DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 3, 2023

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

RE: CCN: 245461
Cycle Start Date: December 1, 2022

Dear Administrator:

On February 1, 2023, the Minnesota Department(s) 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 3, 2023

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

Re: Reinspection Results
Event ID: XDB812

Dear Administrator:

On February 1, 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 December 1, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 20, 2022

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

RE: CCN: 245461
Cycle Start Date: December 1, 2022

Dear Administrator:

On December 1, 2022, 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:

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, 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 March 1, 2023 (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 June 1, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 20, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: XDB811

Dear Administrator:

The above facility was surveyed on November 30, 2022 through December 1, 2022 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@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 12/01/2022

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 11/30/22, to 12/1/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to NOT IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H54616148C (MN00088694) with a deficiencies at F580, F684, and F689. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		1/16/23

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

Electronically Signed | 12/27/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the resident's designated representative was not notified in change of condition for 1 of 1 resident (R1) reviewed for accidents who during an unwitnessed fall sustained a left hip fracture. Findings include:	F 580	1. The facility is unable to correct the fact that FM-A was not notified of the fall and need for x-ray until 9/29/2022 when the incident occurred on 9/26/2022. 2. Any responsible party of a resident who has fallen has the potential to be affected. The facility has identified all residents who	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 580	Continued From page 2 R1's Admission Minimum Data Set dated 9/5/22, identified R1's cognition was moderately impaired. R1 required total assistance of two staff to transfer. R1 required extensive assistance of one to two for bed mobility, and dressing. R1 was frequently incontinent of bladder and always incontinent of bowel. R1 had no previous falls. R1's diagnoses included history of Alzheimer's, dementia, and psychotic disorder. R1's medical record revealed family member (FM)-A as family emergency contact number one and guardian. R1's progress notes revealed: -On 9/2/22, at 12:40 p.m. social services (SS) met with FM-A and completed admission paperwork. FM-A indicated she was R1's guardian and the only one who would make decisions for R1. -On 9/26/22, at 6:19 p.m. heard R1 yelling, entered room and found R1 lying on the floor on her back located between the bed and bathroom doorway, legs bent with feet flat on the floor. R1 was unable to tell staff what she needed or why she was out of bed and was incontinent of bowel and bladder. Facility staff used a total lift machine to transfer resident from floor back to bed. Practitioner and FM-B notified. Documentation did not identify R1's designated resident representative FM-A was notified. -On 9/29/22, at 7:55 a.m. R1 moved left leg with guarded movement. Physical therapy updated and certified nurse practitioner (CNP) notified.	F 580	have fallen in the past 3 months and ensured that the resident's responsible party was notified. 3. The facility's falls policy and HIPAA Privacy Rule policy have been reviewed and are appropriate. Education has been provided to LPN-B regarding notification of the appropriate responsible party: those listed as "Emergency Contact #1" or "legal guardian." Education on the same information will be provided to all nursing and social services staff on 1/4/22. 4. The DON or designee will audit all falls for one month, 10 falls/month for 3 months, and 5 falls/month for 3 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 580	Continued From page 3 -On 9/29/22, at 1:08 p.m. CNP ordered x-ray of the left hip due to pain. Responsible party FM-A and FM-B updated. -On 9/29/22, 3:25 p.m. CNP ordered transport to orthopedic clinic via non-emergent ambulance. R1's responsible party FM-A notified. During an interview on 11/30/22, at 1:23 p.m. FM-B stated R1 had a fall about two months ago and staff had found her lying on the floor in her room. FM-B also stated one of the nurses called him instead of FM-A and not sure why. During a telephone interview on 11/30/22, at 2:38 p.m. FM-A stated when R1 was admitted to the facility, met with the social worker, made it very clear she was to be listed as the number one family contact, and FM-B should not be the first contact. FM-A also indicated FM-B asked her to be R1's guardian and then she was appointed by a judge. FM-A also stated FM-B did not inform her about the fall with the fracture and he had asked staff to call her. FM-A indicated she was not contacted regarding the fall until days afterwards and then informed an x-ray of her left hip was needed. FM-A stated she would have requested an x-ray right after fall happened. During an interview on 11/30/22, at 3:30 p.m. licensed practical nurse (LPN)-B verified R1 had fallen in her room and FM-B was notified. LPN-B stated the facility protocol/policy was to contact the person listed as the number one contact in the medical record then update the provider and manager. During an interview on 12/1/22, at 10:30 am LPN-A stated on 9/26/22, worked as charge	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 580	Continued From page 4	F 580		

nurse. LPN-A indicated staff called her to R1's room and found her on the floor incontinent of bowel and bladder. LPN-A verified vital signs were taken, neuro check and range of motion (ROM) were completed. LPN-A indicated staff moved R1 from floor to bed with a mechanical lift. LPN-A also stated she notified R1's primary provider, director, and who she thought was the number one family contact, FM-B, listed in R1's medical record. LPN-A verified she did not contact the number one family contact, FM-A.

During an interview on 12/1/22, at 1:20 p.m. LPN-C stated staff were expected to notify the number one emergency contact when R1 fell and fractured her left hip. LPN-C also stated FM-B had been notified in error, not sure why it happened, and would be important to only contact the number one emergency contact for HIPAA (Health Insurance Portability and Accountability Act- a federal law to protect sensitive patient health information from being disclosed without patient's consent or knowledge). LPN-C verified FM-A had been listed on the electronic medical record as the number one emergency contact and an admission representative document should have been signed but was unaware of where it was located.

During an interview on 12/1/22, at 2:05 p.m. director of nursing (DON) verified R1 had fallen September 2022, found on the floor in her room, and sustained a fracture to her hip. DON indicated the staff nurse contacted FM-B but should have contacted the number one FM-A listed in her medical record instead. DON stated FM-A had been listed as the one that made the decisions on R1's care and should have been called first. DON also stated FM-A should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 580	Continued From page 5 been updated prior to 9/29/22, when she was notified three days after the incident about an x-ray needed of R1's hip. DON indicated they were unaware FM-A did not want FM-B contacted about those emergencies, as it upsets him. Review of facility policy titled HIPAA Privacy Rule Policy dated 11/2016, revealed all employees are required to comply with this policy. A person has authority to act on behalf of a resident in making decisions related to healthcare and such person will be treated as a personal representative unset the rule with respect to protected health information (PHI) relevant to such personal representation. Facility policy titled Falls revised last 3/2022, identified any injury that required an update to provider and the responsible party must be notified immediately.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate positioning for 1 of 1 resident (R1) who had a left hip surgical repair and was experiencing pain	F 684	1. We were unable to identify NA-C, NA-D, and NA-F, but education has been provided for all staff who worked with R1 on 11/30 on reading and following the	1/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 684	Continued From page 6 when turned in bed and transferred with mechanical lift. Findings include: R1's Admission Minimum Data Set dated 9/5/22, identified R1's cognition was moderately impaired. R1 required total assistance of two staff to transfer, extensive assistance of one to two for bed mobility, and dressing. R1 was frequently incontinent of bladder and always incontinent of bowel. R1 had no previous falls. R1's diagnoses included history of Alzheimer's, dementia, and psychotic disorder. R1's care plan updated 10/19/22, indicated R1 was at risk for falls and the potential for discomfort related to left femur fracture. The care plan directed staff to transfer R1 with assist of two with medium Hoyer sling and support left leg with transfers. The care plan directed staff to make sure not to cross legs and place a pillow between knees when turning. R1's current nursing assistant (NA) care sheet identified staff were to provide support to left leg with transfers, a pillow to be placed between R1's knees when turning, and make sure legs do not cross. During an observation on 11/30/22, at 11:45 a.m. NA-D and NA-C entered R1's room with a Hoyer lift. NA-C raised entire bed and removed covers from R1. NA-D pulled down the brief from the front and NA-C completed peri cares from front to back. NA-D rolled R1 onto her left side without a pillow between her legs. R1's right leg rested on top of left leg and R1 moaned out loud and clean	F 684	care plan for R1. Care plan competency checks have been completed for all 2nd floor CNAs working on 11/30/22. 2. All residents with recent hip fractures have the potential to be affected. The facility has reviewed all falls with hip fractures in the past 3 months and ensured that appropriate interventions have been care planned and implemented. 3. Education has been provided to all nursing staff on following the resident's individualized care plan and that all complaints of pain need to be reported to the nurse. Education will be provided on 1/4/23. 4. The DON or designee will audit cares to observe pain control measures and compliance with care plans. The DON or designee will audit 15 care observations for one month, 10 observations/month for 3 months, and 5 observations/month for 3 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 684	Continued From page 7 brief was placed after cleaning rectal area. NA-C rolled R1 onto her right side and left leg rested on top of the right leg and clean brief pulled through. R1 was then placed onto her back. NA-D rolled R1 onto her left side and R1 yelled out "no no no don't hurt me" and moaned out loud. R1's right leg rested on top of the left leg. R1 was then rolled onto her back and lift sheet was attached to the Hoyer lift. NA-C lifted R1 off the mattress with the mechanical lift and NA-D took a hold of R1's legs/feet together and lifted them off the bed then let go and allowed them to hang down. NA-C lowered R1 into her wheel chair and released the loops to the lift sheet. NA-C covered her up with a blanket, positioned call light, and exited the room. During an interview on 11/30/22, at 1:43 p.m. NA-D stated R1 was total assistance for all cares and meals. NA-D indicated R1 had a fall and fractured her hip and since she returned to the facility from hip surgery she is to be turned and repositioned every hour. NA-D also stated repositioning is to off load weight due to the hip surgery, prevent pain, and skin breakdown. NA-D added,"I am not aware of any other interventions we are to do since her fall." NA-D verified they do not place a pillow between legs when turning her, and the lift sheet usually helps support the legs so no need to support the legs during transfers. During an observation on 12/1/22, at 8:51 a.m. NA-C entered R1's room with towels and washcloths. NA-C brought basin of water over to R1's bedside to provide cares. At 9:00 a.m. NA-F entered R1's room, applied gloves and stood next to bed by the wall. NA-C pulled R1's brief down in front. NA-F placed her hands on R1's left hip and left side and rolled her towards the wall without a pillow between her legs. R1's left leg was bent	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 684	Continued From page 8 slightly and rested on top of the right leg. R1 moaned out loud and said "ouch". NA-C placed a clean brief underneath R1 after providing peri care. NA-C and NA-F together rolled R1 onto her back and then onto her left side and R1 yelled out "oh such pain such pain, don't, such pain" and started to cry. R1 laid on her left side with her right leg resting on top of the left leg without a pillow in between them. R1 was then placed onto her back and quit crying. NA-C placed a pillow behind her back on the left side and another pillow placed underneath her knees horizontally. NA-C lowered bed, NC-F covered resident up with a blanket and both exited the room. During an observation on 12/1/22, at 12:05 p.m. NA-C entered R1's room and then NA-F entered the room and pushed the Hoyer lift over to R1's bed. NA-F uncovered R1 and pulled resident onto her right side without a pillow between her legs. R1 yelled out "don't do that to me it hurts." R1's left leg rested on top of the right leg and R1 moaned out loud during the turn while NA-C placed the lift sheet underneath her. NA-F rolled R1 onto her back then onto her left side without a pillow between her knees. R1 moaned out loud and her right leg rested on top of the left leg so that her knees touched. NA-C rolled R1 onto her back and hooked up the loops to the mechanical lift. NA-C lifted R1 off the bed with the Hoyer and as her left leg came off the mattress and hung down unsupported by the bottom edge of the lift sheet. NA-C then lowered R1 down into wheelchair, unhooked loops from lift, and both NAs exited the room. During an interview on 12/1/22, at 1:20 p.m. licensed practical nurse (LPN)-C stated R1 has dementia and confusion, history of falls, and	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 684	Continued From page 9 fractured left hip. LPN-C also stated placing a pillow between legs during turns /repositioning and avoiding the crossing of the legs would be important for someone that just had hip surgery but not sure that would still need to be done, but most likely continued to help with pain control in that left hip. LPN-C indicated staff are expected to support R1's legs/feet during transfers to help reduce left hip pain. During an interview on 12/1/22, at 2:05 p.m. director of nursing (DON) stated R1 had a fall and fractured her hip. DON stated R1's interventions regarding the pillow between legs, avoid crossing of the legs, and support the left leg with transfers were added to the plan of care by LPN-A. DON verified LPN-A felt it was necessary to add the interventions after R1's hip surgery for pain control and comfort. DON indicated she expected staff to follow the care plan and implement interventions for each resident. During an interview on 12/1/22, at 2:15 p.m. NA-F stated R1 fell not too long ago and they are expected to reposition her every hour with assist of two staff. NA-F indicated a pillow should be placed between R1's legs when repositioned and turned but sometimes the pillow is not placed because she is in pain. NA-F verified R1's legs were supported when moved in the Hoyer lift to help prevent bumping her feet on things. NA-F indicated she was not aware she was to prevent R1's legs from crossing.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		1/16/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 §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: Based on observation, interview and document, the facility failed to ensure interventions were implemented to reduce the risk of falls for 1 of 3 residents (R2) who were investigated for falls. Findings include: R2's annual Minimum Data Set (MDS) dated 9/19/22, identified R2 had severely impaired cognition and diagnoses of non traumatic brain dysfunction, dementia, arthritis, and macular degeneration (eye disorder causing vision loss). R2 required extensive assistance of one with bed mobility, walking in room, transfers, dressing, toileting, and personal hygiene. Further, R2's MDS identified unsteady balance from surface to surface and only able to stabilize with human assistance and history of one fall. R2's Fall Risk Assessment dated 9/13/22, identified high risk for falls, poor recall judgement and safety awareness, and required assistive devices during ambulation. R2's care plan revised 11/5/22, identified R2 was at risk for falls due to gait disturbance and hallucinations. R2's interventions included assistance of one and walker for ambulation, keep wheelchair next to dresser when in bed, and keep walker at bedside when in bed.	F 689	1. After reviewing fall interventions for R2, it was determined that the wheelchair is appropriate to be at bedside. NA-C and NA-D could not be identified, but education has been provided to all staff working on R2's unit on 11/30 for following R2's care plan, specifically with regard to fall interventions. Education has been provided to NA-B on Eventide's policy of utilizing a gait belt with all assisted transfers. Care observations during which NA-B used a gait belt were completed on 12/1 and 12/9. 2. All residents who require assistance with transfers have the potential to be affected as well as all residents who are at risk for falls. 3. Education has been provided to all nursing staff regarding following resident's individualized care plans and appropriate gait belt use. Education will be provided on 1/4/23. 4. The DON or designee will audit fall interventions according to care plan. The DON or designee will audit 15 care observations for one month, 10 observations/month for 3 months, 5 observations/month for 3 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 R2's current nursing assistant (NA) care sheet identified transferred with assist of one and walker to toilet every two hours and as needed (PRN), keep walker at bedside when in bed and wheelchair next to dresser when not in it. During an observation on 11/30/22, at 11:19 a.m. R2 laid in bed on her back with wheelchair and walker placed across the room along the wall by the dresser, unreachable by resident. During a continuous observation on 11/30/22: -At 1:06 p.m. NA-D pushed resident into her room via wheelchair. NA-D transferred R2 from wheel chair to bed with gait belt, assisted her to lay down on her back. NA-D completed a check and change, covered up R2 with warm blanket, lowered bed, and placed call light. NA-D placed the wheelchair with locked brakes next to the side of the bed, walker placed next to dresser across room, washed hands, and exited the room -At 2:00 p.m., 2:30 p.m., and 3:00 p.m. R2 laid in on her back in same position. R2's wheelchair with brakes on was positioned next to R2's bed and walker located across room by dresser. During an observation on 12/1/22, at 9:13 a.m. NA-B pushed R2 in wheelchair from dining room to her room. NA-B asked R2 if she had to use the bathroom and R2 stated yes. NA-B pushed R2 into the bathroom, applied gloves, removed foot peddles from wheelchair, and placed resident next to toilet. NA-B did not apply a gait belt and instructed R2 to grab hold of bar on bathroom wall and stand up. NA-B grabbed a hold of R2's pants around her waist area and pulled her up to a standing position while R2 held onto bar on the wall. R2 started to lean backwards, bent her knees, and sat back down onto wheelchair. NA-B	F 689	implemented. The results of the audits will be reported to the QA committee for further review and recommendation. Upon this review, system revisions and/or staff education will be implemented if indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 12/01/2022

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 cued R2 to stand up again and hold onto bar on wall. R2 grabbed bar on wall, stood up again while NA-B pulled R2's pants upward from the waistline. R2 started to lean back again and was about to sit down onto wheelchair until NA-B pulled up on her pants again from the waste line. NA-B was unable to move her feet. R2 stood straight up, NA-B let go of R2's pants, placed a hand on each of R2's hips and pushed her hips around so that she was positioned in front of the toilet. NA-B quickly pulled down R2's pants and incontinence product, and then R2 plopped herself onto the toilet seat. After R2 voided in the toilet NA-B cued R2 to stand up and hold onto bar on bathroom wall. R2 grabbed the bar on the wall and pulled herself up without any assistance. NA-B quickly provided peri care when R2 started to lean backwards to sit down onto toilet seat. NA-B pulled up R2's pants and took hold of the waistband to stabilize her. NA-B let go of R2's pants, placed his hands on each side of her hips, and pushed her hips around so that she was positioned in front of the wheelchair. R2 plopped herself down into the wheelchair. NA-B removed gloves, washed hands, and then pushed R2 in wheelchair over to her bed. NA-B locked wheelchair, took hold of R2's waist band, pulled up as R2 placed her hands on wheel chair armrests, and stood up. NA-B pulled on R2's pants to position her in front of bed, and then let go as R2 plopped herself down on to the bed. NA-B assisted R2 to laying position, raised head of bed, covered her up, and placed call light. NA-B then placed wheeled walker next to her bed with brakes locked only on left side and wheelchair placed on the side of the bed towards the end with locked brakes. A gait belt was not used during this observation.	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 12/01/2022

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 13 During an interview on 11/30/22, at 1:43 p.m. NA-D stated R2 needs total assistance of one for all cares. NA-D stated R2 does not go on toilet as it scared her, refused it, and pushed back. NA-D indicated R2 had a fall after a meal when she tried to get herself back to bed. NA-D verified R2 was impulsive, needed be checked on frequently, and wheelchair must be placed next to her bed with brakes on in case she self-transferred herself. NA-D indicated if the wheelchair was not placed next to the bed while she's laying in bed she will fall when she tried to get to it. During an interview on 11/30/22, at 2:07 p.m. NA-C stated R2 was total assist of one for all cares. NA-C indicated R2 has a history of falls and prior to that her walker was placed by the bed and she tried to take herself to the toilet and fell. NA-C verified they made sure her wheelchair was placed next to her bed to try and prevent falls now. During an observation on 12/1/22, at 9:33 a.m. LPN-D entered R2's room and administered her medication. LPN-D exited room and left privacy curtain pulled so that R2 was not visible from doorway, and wheelchair and walker located next to bedside. During an observation on 12/1/22, at 12:13 p.m. NA-B entered R2's room woke her up and attempted to assist resident to bathroom. NA-B reached behind NA-B's shoulder and assisted her to side of the bed. R2 stated "no no" and laid back down. NA-B exited the room and at 12:15 p.m. NA-C entered R2's room and verified R2 was incontinent of urine and needed to be changed. The privacy curtain remained pulled across the room. R2 started hitting NA-C while	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 12/01/2022

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 14 pulling her pants down while she laid in bed. NA-C reassured R2 and she calmed down. NA-C completed a check and change, assisted R2 to sitting position and R2 laid back down. NA-C stated ok then, covered up R2, lowered the entire bed, placed call light, and exited the room. R2's privacy curtain remained pulled across room so R2 was not visible from doorway, wheelchair remained next to bed with brakes on, and walker located against privacy curtain not within reach without brakes on. During an interview on 12/1/22, at 12:15 p.m. NA-B stated R2 was assist of one with all cares and transfers. NA-B also stated R2 had a history of falls and staff needed to do what they can to help prevent those falls. NA-B verified he did not know R2 very well, was unaware she used the walker much, and did not usually use the walker when transferred in bathroom or to the bed. NA-B indicated R2 should have had a gait belt on for all transfers to help prevent falls. NA-B stated not sure if R2 can ambulate and not the best at pivoting either. NA-B verified he checked the wheelchair for a gait belt and did not see one so decided to use R2's belt loops on her pants to guide and steady her and usually it went well. NA-B also stated he had seen pant loops rip and it was not the safest way to transfer her but also used his body to help her pivot and his strength to lower her down. NA-B indicated R2's legs tend to rock back and forth and a gait belt should have been used to be safe and prevent falls from happening. During an interview on 12/1/22, at 1:20 p.m. floor charge nurse LPN-C stated R2 was high risk for falls and had a history of falls. LPN-C indicated staff are expected to use a gait belt on a resident	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 12/01/2022

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 15 when ever they transferred them from one place to another. LPN-C stated R2 had a decline in cognition, more stiff all over, and does not initiate much walking anymore. LPN-C verified the use of a gait belt would help prevent falls and prevent injury to the resident such as ribs, shoulders, and for general safety. LPN-C indicated R2's wheelchair should not be left by her bedside because she tried to get to it and fell quite a while ago. R2's walker should be left by the bedside while in bed so that if she happened to get up by her own there would be something to grab onto. LPN-C also stated staff are expected to provide walker to R2 to use during all transfers from bed to wheelchair and back again. During an interview on 12/1/22, at 2:05 p.m. director of nursing (DON) stated R2 required assistance of one with cares and transfers. DON also stated staff are expected to keep R2's walker within reach when in bed in case she tried to get up and needed something to assist her and possibly prevent falls. DON indicated R2's wheelchair should be placed out of reach because of her history of self-transfers and would be best if catch her prior to getting up by herself. DON verified staff were expected to use a gait belt on a resident any time they are transferred from one place to another. DON stated the use of the gait belt was needed to help prevent pulling on arms and if a resident began to fall the staff could hang onto it. Facility policy titled Falls revised last 3/2022, identified all residents will be assessed for fall risk and individual interventions will be developed and implemented as appropriate Facility policy titled Care Plans revised 11/2021,	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 12/01/2022

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 16 revealed standards to help guide staff in order to provide quality, safe care to the residents included the use of a gait belt for all assisted transfers and ambulation. The gait belt was considered a part of the uniform for nurses and nursing assistants and should be in their possession at times.	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 12/01/2022

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 11/30/22, to 12/1/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT IN compliance with the MN State Licensure. The following complaint was found to be	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 12/01/2022

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 SUBSTANTIATED: H54616148C (MN00088694) with licensing orders issued at 0265 and 0830 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;	2 265		1/16/23

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 12/01/2022

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
2 265	Continued From page 2 C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the resident's designated representative was not notified in change of condition for 1 of 1 resident (R1) reviewed for accidents who during an unwitnessed fall sustained a left hip fracture. Findings include: R1's Admission Minimum Data Set dated 9/5/22, identified R1's cognition was moderately impaired. R1 required total assistance of two staff to transfer. R1 required extensive assistance of one to two for bed mobility, and dressing. R1 was frequently incontinent of bladder and always incontinent of bowel. R1 had no previous falls. R1's diagnoses included history of Alzheimer's, dementia, and psychotic disorder. R1's medical record revealed family member (FM)-A as family emergency contact number one and guardian. R1's progress notes revealed: -On 9/2/22, at 12:40 p.m. social services (SS) met with FM-A and completed admission	2 265	Corrected	

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 12/01/2022

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
2 265	Continued From page 3 paperwork. FM-A indicated she was R1's guardian and the only one who would make decisions for R1. -On 9/26/22, at 6:19 p.m. heard R1 yelling, entered room and found R1 lying on the floor on her back located between the bed and bathroom doorway, legs bent with feet flat on the floor. R1 was unable to tell staff what she needed or why she was out of bed and was incontinent of bowel and bladder. Facility staff used a total lift machine to transfer resident from floor back to bed. Practitioner and FM-B notified. Documentation did not identify R1's designated resident representative FM-A was notified. -On 9/29/22, at 7:55 a.m. R1 moved left leg with guarded movement. Physical therapy updated and certified nurse practitioner (CNP) notified. -On 9/29/22, at 1:08 p.m. CNP ordered x-ray of the left hip due to pain. Responsible party FM-A and FM-B updated. -On 9/29/22, 3:25 p.m. CNP ordered transport to orthopedic clinic via non-emergent ambulance. R1's responsible party FM-A notified. During an interview on 11/30/22, at 1:23 p.m. FM-B stated R1 had a fall about two months ago and staff had found her lying on the floor in her room. FM-B also stated one of the nurses called him instead of FM-A and not sure why. During a telephone interview on 11/30/22, at 2:38 p.m. FM-A stated when R1 was admitted to the facility, met with the social worker, made it very clear she was to be listed as the number one family contact, and FM-B should not be the first contact. FM-A also indicated FM-B asked her to	2 265		

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 12/01/2022

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
2 265	Continued From page 4 be R1's guardian and then she was appointed by a judge. FM-A also stated FM-B did not inform her about the fall with the fracture and he had asked staff to call her. FM-A indicated she was not contacted regarding the fall until days afterwards and then informed an x-ray of her left hip was needed. FM-A stated she would have requested an x-ray right after fall happened. During an interview on 11/30/22, at 3:30 p.m. licensed practical nurse (LPN)-B verified R1 had fallen in her room and FM-B was notified. LPN-B stated the facility protocol/policy was to contact the person listed as the number one contact in the medical record then update the provider and manager. During an interview on 12/1/22, at 10:30 am LPN-A stated on 9/26/22, worked as charge nurse. LPN-A indicated staff called her to R1's room and found her on the floor incontinent of bowel and bladder. LPN-A verified vital signs were taken, neuro check and range of motion (ROM) were completed. LPN-A indicated staff moved R1 from floor to bed with a mechanical lift. LPN-A also stated she notified R1's primary provider, director, and who she thought was the number one family contact, FM-B, listed in R1's medical record. LPN-A verified she did not contact the number one family contact, FM-A. During an interview on 12/1/22, at 1:20 p.m. LPN-C stated staff were expected to notify the number one emergency contact when R1 fell and fractured her left hip. LPN-C also stated FM-B had been notified in error, not sure why it happened, and would be important to only contact the number one emergency contact for HIPAA (Health Insurance Portability and Accountability Act- a federal law to protect sensitive patient	2 265		

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 12/01/2022

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
2 265	Continued From page 5 health information from being disclosed without patient's consent or knowledge). LPN-C verified FM-A had been listed on the electronic medical record as the number one emergency contact and an admission representative document should have been signed but was unaware of where it was located. During an interview on 12/1/22, at 2:05 p.m. director of nursing (DON) verified R1 had fallen September 2022, found on the floor in her room, and sustained a fracture to her hip. DON indicated the staff nurse contacted FM-B but should have contacted the number one FM-A listed in her medical record instead. DON stated FM-A had been listed as the one that made the decisions on R1's care and should have been called first. DON also stated FM-A should have been updated prior to 9/29/22, when she was notified three days after the incident about an x-ray needed of R1's hip. DON indicated they were unaware FM-A did not want FM-B contacted about those emergencies, as it upsets him. Review of facility policy titled HIPAA Privacy Rule Policy dated 11/2016, revealed all employees are required to comply with this policy. A person has authority to act on behalf of a resident in making decisions related to healthcare and such person will be treated as a personal representative unset the rule with respect to protected health information (PHI) relevant to such personal representation. Facility policy titled Falls revised last 3/2022, identified any injury that required an update to provider and the responsible party must be notified immediately. SUGGESTED METHOD OF CORRECTION:	2 265		

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 12/01/2022

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
2 265	Continued From page 6 The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 265		
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, the facility failed to ensure interventions were implemented to reduce the risk of falls for 1 of 3 residents (R2) who were investigated for falls. Findings include:	2 830	Corrected	1/16/23

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 12/01/2022

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's annual Minimum Data Set (MDS) dated 9/19/22, identified R2 had severely impaired cognition and diagnoses of non traumatic brain dysfunction, dementia, arthritis, and macular degeneration (eye disorder causing vision loss). R2 required extensive assistance of one with bed mobility, walking in room, transfers, dressing, toileting, and personal hygiene. Further, R2's MDS identified unsteady balance from surface to surface and only able to stabilize with human assistance and history of one fall. R2's Fall Risk Assessment dated 9/13/22, identified high risk for falls, poor recall judgement and safety awareness, and required assistive devices during ambulation. R2's care plan revised 11/5/22, identified R2 was at risk for falls due to gait disturbance and hallucinations. R2's interventions included assistance of one and walker for ambulation, keep wheelchair next to dresser when in bed, and keep walker at bedside when in bed. R2's current nursing assistant (NA) care sheet identified transferred with assist of one and walker to toilet every two hours and as needed (PRN), keep walker at bedside when in bed and wheelchair next to dresser when not in it. During an observation on 11/30/22, at 11:19 a.m. R2 laid in bed on her back with wheelchair and walker placed across the room along the wall by the dresser, unreachable by resident. During a continuous observation on 11/30/22: -At 1:06 p.m. NA-D pushed resident into her room via wheelchair. NA-D transferred R2 from wheel chair to bed with gait belt, assisted her to lay	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 12/01/2022

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 down on her back. NA-D completed a check and change, covered up R2 with warm blanket, lowered bed, and placed call light. NA-D placed the wheelchair with locked brakes next to the side of the bed, walker placed next to dresser across room, washed hands, and exited the room -At 2:00 p.m., 2:30 p.m., and 3:00 p.m. R2 laid in on her back in same position. R2's wheelchair with brakes on was positioned next to R2's bed and walker located across room by dresser. During an observation on 12/1/22, at 9:13 a.m. NA-B pushed R2 in wheelchair from dining room to her room. NA-B asked R2 if she had to use the bathroom and R2 stated yes. NA-B pushed R2 into the bathroom, applied gloves, removed foot peddles from wheelchair, and placed resident next to toilet. NA-B did not apply a gait belt and instructed R2 to grab hold of bar on bathroom wall and stand up. NA-B grabbed a hold of R2's pants around her waist area and pulled her up to a standing position while R2 held onto bar on the wall. R2 started to lean backwards, bent her knees, and sat back down onto wheelchair. NA-B cued R2 to stand up again and hold onto bar on wall. R2 grabbed bar on wall, stood up again while NA-B pulled R2's pants upward from the waistline. R2 started to lean back again and was about to sit down onto wheelchair until NA-B pulled up on her pants again from the waste line. NA-B was unable to move her feet. R2 stood straight up, NA-B let go of R2's pants, placed a hand on each of R2's hips and pushed her hips around so that she was positioned in front of the toilet. NA-B quickly pulled down R2's pants and incontinence product, and then R2 plopped herself onto the toilet seat. After R2 voided in the toilet NA-B cued R2 to stand up and hold onto bar on bathroom wall. R2 grabbed the bar on the wall and pulled herself up without any assistance.	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 12/01/2022

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 NA-B quickly provided peri care when R2 started to lean backwards to sit down onto toilet seat. NA-B pulled up R2's pants and took hold of the waistband to stabilize her. NA-B let go of R2's pants, placed his hands on each side of her hips, and pushed her hips around so that she was positioned in front of the wheelchair. R2 plopped herself down into the wheelchair. NA-B removed gloves, washed hands, and then pushed R2 in wheelchair over to her bed. NA-B locked wheelchair, took hold of R2's waist band, pulled up as R2 placed her hands on wheel chair armrests, and stood up. NA-B pulled on R2's pants to position her in front of bed, and then let go as R2 plopped herself down on to the bed. NA-B assisted R2 to laying position, raised head of bed, covered her up, and placed call light. NA-B then placed wheeled walker next to her bed with brakes locked only on left side and wheelchair placed on the side of the bed towards the end with locked brakes. A gait belt was not used during this observation. During an interview on 11/30/22, at 1:43 p.m. NA-D stated R2 needs total assistance of one for all cares. NA-D stated R2 does not go on toilet as it scared her, refused it, and pushed back. NA-D indicated R2 had a fall after a meal when she tried to get herself back to bed. NA-D verified R2 was impulsive, needed be checked on frequently, and wheelchair must be placed next to her bed with brakes on in case she self-transferred herself. NA-D indicated if the wheelchair was not placed next to the bed while she's laying in bed she will fall when she tried to get to it. During an interview on 11/30/22, at 2:07 p.m. NA-C stated R2 was total assist of one for all cares. NA-C indicated R2 has a history of falls and prior to that her walker was placed by the bed	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 12/01/2022

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 and she tried to take herself to the toilet and fell. NA-C verified they made sure her wheelchair was placed next to her bed to try and prevent falls now. During an observation on 12/1/22, at 9:33 a.m. LPN-D entered R2's room and administered her medication. LPN-D exited room and left privacy curtain pulled so that R2 was not visible from doorway, and wheelchair and walker located next to bedside. During an observation on 12/1/22, at 12:13 p.m. NA-B entered R2's room woke her up and attempted to assist resident to bathroom. NA-B reached behind NA-B's shoulder and assisted her to side of the bed. R2 stated "no no" and laid back down. NA-B exited the room and at 12:15 p.m. NA-C entered R2's room and verified R2 was incontinent of urine and needed to be changed. The privacy curtain remained pulled across the room. R2 started hitting NA-C while pulling her pants down while she laid in bed. NA-C reassured R2 and she calmed down. NA-C completed a check and change, assisted R2 to sitting position and R2 laid back down. NA-C stated ok then, covered up R2, lowered the entire bed, placed call light, and exited the room. R2's privacy curtain remained pulled across room so R2 was not visible from doorway, wheelchair remained next to bed with brakes on, and walker located against privacy curtain not within reach without brakes on. During an interview on 12/1/22, at 12:15 p.m. NA-B stated R2 was assist of one with all cares and transfers. NA-B also stated R2 had a history of falls and staff needed to do what they can to help prevent those falls. NA-B verified he did not know R2 very well, was unaware she used the	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 12/01/2022

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 walker much, and did not usually use the walker when transferred in bathroom or to the bed. NA-B indicated R2 should have had a gait belt on for all transfers to help prevent falls. NA-B stated not sure if R2 can ambulate and not the best at pivoting either. NA-B verified he checked the wheelchair for a gait belt and did not see one so decided to use R2's belt loops on her pants to guide and steady her and usually it went well. NA-B also stated he had seen pant loops rip and it was not the safest way to transfer her but also used his body to help her pivot and his strength to lower her down. NA-B indicated R2's legs tend to rock back and forth and a gait belt should have been used to be safe and prevent falls from happening. During an interview on 12/1/22, at 1:20 p.m. floor charge nurse LPN-C stated R2 was high risk for falls and had a history of falls. LPN-C indicated staff are expected to use a gait belt on a resident when ever they transferred them from one place to another. LPN-C stated R2 had a decline in cognition, more stiff all over, and does not initiate much walking anymore. LPN-C verified the use of a gait belt would help prevent falls and prevent injury to the resident such as ribs, shoulders, and for general safety. LPN-C indicated R2's wheelchair should not be left by her bedside because she tried to get to it and fell quite a while ago. R2's walker should be left by the bedside while in bed so that if she happened to get up by her own there would be something to grab onto. LPN-C also stated staff are expected to provide walker to R2 to use during all transfers from bed to wheelchair and back again. During an interview on 12/1/22, at 2:05 p.m. director of nursing (DON) stated R2 required assistance of one with cares and transfers. DON	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 12/01/2022

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 also stated staff are expected to keep R2's walker within reach when in bed in case she tried to get up and needed something to assist her and possibly prevent falls. DON indicated R2's wheelchair should be placed out of reach because of her history of self-transfers and would be best if catch her prior to getting up by herself. DON verified staff were expected to use a gait belt on a resident any time they are transferred from one place to another. DON stated the use of the gait belt was needed to help prevent pulling on arms and if a resident began to fall the staff could hang onto it. Facility policy titled Falls revised last 3/2022, identified all residents will be assessed for fall risk and individual interventions will be developed and implemented as appropriate Facility policy titled Care Plans revised 11/2021, revealed standards to help guide staff in order to provide quality, safe care to the residents included the use of a gait belt for all assisted transfers and ambulation. The gait belt was considered a part of the uniform for nurses and nursing assistants and should be in their possession at times. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days	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 12/01/2022

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