal stenosis (narrowing) lumbar region with neurogenic claudication (nerves get pinched within the center of the lumbar spine, causing intermittent leg pain), radiculopathy (injury or damage to nerve roots in the area where they leave the spine) lumbar region, low back pain, retention of urine, lumbago with sciatica left side (pain, usually on one side, felt in the lumbar spine, thighs and buttocks, and may radiate to the ankles or toes), polyarthritis (a term used when at least five joints are affected with arthritis), obesity, left foot drop, and need for assistance with personal care. R2's orders dated 9/13/23 identified:	F 689	How corrective action will be accomplished for the resident(s) impacted: • R2's fall care plan has been reviewed and updated. AFO braces were added to the treatment administration record and care plan as ordered. Additional interventions to prevent further falls have also been added to R2's care plan. How the facility will identify other residents who have the potential to be affected: • All residents who are a fall risk and have orders for an immobilization device have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: • Education will be provided to all nursing staff on 10/2/2023 on the facility's policy titled, "Falls-Resident," ensuring interventions are implemented to reduce fall risks. Education will also be provided to all nursing staff on 10/2/2023 on the facility's policy titled, "Care Plans." • All care plans for residents who are at risk for falls and have orders for immobilization devices have been reviewed and updated as needed. The orders for the immobilization device are on the treatment administration record for residents identified. • The policies titled, "Falls-Resident" and "Care Plans" have been reviewed and remain appropriate.	

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2 -WBAT (weight bearing as tolerated) only when brace is on. NWB (non-weight bearing) when brace is off every shift. Date order 9/5/23. -Left knee T-scooped hinged brace locked in extension. Remove brace only for hygiene cares every shift. Date order 9/5/23. -Make sure the instep strap is worn properly snug. Please make sure the lining of the shoe is not in the shoe when R1 was wearing her ankle foot orthosis (AFO) (hard brace worn on lower leg/foot that provides gait stability, help compensate for muscle weakness, and improves overall walking safety). Start 1 to 2 hours today-adding 1 hour per day. If the little toe stays irritated, then may need to stretch her shoe overnight. Date order 10/24/22. R2's care plan last updated 9/14/23, identified R2 had the potential for falls related to L3 (lumbar spine level 3) pelvic fusion (procedure performed to encourage bones to grown together to provide more stability to the area) with interbody L4-S1 (area between the lumbar spine and the sacral spine in the lower back) and laminectomy (removal of spinal bone to relieve compression on the spinal cord). Staff were directed to provide assistance of one with toileting, AFO and donning of the AFO. R2 must have AFOs on for all transfers and ambulation (date initiated 5/20/22). Staff were to remind R2 to wear shoe with AFO's at all times when transferring/standing (date initiated 2/20/23 and removed on 9/14/23). Toileting: Independent with a FWW (front wheeled walker), assist PRN (as needed) (date initiated: 05/20/2022 and removed on 9/14/23). Ambulation: Independent in room with FWW, continue with supervision assist of one in	F 689	How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: • The Director of Nursing or designee will audit all resident falls for one month, 10 falls a month for 3 months and 5 falls a month for 1 month to ensure appropriate fall interventions were implemented with additional audits as recommended by the QA committee. • If concerns are identified, immediate corrective action will be implemented. The Director of Quality and Infection Prevention or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

hallways/walk to dine. Encourage to wear AFO braces (date Initiated: 05/20/2022 and removed independent ambulation on 9/14/23). Staff were also directed to anticipate and meet R2's needs.

R2's care plan nursing assistant (NA) care sheet dated 9/14/23, identified independent with a FWW (front wheeled walker), transfers assist of 1, right and left AFO.

R2's fall assessment dated 6/1/23, identified R2 required use of assistive devices scored 5 on assessment. R2 was at risk for falls.

R2's fall assessment dated 8/11/23, identified R2 had 1 to 2 falls in the past 3 months, required use of assistive devices, and scored 7 on assessment. R2 was at risk for falls.

R2's progress notes identified:

-7/14/23 at 9:00 p.m. NA checked on R2 to assist with evening cares and found R2 on her knees on floor in her room at bedside and attempted to get back up. R2 had shoes on and no AFOs were on her feet. R2 stated she had picked out clothes in the closet and walked back, left ankle rolled, lost balance, and fell. R2 was asked why the AFOS were not on, and indicated they hurt, and she removed them. Action plan/intervention: education provided to always assure AFO brace to both legs when up ambulating to support ankles, notified therapy to see if adjustments could be made to AFOs. Practitioner notified.

-7/15/23 at 11:01 am. fall update: reviewed R2's fall and root cause of fall was resident was not wearing AFO braces to legs, removed them because they hurt her feet. R2 was independent

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 with transfers and ambulation with front wheeled walker in her room. Immediate intervention placed to educate resident on the need to keep AFO braces on when she transferred or ambulated in her room. R2 agreed with intervention and notified therapy AFO braces hurt her feet to see if adjustments could have been made. -8/19/23 at 4:45 p.m. TMA (trained medication aide) heard a noise in R2's room, entered and found her lying on right side on the floor at the foot of her bed. R2's legs were extended outward towards the door, walker tipped over directly in front of her. R2 had tried to transfer out of her electric wheelchair and into her manual wheelchair located directly in front of her. R2 stood up to walk and her shoe caught on the title of the floor, caused her to trip, lost balance, hit right elbow against the foot of bed, and thought she had also hit her head. R2's right elbow had a light purple bruise and a bit of swelling and one hour later a very small raised light purple discoloration area noted on the right anterior parietal lobe (top back of head). Action Plan/Intervention: R2's care plan was followed as written. Root cause of fall seemed to be the tennis shoes R2 had been wearing the time of the fall. R2 indicated she would no longer wear those tennis shoes. Practitioner notified. -8/21/23 at 4:14 p.m. fall update: fall from 8/19/23 was discussed with nurse leadership. Care plan was followed at time of fall. Root cause of fall R2's foot did not raise when ambulating from electric wheelchair to manual wheelchair. R2 interviewed and indicated she had on her purple shoes when she went to therapy and they were not the issue, declined those shoes to be	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 removed from room and stated currently seen by therapy for that. R2 indicated sometimes when she walked her foot did not pick up like it should, when AFOs were worn did not have issues when she walked. Education was provided to resident to not ambulate without her AFOS on and perform stand turn and sit transfers and avoid ambulating or completely turned around to get into the chairs. R2 voiced understanding. -9/1/23 at 9:21 p.m. R2 found on floor parallel to her bed and faced her manual wheelchair located at the head of bed. R2 ambulated from electric scooter to her manual wheelchair, while ambulating tennis shoes got stuck on the floor, R2 lost control of her balance, and came down onto floor with both knees. R2 complained of pain in her leg (left or right was not identified) post fall both knees were noted to be bruised. Practitioner notified. -9/2/23 at 5:12 p.m., Fall update: fall from 9/1/23 reviewed along with care plan interventions. R2 currently independent with transfers and ambulation in room. R2 had AFO braces due to foot drop and was encouraged to wear during transfers and ambulation. R2 had been at therapy earlier in the day and had a new pair of shoes on (ones she had worn during the fall) and cannot wear the AFOs while she completed exercises. R2 forgot to change them after returning to her room. When AFOs were not worn placed R2 at increased risk for falling due to ankle weakness and gait instability from her diagnosis of foot drop. R2 took 4 steps, knew she was going to fall from her ankle not working, caused her to trip, and she went down slowly. R2 felt not wearing the AFO braces had been the cause of her fall. Therapy was updated and AFO braces were to be applied	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6 after therapy sessions to prevent reoccurrence. R2 verbalized understanding the importance of wearing the AFOs and agreed to have those placed back on after therapy sessions. R2's primary medical doctor (MD) follow-up rounds dated 9/1/23, identified continued to have issues with foot drop. R2 noted right foot drop had been somewhat worse since surgery. R2 had known left sided foot drop. Neurosurgery recommended AFO for right foot drop. R2's wellness center documentation dated 9/1/23, identified R2 entered facility to complete exercises at 12:50 p.m. R2's toileting record dated 9/1/23, identified R2 required extensive assistance at: 2:14 p.m., 4:05 p.m., 5:06 p.m., 8:37 p.m. R2's toileting record identified extensive assistance was given at 8:37 p.m. prior to fall at 9:10 p.m. R2's medical record did not identify whether the AFO's were applied during toileting. R2's eating record dated 9/1/23, identified R2 ate supper at 6:08 p.m. R2's Nurse practitioner (NP) visit progress notes dated 9/5/23, identified NP visited R2 in nursing home today and R2 reported pain to the left lateral side of her kneed moderate in severity, worsened by movement and palpitation. R2 had a history of left knee replacement. R2's x-ray showed a closed nondisplaced transverse fracture of left patella. Orthopedics were consulted and recommended weight bearing as tolerated in a t-scope hinged knee brace locked in extension times 6 weeks, off for hygiene only.	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 Repeat x-rays in 2 weeks. These are generally not surgical fractures. During an interview/observation on 9/13/23 at 11:30 a.m., R2 sat in her room in wheelchair, with brace on left thigh to her ankle. R2's AFO was not on her right lower leg/foot and noted to be located on the floor next to the bedside stand. R2 stated they will not allow me to be independent anymore and needed to have staff with when going to the bathroom to prevent falls. R2 stated on the day of her fall she had gone from her electric wheelchair to regular wheelchair with only 4 steps to take however had taken 3 steps and her right foot got stuck on the floor and rolled ankle over onto the side. R2 stated she had bilateral foot drop and wore AFOs on both lower legs but had advanced and understood she was allowed to move around in her room without the AFOs. R2 stated she had just returned from therapy, did not have the AFOs on, and should have asked staff for help. R2 indicted the AFOs supported her ankle and foot and prevented foot drop. R2 stated she was lifted off the floor with a total lift machine and x-ray confirmed a fracture of the left knee cap. During observation on 9/13/23 at 2:33 p.m., R2 sat in recliner with both feet elevated. R2's AFOs remained located on the floor next to the bedside stand. During an observation/interview on 9/14/23 at 8:05 a.m., R2 sat in her wheelchair and indicted she just got done with morning cares where staff assisted me. R2 confirmed she was unable to apply her own AFO's and did not use them during the transfer this morning adding, "they must have forgotten to apply them." R2 indicated after back surgery it was difficult to bend over and reach	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8 down which may it hard to pick up items off the floor, pointing to AFO's located on the floor next to her recliner. R2 stated since the fracture of her kneecap she had a brace on the left leg and only wore one AFO on the right foot. During an observation on 9/14/23 at 9:20 a.m., R2 sat in wheelchair in her room without AFO on right foot. Both AFO's remained on the floor next to the recliner while she ate breakfast. During a follow up interview on 9/15/23 at 11:56 a.m., R2 stated she had always been willing to try and wear the AFOs but required reminders and assistance with putting it on. R2 stated there was no way she was able to have placed the AFO on, her back would not have allowed her to. R2 stated she had eaten supper in her room that evening prior to the fall on 9/1/23. During an interview on 9/14/23 at 12:15 p.m., physical therapist (PT) stated R2 had bilateral foot drop and AFOs to stop the foot from exceeding into an excessive plantar flexion (the movement of the foot in a downward motion away from the body and a movement is crucial in many actions including the everyday action of walking) due to weak or inability to pull the foot/ankle into a dorsiflexion. PT stated R2 could potentially catch her toes on the floor or surface, dragging the toes, and essentially result in foot drop, and therefore potentially cause a fall. PT stated prior to R2's last fall she should have worn AFOs while up walking or transferring. PT verified R2 was evaluated and assessed within the last plan of care and was unable to place the AFOs on by herself. PT indicated nursing were responsible for the application of the AFOs. PT stated communication with nursing would be expected to	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9 be in the plan of care. PT also stated nursing staff would be expected to assist R2 with the application of the AFOS prior to transfers and ambulation. During an interview on 9/14/23 at 12:50 p.m., nursing assistant (NA)-A stated had taken R2 to bathroom this morning and twice again after that. NA-A indicted R2 was no longer independent with transfers since her last fall on 9/1/23. NA-A verified R2 was unable to stand on the right leg or move the wheelchair out of the way. NA-A stated R2's care plan sheet indicated she was independent with toileting and AFO right and left, but it had not been updated yet. NA-A stated R2 informed NA-A she only needed to wear AFO on the right foot when ambulating. NA-A indicted the shoes R2 had on did not work with the AFO and she was unable to apply the AFO by herself. NA-A verified she had transferred R2 three times today without the AFO on her right foot and should have applied AFO to help stabilize the ankle and prevent foot drop. NA-A stated R2 usually asked during the day to have the AFO placed on her foot bud did not today. NA-A stated she just figured R2 felt she probably did not need the AFO on. During an interview 9/14/23 at 2:40 p.m., registered nurse (RN)-A stated R2's AFO's were not on her lower legs during the falls on 8/14/23, or 9/1/23. RN-A verified the AFO's were not listed on the treatment documentation. RN-A also stated once the order was received for the AFO's the nurse should have entered AFO's under treatment section on point click care (PCC). RN-A indicated nursing was responsible and held accountable to assure the AFO's were on consistently and properly. RN-A stated R2 had	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10 been pretty much consistent and wore ted hose daily and daily weight checks and did not believe R2 refused to wear the AFO's. During an interview on 9/15/23 at 9:30 a.m., NP stated R2 had bilateral foot drop and had been followed by a neurologist. NP stated R2 had spinal stenosis and a fusion of the lower back April 2022. NP verified R2 received AFO's to be applied and worn when ambulating and during transfers. NP stated R2 had the right to refuse orders such as the AFOs however staff would be expected to document refusal. NP also stated R2 had osteoporotic (weakening of the bones) and agreed with neurosurgery R2 needed assistance that kept her toes up and helped the foot drop to avoid further falls R2 would benefit from wearing the AFOS. During an interview on 9/15/23 at 12:15 p.m., licensed practical nurse (LPN)-A stated R2 would head down to therapy and bring a different pair of tennis shoes and when R2 returned to her room she had the other pair of tennis shoes along with the AFOs laid in her lap. LPN-A stated R2 removed her own AFO's but was unable to reapply them. LPN-A verified R2 was cognitively intact and requested assistance when they needed to be applied. LPN-A was unsure whether the NA's placed the AFO's on R2 and had not check on that. LPN-A stated R2 had foot drop, AFO's helped prevent the foot drop, and R2 occasionally refused to wear AFOs but was not well documented. During an interview on 9/15/23 at 1:30 p.m., wellness center coordinator (WCC) stated R2 needed AFOs on when she transferred and ambulated but not at rest. WCC stated she	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11 removed R2's AFOS, was difficult for her to bend over. WCC stated on 9/1/23 prior to her fall there were times when she pushed herself down the hallway with her feet and arrived at the wellness center without her AFOs. WCC indicated R2's memory had not been the best at times and had forgot to bring her AFOS with her when she came down to the wellness center. WCC stated R2 made a lot of progress in therapy and needed to wear the AFOs to avoid losing the progress she had already made while she transferred or ambulated. During an interview on 9/15/23 at 3:08 p.m., RN-B stated R2 was cognitively intact and identified what happened on all 3 falls: 7/14/23, ankle rolled, R2 removed the AFO's prior to the fall and was a contributing factor. R2 was provided education to keep AFO's on when up, 8/19/23, fall tried to transfer from electric wheelchair to manual wheelchair without AFO's on, education provided to R2 should ambulate with AFO's on and instructed how to stand pivot without having to ambulate, 9/1/23 fall AFO's were not applied during a self-transfer from electric wheelchair to the manual wheelchair. RN-B stated R2 was unable to place the AFO's on her lower legs/feet, required assistance, and was able to request help. RN-B also stated staff were expected to anticipate and provide cues for R2's needs (food, toileting, bathing, application of devices/AFO's) even though she was cognitively intact. During an interview on 9/15/23 at 4:49 p.m., director of nursing (DON) stated R2 was cognitively intact and unable to apply the AFO's herself. DON stated she expected nursing staff to anticipate R2 needs which included application of	F 689		

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 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 the AFO's and check in with R2 in which assistance would be provided to apply the AFO's and transfers to the toilet. DON indicated R2 occasionally forgot to ask for assistance with the application of the AFO's. DON verified R2 had three falls without AFO's applied, AFO's helped with foot drop, was a contributing factor which placed R2 at increased right for falls. DON stated documentation of the application of the AFO's was not a typical process we have done however moving forward it has been added to the nursing tasks. Facility policy titled Falls-Resident dated 3/2022, identified all residents would be assessed for fall risk and interventions implemented as appropriate. A comprehensive assessment will be completed with every fall to determine the root cause and to develop individualized interventions. Resident's care plan interventions will be updated after each fall. Facility policy titled Care Plans dated 11/2021, identified a person-centered care plan in conjunction with the interdisciplinary team and resident will be developed that reflects the actual care, condition, and preferences of each resident, revised at least monthly, and changes will be also made as they occur to ensure the most current plan for the resident.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 9/13/23, through 9/15/23, 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed. H54615335C (MN00096740) H54615522C (MN00096685) with a licensing order issued at 0830. 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 Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure interventions were implemented to reduce the fall risk for 1 of 3 residents (R2) reviewed for accidents. This deficient practice caused actual harm when R2 fell and sustained a left fractured patella (knee cap). Findings include: R2's quarterly Minimum Data Set (MDS) dated	2 830	Corrected.	9/29/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 8/17/23, identified intact cognition with no behaviors, extensive assistance with bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. R2 was not on a toileting program, had frequent bladder incontinence and continent of bowel. R2 received anticoagulants and antidepressants 7 out of the 7 days during the look back period. R2 had three falls since admission, one without injury and two with minor injuries. R2's diagnoses dated 9/15/23, identified spinal stenosis (narrowing) lumbar region with neurogenic claudication (nerves get pinched within the center of the lumbar spine, causing intermittent leg pain), radiculopathy (injury or damage to nerve roots in the area where they leave the spine) lumbar region, low back pain, retention of urine, lumbago with sciatica left side (pain, usually on one side, felt in the lumbar spine, thighs and buttocks, and may radiate to the ankles or toes), polyarthritis (a term used when at least five joints are affected with arthritis), obesity, left foot drop, and need for assistance with personal care. R2's orders dated 9/13/23 identified: -WBAT (weight bearing as tolerated) only when brace is on. NWB (non-weight bearing) when brace is off every shift. Date order 9/5/23. -Left knee T-scooped hinged brace locked in extension. Remove brace only for hygiene cares every shift. Date order 9/5/23. -Make sure the instep strap is worn properly snug. Please make sure the lining of the shoe is not in the shoe when R1 was wearing her ankle foot orthosis (AFO) (hard brace worn on lower	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 4 leg/foot that provides gait stability, help compensate for muscle weakness, and improves overall walking safety). Start 1 to 2 hours today-adding 1 hour per day. If the little toe stays irritated, then may need to stretch her shoe overnight. Date order 10/24/22. R2's care plan last updated 9/14/23, identified R2 had the potential for falls related to L3 (lumbar spine level 3) pelvic fusion (procedure performed to encourage bones to grown together to provide more stability to the area) with interbody L4-S1 (area between the lumbar spine and the sacral spine in the lower back) and laminectomy (removal of spinal bone to relieve compression on the spinal cord). Staff were directed to provide assistance of one with toileting, AFO and donning of the AFO. R2 must have AFOs on for all transfers and ambulation (date initiated 5/20/22). Staff were to remind R2 to wear shoe with AFO's at all times when transferring/standing (date initiated 2/20/23 and removed on 9/14/23). Toileting: Independent with a FWW (front wheeled walker), assist PRN (as needed) (date initiated: 05/20/2022 and removed on 9/14/23). Ambulation: Independent in room with FWW, continue with supervision assist of one in hallways/walk to dine. Encourage to wear AFO braces (date Initiated: 05/20/2022 and removed independent ambulation on 9/14/23). Staff were also directed to anticipate and meet R2's needs. R2's care plan nursing assistant (NA) care sheet dated 9/14/23, identified independent with a FWW (front wheeled walker), transfers assist of 1, right and left AFO. R2's fall assessment dated 6/1/23, identified R2 required use of assistive devices scored 5 on assessment. R2 was at risk for falls.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 5 R2's fall assessment dated 8/11/23, identified R2 had 1 to 2 falls in the past 3 months, required use of assistive devices, and scored 7 on assessment. R2 was at risk for falls. R2's progress notes identified: -7/14/23 at 9:00 p.m. NA checked on R2 to assist with evening cares and found R2 on her knees on floor in her room at bedside and attempted to get back up. R2 had shoes on and no AFOs were on her feet. R2 stated she had picked out clothes in the closet and walked back, left ankle rolled, lost balance, and fell. R2 was asked why the AFOS were not on, and indicated they hurt, and she removed them. Action plan/intervention: education provided to always assure AFO brace to both legs when up ambulating to support ankles, notified therapy to see if adjustments could be made to AFOs. Practitioner notified. -7/15/23 at 11:01 am. fall update: reviewed R2's fall and root cause of fall was resident was not wearing AFO braces to legs, removed them because they hurt her feet. R2 was independent with transfers and ambulation with front wheeled walker in her room. Immediate intervention placed to educate resident on the need to keep AFO braces on when she transferred or ambulated in her room. R2 agreed with intervention and notified therapy AFO braces hurt her feet to see if adjustments could have been made. -8/19/23 at 4:45 p.m. TMA (trained medication aide) heard a noise in R2's room, entered and found her lying on right side on the floor at the foot of her bed. R2's legs were extended outward towards the door, walker tipped over directly in	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 front of her. R2 had tried to transfer out of her electric wheelchair and into her manual wheelchair located directly in front of her. R2 stood up to walk and her shoe caught on the title of the floor, caused her to trip, lost balance, hit right elbow against the foot of bed, and thought she had also hit her head. R2's right elbow had a light purple bruise and a bit of swelling and one hour later a very small raised light purple discoloration area noted on the right anterior parietal lobe (top back of head). Action Plan/Intervention: R2's care plan was followed as written. Root cause of fall seemed to be the tennis shoes R2 had been wearing the time of the fall. R2 indicated she would no longer wear those tennis shoes. Practitioner notified. -8/21/23 at 4:14 p.m. fall update: fall from 8/19/23 was discussed with nurse leadership. Care plan was followed at time of fall. Root cause of fall R2's foot did not raise when ambulating from electric wheelchair to manual wheelchair. R2 interviewed and indicated she had on her purple shoes when she went to therapy and they were not the issue, declined those shoes to be removed from room and stated currently seen by therapy for that. R2 indicated sometimes when she walked her foot did not pick up like it should, when AFOs were worn did not have issues when she walked. Education was provided to resident to not ambulate without her AFOS on and perform stand turn and sit transfers and avoid ambulating or completely turned around to get into the chairs. R2 voiced understanding. -9/1/23 at 9:21 p.m. R2 found on floor parallel to her bed and faced her manual wheelchair located at the head of bed. R2 ambulated from electric scooter to her manual wheelchair, while ambulating tennis shoes got stuck on the floor,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 R2 lost control of her balance, and came down onto floor with both knees. R2 complained of pain in her leg (left or right was not identified) post fall both knees were noted to be bruised. Practitioner notified. -9/2/23 at 5:12 p.m., Fall update: fall from 9/1/23 reviewed along with care plan interventions. R2 currently independent with transfers and ambulation in room. R2 had AFO braces due to foot drop and was encouraged to wear during transfers and ambulation. R2 had been at therapy earlier in the day and had a new pair of shoes on (ones she had worn during the fall) and cannot wear the AFOs while she completed exercises. R2 forgot to change them after returning to her room. When AFOs were not worn placed R2 at increased risk for falling due to ankle weakness and gait instability from her diagnosis of foot drop. R2 took 4 steps, knew she was going to fall from her ankle not working, caused her to trip, and she went down slowly. R2 felt not wearing the AFO braces had been the cause of her fall. Therapy was updated and AFO braces were to be applied after therapy sessions to prevent reoccurrence. R2 verbalized understanding the importance of wearing the AFOs and agreed to have those placed back on after therapy sessions. R2's primary medical doctor (MD) follow-up rounds dated 9/1/23, identified continued to have issues with foot drop. R2 noted right foot drop had been somewhat worse since surgery. R2 had known left sided foot drop. Neurosurgery recommended AFO for right foot drop. R2's wellness center documentation dated 9/1/23, identified R2 entered facility to complete exercises at 12:50 p.m.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 R2's toileting record dated 9/1/23, identified R2 required extensive assistance at: 2:14 p.m., 4:05 p.m., 5:06 p.m., 8:37 p.m. R2's toileting record identified extensive assistance was given at 8:37 p.m. prior to fall at 9:10 p.m. R2's medical record did not identify whether the AFO's were applied during toileting. R2's eating record dated 9/1/23, identified R2 ate supper at 6:08 p.m. R2's Nurse practitioner (NP) visit progress notes dated 9/5/23, identified NP visited R2 in nursing home today and R2 reported pain to the left lateral side of her kneed moderate in severity, worsened by movement and palpitation. R2 had a history of left knee replacement. R2's x-ray showed a closed nondisplaced transverse fracture of left patella. Orthopedics were consulted and recommended weight bearing as tolerated in a t-scope hinged knee brace locked in extension times 6 weeks, off for hygiene only. Repeat x-rays in 2 weeks. These are generally not surgical fractures. During an interview/observation on 9/13/23 at 11:30 a.m., R2 sat in her room in wheelchair, with brace on left thigh to her ankle. R2's AFO was not on her right lower leg/foot and noted to be located on the floor next to the bedside stand. R2 stated they will not allow me to be independent anymore and needed to have staff with when going to the bathroom to prevent falls. R2 stated on the day of her fall she had gone from her electric wheelchair to regular wheelchair with only 4 steps to take however had taken 3 steps and her right foot got stuck on the floor and rolled ankle over onto the side. R2 stated she had bilateral foot drop and wore AFOs on both lower legs but had advanced	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 and understood she was allowed to move around in her room without the AFOs. R2 stated she had just returned from therapy, did not have the AFOs on, and should have asked staff for help. R2 indicted the AFOs supported her ankle and foot and prevented foot drop. R2 stated she was lifted off the floor with a total lift machine and x-ray confirmed a fracture of the left knee cap. During observation on 9/13/23 at 2:33 p.m., R2 sat in recliner with both feet elevated. R2's AFOs remained located on the floor next to the bedside stand. During an observation/interview on 9/14/23 at 8:05 a.m., R2 sat in her wheelchair and indicted she just got done with morning cares where staff assisted me. R2 confirmed she was unable to apply her own AFO's and did not use them during the transfer this morning adding, "they must have forgotten to apply them." R2 indicated after back surgery it was difficult to bend over and reach down which may it hard to pick up items off the floor, pointing to AFO's located on the floor next to her recliner. R2 stated since the fracture of her kneecap she had a brace on the left leg and only wore one AFO on the right foot. During an observation on 9/14/23 at 9:20 a.m., R2 sat in wheelchair in her room without AFO on right foot. Both AFO's remained on the floor next to the recliner while she ate breakfast. During a follow up interview on 9/15/23 at 11:56 a.m., R2 stated she had always been willing to try and wear the AFOs but required reminders and assistance with putting it on. R2 stated there was no way she was able to have placed the AFO on, her back would not have allowed her to. R2 stated she had eaten supper in her room that	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 evening prior to the fall on 9/1/23. During an interview on 9/14/23 at 12:15 p.m., physical therapist (PT) stated R2 had bilateral foot drop and AFOs to stop the foot from exceeding into an excessive plantar flexion (the movement of the foot in a downward motion away from the body and a movement is crucial in many actions including the everyday action of walking) due to weak or inability to pull the foot/ankle into a dorsiflexion. PT stated R2 could potentially catch her toes on the floor or surface, dragging the toes, and essentially result in foot drop, and therefore potentially cause a fall. PT stated prior to R2's last fall she should have worn AFOs while up walking or transferring. PT verified R2 was evaluated and assessed within the last plan of care and was unable to place the AFOs on by herself. PT indicated nursing were responsible for the application of the AFOs. PT stated communication with nursing would be expected to be in the plan of care. PT also stated nursing staff would be expected to assist R2 with the application of the AFOS prior to transfers and ambulation. During an interview on 9/14/23 at 12:50 p.m., nursing assistant (NA)-A stated had taken R2 to bathroom this morning and twice again after that. NA-A indicted R2 was no longer independent with transfers since her last fall on 9/1/23. NA-A verified R2 was unable to stand on the right leg or move the wheelchair out of the way. NA-A stated R2's care plan sheet indicated she was independent with toileting and AFO right and left, but it had not been updated yet. NA-A stated R2 informed NA-A she only needed to wear AFO on the right foot when ambulating. NA-A indicted the shoes R2 had on did not work with the AFO and she was unable to apply the AFO by herself.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 NA-A verified she had transferred R2 three times today without the AFO on her right foot and should have applied AFO to help stabilize the ankle and prevent foot drop. NA-A stated R2 usually asked during the day to have the AFO placed on her foot bud did not today. NA-A stated she just figured R2 felt she probably did not need the AFO on. During an interview 9/14/23 at 2:40 p.m., registered nurse (RN)-A stated R2's AFO's were not on her lower legs during the falls on 8/14/23, or 9/1/23. RN-A verified the AFO's were not listed on the treatment documentation. RN-A also stated once the order was received for the AFO's the nurse should have entered AFO's under treatment section on point click care (PCC). RN-A indicated nursing was responsible and held accountable to assure the AFO's were on consistently and properly. RN-A stated R2 had been pretty much consistent and wore ted hose daily and daily weight checks and did not believe R2 refused to wear the AFO's. During an interview on 9/15/23 at 9:30 a.m., NP stated R2 had bilateral foot drop and had been followed by a neurologist. NP stated R2 had spinal stenosis and a fusion of the lower back April 2022. NP verified R2 received AFO's to be applied and worn when ambulating and during transfers. NP stated R2 had the right to refuse orders such as the AFOs however staff would be expected to document refusal. NP also stated R2 had osteoporotic (weakening of the bones) and agreed with neurosurgery R2 needed assistance that kept her toes up and helped the foot drop to avoid further falls R2 would benefit from wearing the AFOS. During an interview on 9/15/23 at 12:15 p.m.,	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 licensed practical nurse (LPN)-A stated R2 would head down to therapy and bring a different pair of tennis shoes and when R2 returned to her room she had the other pair of tennis shoes along with the AFOs laid in her lap. LPN-A stated R2 removed her own AFO's but was unable to reapply them. LPN-A verified R2 was cognitively intact and requested assistance when they needed to be applied. LPN-A was unsure whether the NA's placed the AFO's on R2 and had not check on that. LPN-A stated R2 had foot drop, AFO's helped prevent the foot drop, and R2 occasionally refused to wear AFOs but was not well documented. During an interview on 9/15/23 at 1:30 p.m., wellness center coordinator (WCC) stated R2 needed AFOs on when she transferred and ambulated but not at rest. WCC stated she removed R2's AFOS, was difficult for her to bend over. WCC stated on 9/1/23 prior to her fall there were times when she pushed herself down the hallway with her feet and arrived at the wellness center without her AFOs. WCC indicated R2's memory had not been the best at times and had forgot to bring her AFOS with her when she came down to the wellness center. WCC stated R2 made a lot of progress in therapy and needed to wear the AFOs to avoid losing the progress she had already made while she transferred or ambulated. During an interview on 9/15/23 at 3:08 p.m., RN-B stated R2 was cognitively intact and identified what happened on all 3 falls: 7/14/23, ankle rolled, R2 removed the AFO's prior to the fall and was a contributing factor. R2 was provided education to keep AFO's on when up, 8/19/23, fall tried to transfer from electric wheelchair to manual wheelchair without AFO's	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 on, education provided to R2 should ambulate with AFO's on and instructed how to stand pivot without having to ambulate, 9/1/23 fall AFO's were not applied during a self-transfer from electric wheelchair to the manual wheelchair. RN-B stated R2 was unable to place the AFO's on her lower legs/feet, required assistance, and was able to request help. RN-B also stated staff were expected to anticipate and provide cues for R2's needs (food, toileting, bathing, application of devices/AFO's) even though she was cognitively intact. During an interview on 9/15/23 at 4:49 p.m., director of nursing (DON) stated R2 was cognitively intact and unable to apply the AFO's herself. DON stated she expected nursing staff to anticipate R2 needs which included application of the AFO's and check in with R2 in which assistance would be provided to apply the AFO's and transfers to the toilet. DON indicated R2 occasionally forgot to ask for assistance with the application of the AFO's. DON verified R2 had three falls without AFO's applied, AFO's helped with foot drop, was a contributing factor which placed R2 at increased right for falls. DON stated documentation of the application of the AFO's was not a typical process we have done however moving forward it has been added to the nursing tasks. Facility policy titled Falls-Resident dated 3/2022, identified all residents would be assessed for fall risk and interventions implemented as appropriate. A comprehensive assessment will be completed with every fall to determine the root cause and to develop individualized interventions. Resident's care plan interventions will be updated after each fall.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 09/15/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 Facility policy titled Care Plans dated 11/2021, identified a person-centered care plan in conjunction with the interdisciplinary team and resident will be developed that reflects the actual care, condition, and preferences of each resident, revised at least monthly, and changes will be also made as they occur to ensure the most current plan for the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		