



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 20, 2026

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

RE: CCN: 245461

Cycle Start Date: June 24, 2026

Dear Administrator:

On July 2, 2026, we notified you a remedy was imposed. On July 16, 2026, the Minnesota Departments 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 July 10, 2026.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 17, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 2, 2026, 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 July 17, 2026, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 10, 2026, 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 Therefore, the NATCEP prohibition is rescinded.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 Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Sarah Lane'.

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

July 20, 2026

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

Re: Reinspection Results
Event ID: 2366FB-H2

Dear Administrator:

On July 15, 2026 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 June 24, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2026

Administrator
Eventide Lutheran Home
1405 7TH STREET SOUTH
MOORHEAD, MN 56560

RE: CCN: 245461

Cycle Start Date: June 24, 2026

Dear Administrator:

On June 24, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant 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 location for imposition. The CMS location 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 July 17, 2026

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 17, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

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 \$13,343; 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 July 17, 2026, 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 July 17, 2026. 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)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

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

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 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 location and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 24, 2026, 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:

tamika.brown@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 Tamika Brown at (312) 353-1502.

Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Sarah Lane".

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

An equal opportunity employer.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2026

Administrator
Eventide Lutheran Home
1405 7TH STREET SOUTH
MOORHEAD, MN 56560

Re: State Nursing Home Licensing Orders

Event ID: 2366FB-H1

Dear Administrator:

The above facility survey was completed on June 24, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted 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:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us
Office: 218-332-5159

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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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	
F0000	INITIAL COMMENTS On 6/23/26 to 6/24/26, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. 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. H54612928C Incident 3043555 with a licensing order issued at F689 and F609.The following complaints were reviewed. H54618000C Incident 2796449 with a licensing order 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.		F0000			07/10/2026	
F0689 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: Based on observation, interview, and document review, the facility failed to provide care consistent		F0689	F689 (G): Free of Accidents Hazards/Supervision/Devices How corrective action will be accomplished for the resident(s) impacted: R1's plan of care was updated to include the need for an escort to all appointments. Education was provided to nursing staff regarding R1 needing an escort to appointments. How facility will identify other residents who have potential to be affected: All residents in the facility who have severe		07/10/2026	

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 1 with a resident's needs and care plan to eliminate/reduce the risk of an accident in bed for 1 of 1 residents (R1). This resulted in actual harm to R1 when she rolled out of bed onto the floor. R1's fall mat was not alongside the bed and her call light was not within reach. As a result, R1 was transported to the emergency department (ED) on 6/12/26, for a laceration to the forehead and a fracture to her right clavicle. The facility had implemented actions to prevent recurrence prior to the survey on 6/23/26, therefore, the citation was issued at past non-compliance. Additionally, the facility failed to provide adequate supervision and secure transportation for R2 who has severe cognitive impairment. Findings include: R1 R1's annual minimum data set (MDS) dated 4/27/26, identified R1 was cognitively intact. R1 was dependent on staff for toileting, bed mobility, and transferring. R1 had anxiety, pain and a history of falls with fractures. R1's care plan revised 6/13/26, identified R1 had a potential for falls related to decreased mobility, a history of falls, and weakness. R1 was alert and orientated to person, place and time. R1's care planned interventions included low bed with fall mat to the floor when R1 was in bed and soft touch call light at the hip to promote use. R1's fall risk predictive factors assessment dated 4/21/26, indicated R1 had poor recall, judgment, and safety awareness. It further indicated R1 had poor vision status and a history of three or more falls in the past three months. R1s care sheet undated, indicated R1 was a fall risk and was to have low bed and floor mat along with soft touch call light to right hip. R1's physical therapy treatment encounter dated 6/15/26, indicated R1 fell and was receiving skilled services to her right shoulder per providers orders. R1's incident report dated 6/12/26 at 4:45p.m., identified the nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck and her			F0689	Continued from page 1 cognitive impairments and go out to appointments have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: All residents who have severe cognitive impairment and go out for appointments will be audited to ensure their care plans accurately reflect their supervision needs and that escort requirements are clearly defined. Resident's escort status will be verified against their medical record before they leave the building for an appointment. All direct care staff and secretaries will be educated on 7/9/2026 on their responsibility to ensure escorts are provided for cognitively impaired residents as needed and transportation is secured for appointments. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The DON or designee will audit all offsite appointments for cognitively impaired residents to verify compliance with escort protocols and transportation coordination for one month, then ten audits for 3 months. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 2 stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. I was determined based on the scene that R1 had raised her bed in a high position and attempted to self-transfer. R1s call light was in the chair next to the bed. R1 has a history of falls. R1 used her bed controller to put the bed up approximately four feet. NA-A confirmed she had the bed in low position but did not have the fall mat next to the bed. R1 was assessed for injuries. R1 was transferred into her bed with a hoyer sling lift. Medical provider notified of all and head injury. Medical provider ordered R1 to be sent to the ED for evaluation and treatment. R1s spouse was notified of the injury. On 6/12/26, electromagnetic waves (X-ray) revealed R1 had an acute comminuted fracture of the lateral right clavicle, and it appeared somewhat impacted. On 6/12/26, computed tomography (CT) revealed R1 had a right lateral scalp hematoma. Provider Communication Forms revealed the following: -6/12/26, found on floor laying on right side, blood near head coming from laceration back of right ear. Was assisted back to bed, cleaned up. Called on-call medical provider, ordered to be sent in for evaluation and treatment. Returned from ED Friday evening. Has right clavicle fracture with sling. Staples to head laceration. Referral to orthopedics. Signed by primary provider 6/15/26. -6/15/26, immobilizer to right upper extremity (RUE) with Velcro at wrist ordered due to right clavicle fracture. Signed by primary provider 6/15/26. -6/15/26, discontinue physical therapy (PT) and speech therapy (ST). Signed by primary provider 6/15/26. -6/15/26, remove scalp staple on 6/20/26. Signed by provider 6/17/26. -6/16/26, R1 refused 2:00 p.m., dose of Tramadol (medication used for pain), then requested it at 4:00 p.m. Give one time only dose of Tramadol 50mg by mouth for pain. Wait four hours until next does. Signed by provider 6/16/26. Sanford Internal Medicine Nursing Home APP visit dated 6/15/26, medical provider indicated the visit was related to a hospital discharge. R1 had a right			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 3 clavicle fracture. R1 was to wear an immobilizer to right upper extremity with Velcro at the wrist for six weeks. R1 will need to follow-up with orthopedics and plan to have a follow-up x-ray in two weeks. R1 had one suture placed and orders were given to remove the scalp staple on 6/20/26, eight days after placement. Progress notes dated 6/1/26 to 6/23/26 revealed the following: -6/3/26 at 10:25 a.m., R1 had her light on and requested help from staff. Staff helped R1 and left room. -6/11/26 at 2:15 p.m., R1 had her light on R1 requested to use the bathroom. R1 didn't need any additional assistance. -6/12/26 at 6:21 p.m., time of fall 4:39 p.m. nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. R1 was drowsy when first checked, R1 awakened when assessed, R1 had a head laceration somewhere behind her right ear on the scalp which she was bleeding from. R1 assisted into bed with hoyer sling lift and two person assist. Care plan updated to keep bed controls turned off by removing the remote. R1 was unable to control the bed functions safely. Medical doctor notified at 4:50 p.m. Spouse notified at 5:15 p.m. -6/12/26 at 6:38 p.m., R1 was transferred to Sanford ED via emergency medical transport (EMT) due to fall and head injury. On-call provider notified and ordered transfer for evaluation and treatment at Sanford ED. Supervisor and husband notified of R1's fall. -6/12/26 at 11:16 p.m., R1 returned from the hospital around 9:30 p.m. Closed displaced fracture of acromial end of right clavicle. Laceration of scalp. R1 has a sling on right hand. CT of head without contrast was done. CT spine cervical without contrast. R1 has been sleeping throughout the night. No complaints of shortness of breath (SOB), no complaints at this time.			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 4 -6/14/26 at 4:47 p.m., writer completed a bed remote assessment with R1. Nursing delegated to client to complete raising and lowering head of bed, food of bed, and height of bed. Nursing delegated to client to complete putting bed at an appropriate height for transfer. Client was not able to complete any of these tasks safely. Will continue to keep bed remote out of reach of R1. -6/15/26 at 1:37 p.m., writer spoke with R1s spouse and daughter about intervention, and they consented to removing the bed remote for R1s safety. -6/15/26 at 3:46 p.m., elbow, wrist, hand range of motion three times a day. No weight bearing to right arm. Use right arm sling/immobilizer when up. Ok to remove for sleep and comfort. During an observation on 6/23/26 at10:50 a.m., R1 was laying in the bed watching television. R1's bed was in low position and fall mat was on the floor next to the bed. R1's call light was hooked to the railing of the bed. R1s legs were hanging off the edge of the bed. R1 had sling on right shoulder. R1 was unable to answer questions during an interview due to difficulties speaking. During an observation on 6/23/26 at 4:03 p.m., R1 was resting in the bed. R1 had removed the sling from right shoulder. R1s bed was in a low position and fall mat was on the floor. Call light was within reach. During an interview on 6/23/26 at 3:32 p.m., nursing assistance (NA)-A indicated NA-A had completed rounds and was helping another resident. NA-A heard over the walkie that R1 had fallen out of bed and was lying on the floor. NA-A indicated R1 had an open wound and there was blood on the floor. NA-A stated R1 had a history of using the remote to bring the bed up. NA-A further stated when NA-A entered the room R1's bed was in a very high position. NA-A confirmed NA-A had forgotten to place the fall mat next to R1's bed and R1's call light was in the chair. NA-A indicated NA-A received training on care plans and continued to work with co-workers completing walk through checklists of each resident's rooms to ensure safety. NA-A further indicated an all staff meeting was going to take place next month. During an interview on 6/23/26 at 3:40 p.m., medical provider (MP) indicated MP was aware of			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 5 R1's fall and that R1 was treated in the ED. MP stated R1 sustained a fracture to R1's right clavicle and a laceration to R1's head. MP further stated MP had seen R1 for a follow up on 6/15/26. MP indicated R1 was to wear a sling and would be seen by orthopedics for a follow-up. MP stated she would expect staff to be following the care plan to prevent any accidents and keep residents safe. On 6/23/26 at 3:45 p.m., call made to registered nurse (RN)-A no answer and a voicemail was left. During an interview on 6/23/26 at 4:10 p.m., licensed practical nurse (LPN)-A stated LPN-A was aware of R1's fall. LPN-A indicated LPN-A received education on care plans, falls, and working with NA's to ensure the safety checklists were being followed. LPN-A further indicated the safety checklists were used to ensure all care planned interventions were being followed for each resident. During an interview on 6/23/26 at 4:59 p.m., director of nursing (DON) stated she was aware of R1s fall and that R1 sustained injuries from the fall. DON confirmed R1's fall mat was not along side R1's bed and R1 did not have R1's call light within reach. DON indicated education was done with all staff working on the second floor immediately and shortly thereafter education was provided to all nursing staff. DON further indicated when NA-A returned for NA-A's next shift, NA-A worked with coworkers to complete safety checks on all residents on the second floor. DON stated when R1 returned staff removed R1's bed controller as an intervention for fall safety. DON stated her expectations were for staff to follow all care planned interventions to ensure resident safety. DON further stated care planned interventions were in place to protect the residents from harm. R2 R2's quarterly MDS dated 4/9/26, identified R2 was severely cognitively impaired. R2 was dependent on staff for toileting, bed mobility, and transferring. R1 had Alzheimer's disease and dementia. R2's care plan revised 3/27/26, potential for safety concerns due to risk for elopement. R2s goal indicated R2 will not leave the facility unattended. Interventions in place were to check wander guard placement every shift and to identify triggers as R2 has a history of wandering the halls and using the			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 6 elevator. R2's elopement risk assessment dated 6/20/26, indicated R2 was cognitively impaired with poor decision making skills and uses a wander guard. Progress notes dated 3/4/26, revealed R2 saw medical doctor at Essentia Dermatology, had cryotherapy completed to top of scalp and left ear. However, progress notes lacked documentation of the time R2 left the facility, when R2 returned to the facility and if R2 had an escort to R2's appointment. Review of a facility calendar dated 3/4/26, identified R2 had a scheduled ride to Essentia Health Dermatology by First-In Line Mobility with a pickup at 1:30 p.m., on 3/4/26 and a will-call return for transportation back to the facility once the appointment was completed. R2's electronic medical record (EMR) lacked documentation of paperwork sent with R2 for R2's dermatology appointment on 3/4/26. During an observation on 6/23/26 at 2:23 p.m., R2 was sitting in R2's wheelchair in the hallway next to the elevator. R2 had a blanket over R2's chest and R2 was moving back and forth. R2 had a wander guard on R2's right ankle. R2 was unable to answer any questions during the interview. During an observation on 6/23/26 at 4:07 p.m., R2 was sitting in the hallway near the nurses' station drinking a cup of coffee. R2 was moving around in R2's wheelchair. R2 had wander guard on right ankle. During an interview on 6/23/26 at 1:17 p.m., trained medical aid (TMA)-A indicated the NA's got resident's ready for appointments and would bring them to the nurses' station for pick-up. TMA-A stated the secretary was responsible for getting the resident's paperwork ready to take to appointments. TMA-A indicated that the transportation driver would come to the floor to pick the resident up. TMA-A stated if family was going to take the resident to an appointment, staff would bring the resident down to the front door. TMA-A was unsure if R2 required an escort to appointments or if any paperwork was sent to R2's dermatology appointment on 3/4/26. During an interview on 6/23/26 at 1:23 p.m., NA-B stated staff would take the resident up front to where their ride would pick them up. NA-B indicated they let the nurse and secretary know when the			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 7 residents are ready for their appointments. NA-B indicated if the resident needed an escort the secretary would make sure they would have the escort before leaving the floor. NA-B stated there usually is an envelope at the desk that would go with the resident when they leave. NA-B was unsure if R2 required an escort to appointments or if any paperwork was sent to R2's dermatology appointment on 3/4/26. During an interview on 6/23/26 at 1:28 p.m., RN-B stated that staff “just know” if a resident required an escort for appointments. RN-B further stated at times, “they will let us know” if an escort was needed. RN-B indicated some residents who have wander guards can just go to appointments on their own. RN-B stated she was unaware if R2 required an escort for appointments or if an envelope was sent with R2 to his dermatology appointment of 3/4/26. RN-B further stated she was unaware of how R2 returned to the facility after his appt on 3/4/26. During an interview on 6/23/26 at 1:30pm LPN-B indicated the secretary was responsible for setting up appointments. LPN-B further indicated rides are provided to residents based on their insurance. LPN-B stated envelopes are provided to the driver, resident or family with information about the resident and was returned to the facility when the resident arrived back. This paperwork was also used for the provider at the appointment to provide any updated orders. LPN-B further stated each envelope had a sticker at the top that provided a number for the provider to call when the appointment was finished for a return ride back to the facility. LPN-B indicated if a resident was not safe to go to the appointment alone family will be contacted for assistance or and escort would be provided. LPN-B stated determination was made on residents’ safety if the resident required an escort. LPN-B further stated there really wasn’t a process on the determination, “they just know what residents are not safe to be out by themselves”. LPN-B looked in R2’s EMR and verified R2 had an appointment on 3/4/25 at 2:00 p.m. LPN-B indicated she was unaware R2 was brought back to the facility by the police department. LPN-B was unaware of what time R2 returned to the facility and did not know how long R2 had been gone. LPN-B confirmed LPN-B put a note in regarding R2’s appointment but did not know how R2 arrived back at the facility from the appointment. LPN-B indicated R2’s daughters would often attend R2’s appointments but LPN-B			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 8 could not confirm if R2's daughters were at the appointment on 3/4/26. LPN LPN-B confirmed R2 had a son but indicated LPN-B just met him for the first time a couple days ago. LPN-B was unsure if an envelope was sent with R2 to his dermatology appointment on 3/4/26. During an interview on 3/4/26 at 1:45 p.m., secretary stated R2 now has an escort for all appointments. Secretary indicated secretary was not in the current position when R2's appointment for 3/4/26 was scheduled. Secretary was unable to confirm if R2 had an escort for the appointment on 3/4/26. Secretary was unable to confirm when and how R2 returned to the facility or if an envelope for the receiving facility was sent with to R2's appointment at the dermatology clinic on 3/4/26. On 6/23/26 at 1:50 p.m., a call to R2's daughter was made and no answer. On 6/23/26 at 1:58 p.m. a call the Fargo Police Department (FPD) was made FPD indicated police reports could be found online by going to www.fargopolice.com. On 6/23/26 at 2:44 p.m., contacted the FPD through online database. 709 requested for police report. On 6/23/26 at 2:48 p.m., call to Nursing Supervisor Essentia Health and left a voicemail. During a phone interview on 6/23/26 at 2:49 p.m. first in line transportation supervisor (FILTS) confirmed R2 was picked up at 1:30 p.m., on 3/4/26. FILTS could not confirm if R2 had an escort or received a return ride to the facility from R2's appointment. FILTS stated envelopes are given to the receiving facility and the receiving facility calls the number when the residents appointment is finished. FILTS could not verify if R2 had an envelope for R2's appointment on 3/4/26. On 6/23/26 at 4:36 p.m., call to Essentia Health Dermatology, no answer. During an interview on 6/23/26 at 4:59 DON indicated DON did not feel there was anyway R2 could have been transported back to the facility by the police department. DON stated R2 was a hoyer			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 9 lift and would have required the use of a lift to transfer R2. DON stated R2 used transportation to get to R2's appointments and family would generally meet R2 at the appointment. DON indicated family was supposed to meet R2 for his appointment on 3/4/26. DON stated R2's daughter was going to relay the appointment with R2's other daughter but had gotten the dates confused. DON confirmed R2 attended R2's appointment alone. DON stated that the resident returned to the facility as there was a note placed in R2's chart. DON could not confirm how or when R2 arrived back to the facility after R2's appointment. DON indicated the facility used an elopement assessment and that would be considered the safety assessment to ensure residents are or are not safe in the community alone. DON stated residents are never alone. DON further stated the transportation service picks the residents up and brings them to appointment. DON could not confirm if First In Line transportation service stayed with R2 for R2's appointment. DON stated the facility sends paperwork with each resident and that is to be handed off during the appointment and returned to the facility after the appointment. DON could not confirm if R2 had paperwork sent with R2 for R2's appointment on 3/4/26. On 6/24/26 at 7:35 a.m., email received from FPD stating no police report containing R2's name was found for 3/4/26. During a phone interview on 6/24/26 at 8:02 a.m., Nursing supervisor Essentia Health (NSEH) stated nursing staff found R2 sitting alone in the lobby and brought R2 back to R2's appointment on 3/4/26. NSEH indicated FILT did not stay with R2 during his appointment. NSEH stated R2 did not have any documentation or paperwork with R2 from the facility providing any direction for nursing staff. Nursing staff were not aware R2 lived in a nursing home and had cognitive impairments. NSEH stated R2 told staff R2's son was going to pick R2 up after the appointment. NSEH indicated nursing staff assumed this was correct as R2 as R2 did not have any other information with R2. NSEH stated once the appointment was finished, staff brought R2 down to the pickup area for R2 to wait for his ride. HSEH stated nursing staff were not aware they needed to call FILT for a ride back to the facility for R2. HSEH further stated staff continued to check on R2 for approximately two hours in the pick-up area. NSEH indicated during this time, nursing staff attempted to contact R2's daughter but never received a call back. HSEH stated the last time nursing staff went to check on R2, R2 was no longer sitting in the pick-up area so nursing staff assumed R2's son			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 10 picked R2 up. HSEH indicated on the morning of 3/5/26 the department received a telephone message from 3/4/26 from Eventide. HSEH stated the message was requesting information about R2's appointment. HSEH further stated nursing staff called Eventide back and spoke with LPN-B. HSEH indicated LPN-B stated R2 had been seen at the clinic on 3/4/26. HSEH stated nursing staff told LPN-B that R2 did not come with any paperwork so NSEH were unaware res lived in a nursing home or that R2 did not have a return ride to the facility, LPN-B indicated there was a mix up with R2's daughters who were usually with R2 for appointments. HSEH stated nursing staff told LPN-B that R2 was picked up by R2's son and LPN-B indicated R2 did not have a son. HSEH further stated LPN-B told nursing staff that R2 had been brought back to the facility by the police department. HSEH indicated LPN-B apologized for the mix up and nursing staff faxed paperwork from the appointment to Eventide. The past noncompliance that began on 6/12/26. The deficient practice was corrected by 6/19/26, after the facility implemented a systemic plan. Verification of corrective action was confirmed and interviewed with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Facility was able to demonstrate monitoring of the corrective action and sustained compliance. Facility Policy titled Care Plans dated 2/10/26, to develop a person-centered care plan in conjunction with the interdisciplinary team and resident/resident representative that reflects the actual care, condition and preferences of each resident. Any changes made to the comprehensive care plan will also be updated in the NAR/CNA care plan. Facility policy titled Falls – Resident dated 2/13/26, all resident will be assessed for fall risk and individualized interventions will be implemented as appropriate to minimized the all risk and reduce injury. Facility policy titled wander guard dated 2/17/26, a wander guard is used to minimize potential resident			F0689			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0689 SS = G	Continued from page 11 elopement.			F0689			07/10/2026
F0609 SS = D	Facility policy titled resident medical appointments dated 2/17/26, to arrange a safe transport and escort procedure for those residents whose families are unavailable to transport and/or accompany them to appointments and to provide the provider with appropriate information. Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to report an incident of neglect of care with serious bodily injury was reported within 2 hours of the State Agency (SA) for 1 of 1 residents (R1) who fell out of bed and sustained a fractured clavicle along with a laceration when staff were not following the care plan. Findings include:			F0609	F609 (D): Reporting of Alleged Violations How corrective action will be accomplished for the resident(s) impacted: The nursing staff caring for R1 at the time the fracture was identified received immediate education regarding reporting requirements for alleged violations. The manager on call received immediate education regarding reporting requirements for alleged violations. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. A retrospective audit was completed on the last 30 days of all incident reports to ensure no other allegations were missed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Nursing staff were educated regarding timing requirements for reporting alleged violations. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The DON or designee will review all clinical notes and incident reports weekly to identify potential reportable events and verify that reporting timeframes were met.		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0609 SS = D	Continued from page 12 R1's annual minimum data set (MDS) dated 4/27/26, identified R1 was cognitively intact. and was dependent on staff for toileting, bed mobility, and transferring. R1 had anxiety, pain and a history of falls with fractures. R1's care plan revised 6/13/26, identified R1 had a potential for falls related to decreased mobility, a history of falls, and weakness. R1 was alert and orientated to person, place and time. R1's care planned interventions included low bed with fall mat to the floor when R1 was in bed and soft touch call light at the hip to promote use. R1's fall risk predictive factors assessment dated 4/21/26, indicated R1 had poor recall, judgment, and safety awareness. It further indicated that R1 had poor vision status and a history of three or more falls in the past three months. R1s care sheet undated, indicated R1 was a fall risk and was to have low bed and floor mat along with soft touch call light to right hip. R1's incident report dated 6/12/26 at 4:45p.m., identified the nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. I was determined based on the scene where R1 had raised her bed in a high position and attempted to self-transfer. R1s call light was in the chair next to the bed. R1 has a history of falls. R1 used her bed controller to put the bed up approximately four feet. NA-A confirmed she had the bed in low position but did not have the fall mat next to the bed. R1 was assessed for injuries. R1 was transferred into her bed with a hoyer sling lift. Medical provider notified of all and head injury. Medical provider ordered R1 to be sent to the ED for evaluation and treatment. R1s spouse was notified of the injury. Progress notes on 6/12/26 at 6:21 p.m., time of fall 4:39 p.m. nurse was alerted via walkie talkie that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s			F0609	Continued from page 12 The DON or designee will conduct audits on all staff across all shifts regarding their knowledge of reporting alleged violations weekly for one month, then monthly for 3 months. If concerns are identified, immediate corrective action will be implemented. The DON or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0609 SS = D	Continued from page 13 bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. R1 was drowsy when first checked, R1 awakened when assessed, R1 had a head laceration somewhere behind her right ear on the scalp which she was bleeding from. R1 assisted into bed with hoier sling lift and two person assist. Care plan updated to keep bed controls turned off by removing the remote. R1 was unable to control the bed functions safely. Medical doctor notified at 4:50 p.m. Spouse notified at 5:15 p.m. Progress notes on 6/12/26 at 11:16 p.m., R1 returned from the hospital around 9:30 p.m. Closed displaced fracture of acromial end of right clavicle. Laceration of scalp. R1 has a sling on right hand. CT of head without contrast was done. CT spine cervical without contrast. R1 has been sleeping throughout the night. No complaints of shortness of breath (SOB), no complaints at this time. Incident report received at SA on 6/13/26 at 9:18 a.m. During a phone interview on 6/24/26 at 11:23 a.m., registered nurse (RN)-C indicated R1 had fallen prior to RN-C's shift. RN-C stated when RN-C arrived for RN-C's shift R1 was currently at the hospital. RN-C indicated RN-C did not receive a call from the emergency department (ED) prior to R1 returning to the facility. RN-C further indicated R1 was transported back from the ED by R1's spouse on 6/12/26, around 9:30 p.m. RN-C stated RN-C indicated RN-C was made aware R1 had a clavicle fracture. RN-C further indicated RN-C thought the manager knew about the facture, so RN-C did not call the on-call manager when R1 arrived back at the facility. RN-C indicated RN-C put a progress note in R1's electronic medical record (EMR) after RN-C completed R1's return assessment. RN-C stated RN-C shared in morning report that R1 had sustained a clavicle fracture. During a phone interview on 6/25/26 ,at 12:23 p.m., director of nursing (DON) verified R1 returned to the facility on 6/12/26. DON further indicated RN-C looked through R1's looked through her discharge paperwork and found R1 had sustained a clavicle fracture. DON stated RN-C had thought it had already been communicated so RN-C documented in R1's EMR and passed the information on during morning report. DON stated it was miscommunication. DON confirmed the report was filed the morning of 6/13/26, which was past the			F0609			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
F0609 SS = D	Continued from page 14 two-hour reporting requirements. DON stated it is important that reports are filed following the correct reporting requirements for residents' safety and also to ensure the facilities processes are on time correct. Review of a facility policy titled Vulnerable Adult-Minnesota dated 2/17/26, identified All staff, residents, and families are required to report suspected abuse or neglect of vulnerable adults. The DON or designee shall be responsible for maintaining a log of any suspected and/or actual cases of abuse or neglect. They shall verify that the report to the proper officials has been made and that appropriate intervention has been taken. Policy further identified, All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries ofunknown source and misappropriation of resident property are to be reported: Immediately but not later than 2 hours after the allegation is made if the events that cause theallegation involve abuse or result in serious bodily injury.			F0609			07/10/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/23/26 to 6/24/26, 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(s) were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed. H54612928C Incident 3043555 with a licensing order issued at			20000			07/10/2026

Office of Primary Care and Health Systems Management

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20000	Continued from page 1 F689 and F609.The following complaints were reviewed. H54618000C Incident 2796449 with a licensing order issued at F689. 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 evidenced 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 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.			20000			07/10/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 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.			20830	Corrected		07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 2 This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide care consistent with a resident's needs and care plan to eliminate/reduce the risk of an accident in bed for 1 of 1 residents (R1). This resulted in actual harm to R1 when she rolled out of bed onto the floor. R1's fall mat was not alongside the bed and her call light was not within reach. As a result, R1 was transported to the emergency department (ED) on 6/12/26, for a laceration to the forehead and a fracture to her right clavicle. The facility had implemented actions to prevent recurrence prior to the survey on 6/23/26, therefore, the citation was issued at past non-compliance. Additionally, the facility failed to provide adequate supervision and secure transportation for R2 who has severe cognitive impairment. Findings include: R1 R1's annual minimum data set (MDS) dated 4/27/26, identified R1 was cognitively intact. R1 was dependent on staff for toileting, bed mobility, and transferring. R1 had anxiety, pain and a history of falls with fractures. R1's care plan revised 6/13/26, identified R1 had a potential for falls related to decreased mobility, a history of falls, and weakness. R1 was alert and orientated to person, place and time. R1's care planned interventions included low bed with fall mat to the floor when R1 was in bed and soft touch call light at the hip to promote use. R1's fall risk predictive factors assessment dated 4/21/26, indicated R1 had poor recall, judgment, and safety awareness. It further indicated R1 had poor vision status and a history of three or more falls in the past three months. R1s care sheet undated, indicated R1 was a fall risk and was to have low bed and floor mat along with soft touch call light to right hip. R1's physical therapy treatment encounter dated 6/15/26, indicated R1 fell and was receiving skilled services to her right shoulder per providers orders. R1's incident report dated 6/12/26 at 4:45p.m., identified the nurse was alerted via walkie talking			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 3 that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. I was determined based on the scene that R1 had raised her bed in a high position and attempted to self-transfer. R1s call light was in the chair next to the bed. R1 has a history of falls. R1 used her bed controller to put the bed up approximately four feet. NA-A confirmed she had the bed in low position but did not have the fall mat next to the bed. R1 was assessed for injuries. R1 was transferred into her bed with a hoyer sling lift. Medical provider notified of all and head injury. Medical provider ordered R1 to be sent to the ED for evaluation and treatment. R1s spouse was notified of the injury. On 6/12/26, electromagnetic waves (X-ray) revealed R1 had an acute comminuted fracture of the lateral right clavicle, and it appeared somewhat impacted. On 6/12/26, computed tomography (CT) revealed R1 had a right lateral scalp hematoma. Provider Communication Forms revealed the following: -6/12/26, found on floor laying on right side, blood near head coming from laceration back of right ear. Was assisted back to bed, cleaned up. Called on-call medical provider, ordered to be sent in for evaluation and treatment. Returned from ED Friday evening. Has right clavicle fracture with sling. Staples to head laceration. Referral to orthopedics. Signed by primary provider 6/15/26. -6/15/26, immobilizer to right upper extremity (RUE) with Velcro at wrist ordered due to right clavicle fracture. Signed by primary provider 6/15/26. -6/15/26, discontinue physical therapy (PT) and speech therapy (ST). Signed by primary provider 6/15/26. -6/15/26, remove scalp staple on 6/20/26. Signed by provider 6/17/26. -6/16/26, R1 refused 2:00 p.m., dose of Tramadol (medication used for pain), then requested it at 4:00 p.m. Give one time only dose of Tramadol 50mg by			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 4 mouth for pain. Wait four hours until next does. Signed by provider 6/16/26. Sanford Internal Medicine Nursing Home APP visit dated 6/15/26, medical provider indicated the visit was related to a hospital discharge. R1 had a right clavicle fracture. R1 was to wear an immobilizer to right upper extremity with Velcro at the wrist for six weeks. R1 will need to follow-up with orthopedics and plan to have a follow-up x-ray in two weeks. R1 had one suture placed and orders were given to remove the scalp staple on 6/20/26, eight days after placement. Progress notes dated 6/1/26 to 6/23/26 revealed the following: -6/3/26 at 10:25 a.m., R1 had her light on and requested help from staff. Staff helped R1 and left room. -6/11/26 at 2:15 p.m., R1 had her light on R1 requested to use the bathroom. R1 didn't need any additional assistance. -6/12/26 at 6:21 p.m., time of fall 4:39 p.m. nurse was alerted via walkie talking that R1 was lying on the floor. R1 was lying on her right side, her head was pointing to the south of her bed approximately a foot away from her bed. R1 had approximately an eight-inch circle of blood at the right of her head hear her right ear area. R1s bedside table base was near her neck, and her stationary chair was near her. Nursing Assistant (NA)-A stated the last time NA-A checked on R1 was around 4:00 p.m. R1 used the restroom and NA-A assisted R1 into bed. R1 was drowsy when first checked, R1 awakened when assessed, R1 had a head laceration somewhere behind her right ear on the scalp which she was bleeding from. R1 assisted into bed with hoyer sling lift and two person assist. Care plan updated to keep bed controls turned off by removing the remote. R1 was unable to control the bed functions safely. Medical doctor notified at 4:50 p.m. Spouse notified at 5:15 p.m. -6/12/26 at 6:38 p.m., R1 was transferred to Sanford ED via emergency medical transport (EMT) due to fall and head injury. On-call provider notified and ordered transfer for evaluation and treatment at Sanford ED. Supervisor and husband notified of R1's fall. -6/12/26 at 11:16 p.m., R1 returned from the hospital around 9:30 p.m. Closed displaced fracture of acromial end of right clavicle. Laceration of scalp.			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 5 R1 has a sling on right hand. CT of head without contrast was done. CT spine cervical without contrast. R1 has been sleeping throughout the night. No complaints of shortness of breath (SOB), no complaints at this time. -6/14/26 at 4:47 p.m., writer completed a bed remote assessment with R1. Nursing delegated to client to complete raising and lowering head of bed, food of bed, and height of bed. Nursing delegated to client to complete putting bed at an appropriate height for transfer. Client was not able to complete any of these tasks safely. Will continue to keep bed remote out of reach of R1. -6/15/26 at 1:37 p.m., writer spoke with R1s spouse and daughter about intervention, and they consented to removing the bed remote for R1s safety. -6/15/26 at 3:46 p.m., elbow, wrist, hand range of motion three times a day. No weight bearing to right arm. Use right arm sling/immobilizer when up. Ok to remove for sleep and comfort. During an observation on 6/23/26 at10:50 a.m., R1 was laying in the bed watching television. R1's bed was in low position and fall mat was on the floor next to the bed. R1's call light was hooked to the railing of the bed. R1s legs were hanging off the edge of the bed. R1 had sling on right shoulder. R1 was unable to answer questions during an interview due to difficulties speaking. During an observation on 6/23/26 at 4:03 p.m., R1 was resting in the bed. R1 had removed the sling from right shoulder. R1s bed was in a low position and fall mat was on the floor. Call light was within reach. During an interview on 6/23/26 at 3:32 p.m., nursing assistance (NA)-A indicated NA-A had completed rounds and was helping another resident. NA-A heard over the walkie that R1 had fallen out of bed and was lying on the floor. NA-A indicated R1 had an open wound and there was blood on the floor. NA-A stated R1 had a history of using the remote to bring the bed up. NA-A further stated when NA-A entered the room R1's bed was in a very high position. NA-A confirmed NA-A had forgotten to place the fall mat next to R1's bed and R1's call light was in the chair. NA-A indicated NA-A received training on care plans and continued to work with co-workers completing walk through checklists of each resident's rooms to ensure safety. NA-A			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 6 further indicated an all staff meeting was going to take place next month. During an interview on 6/23/26 at 3:40 p.m., medical provider (MP) indicated MP was aware of R1's fall and that R1 was treated in the ED. MP stated R1 sustained a fracture to R1's right clavicle and a laceration to R1's head. MP further stated MP had seen R1 for a follow up on 6/15/26. MP indicated R1 was to wear a sling and would be seen by orthopedics for a follow-up. MP stated she would expect staff to be following the care plan to prevent any accidents and keep residents safe. On 6/23/26 at 3:45 p.m., call made to registered nurse (RN)-A no answer and a voicemail was left. During an interview on 6/23/26 at 4:10 p.m., licensed practical nurse (LPN)-A stated LPN-A was aware of R1's fall. LPN-A indicated LPN-A received education on care plans, falls, and working with NA's to ensure the safety checklists were being followed. LPN-A further indicated the safety checklists were used to ensure all care planned interventions were being followed for each resident. During an interview on 6/23/26 at 4:59 p.m., director of nursing (DON) stated she was aware of R1s fall and that R1 sustained injuries from the fall. DON confirmed R1's fall mat was not along side R1's bed and R1 did not have R1's call light within reach. DON indicated education was done with all staff working on the second floor immediately and shortly thereafter education was provided to all nursing staff. DON further indicated when NA-A returned for NA-A's next shift, NA-A worked with coworkers to complete safety checks on all residents on the second floor. DON stated when R1 returned staff removed R1's bed controller as an intervention for fall safety. DON stated her expectations were for staff to follow all care planned interventions to ensure resident safety. DON further stated care planned interventions were in place to protect the residents from harm. R2 R2's quarterly MDS dated 4/9/26, identified R2 was severely cognitively impaired. R2 was dependent on staff for toileting, bed mobility, and transferring. R1 had Alzheimer's disease and dementia.			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 7 R2's care plan revised 3/27/26, potential for safety concerns due to risk for elopement. R2s goal indicated R2 will not leave the facility unattended. Interventions in place were to check wander guard placement every shift and to identify triggers as R2 has a history of wandering the halls and using the elevator. R2's elopement risk assessment dated 6/20/26, indicated R2 was cognitively impaired with poor decision making skills and uses a wander guard. Progress notes dated 3/4/26, revealed R2 saw medical doctor at Essentia Dermatology, had cryotherapy completed to top of scalp and left ear. However, progress notes lacked documentation of the time R2 left the facility, when R2 returned to the facility and if R2 had an escort to R2's appointment. Review of a facility calendar dated 3/4/26, identified R2 had a scheduled ride to Essentia Health Dermatology by First-In Line Mobility with a pickup at 1:30 p.m., on 3/4/26 and a will-call return for transportation back to the facility once the appointment was completed. R2's electronic medical record (EMR) lacked documentation of paperwork sent with R2 for R2's dermatology appointment on 3/4/26. During an observation on 6/23/26 at 2:23 p.m., R2 was sitting in R2's wheelchair in the hallway next to the elevator. R2 had a blanket over R2's chest and R2 was moving back and forth. R2 had a wander guard on R2's right ankle. R2 was unable to answer any questions during the interview. During an observation on 6/23/26 at 4:07 p.m., R2 was sitting in the hallway near the nurses' station drinking a cup of coffee. R2 was moving around in R2's wheelchair. R2 had wander guard on right ankle. During an interview on 6/23/26 at 1:17 p.m., trained medical aid (TMA)-A indicated the NA's got resident's ready for appointments and would bring them to the nurses' station for pick-up. TMA-A stated the secretary was responsible for getting the resident's paperwork ready to take to appointments. TMA-A indicated that the transportation driver would come to the floor to pick the resident up. TMA-A stated if family was going to take the resident to an appointment, staff would bring the resident down to the front door. TMA-A was unsure if R2 required an escort to appointments or if any paperwork was sent			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 8 to R2's dermatology appointment on 3/4/26. During an interview on 6/23/26 at 1:23 p.m., NA-B stated staff would take the resident up front to where their ride would pick them up. NA-B indicated they let the nurse and secretary know when the residents are ready for their appointments. NA-B indicated if the resident needed an escort the secretary would make sure they would have the escort before leaving the floor. NA-B stated there usually is an envelope at the desk that would go with the resident when they leave. NA-B was unsure if R2 required an escort to appointments or if any paperwork was sent to R2's dermatology appointment on 3/4/26. During an interview on 6/23/26 at 1:28 p.m., RN-B stated that staff “just know” if a resident required an escort for appointments. RN-B further stated at times, “they will let us know” if an escort was needed. RN-B indicated some residents who have wander guards can just go to appointments on their own. RN-B stated she was unaware if R2 required an escort for appointments or if an envelope was sent with R2 to his dermatology appointment of 3/4/26. RN-B further stated she was unaware of how R2 returned to the facility after his appt on 3/4/26. During an interview on 6/23/26 at 1:30pm LPN-B indicated the secretary was responsible for setting up appointments. LPN-B further indicated rides are provided to residents based on their insurance. LPN-B stated envelopes are provided to the driver, resident or family with information about the resident and was returned to the facility when the resident arrived back. This paperwork was also used for the provider at the appointment to provide any updated orders. LPN-B further stated each envelope had a sticker at the top that provided a number for the provider to call when the appointment was finished for a return ride back to the facility. LPN-B indicated if a resident was not safe to go to the appointment alone family will be contacted for assistance or and escort would be provided. LPN-B stated determination was made on residents’ safety if the resident required an escort. LPN-B further stated there really wasn’t a process on the determination, “they just know what residents are not safe to be out by themselves”. LPN-B looked in R2’s EMR and verified R2 had an appointment on 3/4/25 at 2:00 p.m. LPN-B indicated she was unaware R2 was brought back to the facility by the police department. LPN-B was unaware of what time			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 9 R2 returned to the facility and did not know how long R2 had been gone. LPN-B confirmed LPN-B put a note in regarding R2's appointment but did not know how R2 arrived back at the facility from the appointment. LPN-B indicated R2's daughters would often attend R2's appointments but LPN-B could not confirm if R2's daughters were at the appointment on 3/4/26. LPN LPN-B confirmed R2 had a son but indicated LPN-B just met him for the first time a couple days ago. LPN-B was unsure if an envelope was sent with R2 to his dermatology appointment on 3/4/26. During an interview on 3/4/26 at 1:45 p.m., secretary stated R2 now has an escort for all appointments. Secretary indicated secretary was not in the current position when R2's appointment for 3/4/26 was scheduled. Secretary was unable to confirm if R2 had an escort for the appointment on 3/4/26. Secretary was unable to confirm when and how R2 returned to the facility or if an envelope for the receiving facility was sent with to R2's appointment at the dermatology clinic on 3/4/26. On 6/23/26 at 1:50 p.m., a call to R2's daughter was made and no answer. On 6/23/26 at 1:58 p.m. a call the Fargo Police Department (FPD) was made FPD indicated police reports could be found online by going to www.fargopolice.com. On 6/23/26 at 2:44 p.m., contacted the FPD through online database. 709 requested for police report. On 6/23/26 at 2:48 p.m., call to Nursing Supervisor Essentia Health and left a voicemail. During a phone interview on 6/23/26 at 2:49 p.m. first in line transportation supervisor (FILTS) confirmed R2 was picked up at 1:30 p.m., on 3/4/26. FILTS could not confirm if R2 had an escort or received a return ride to the facility from R2's appointment. FILTS stated envelopes are given to the receiving facility and the receiving facility calls the number when the residents appointment is finished. FILTS could not verify if R2 had an envelope for R2's appointment on 3/4/26. On 6/23/26 at 4:36 p.m., call to Essentia Health			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 10 Dermatology, no answer. During an interview on 6/23/26 at 4:59 DON indicated DON did not feel there was anyway R2 could have been transported back to the facility by the police department. DON stated R2 was a hoyer lift and would have required the use of a lift to transfer R2. DON stated R2 used transportation to get to R2's appointments and family would generally meet R2 at the appointment. DON indicated family was supposed to meet R2 for his appointment on 3/4/26. DON stated R2's daughter was going to relay the appointment with R2's other daughter but had gotten the dates confused. DON confirmed R2 attended R2's appointment alone. DON stated that the resident returned to the facility as there was a note placed in R2's chart. DON could not confirm how or when R2 arrived back to the facility after R2's appointment. DON indicated the facility used an elopement assessment and that would be considered the safety assessment to ensure residents are or are not safe in the community alone. DON stated residents are never alone. DON further stated the transportation service picks the residents up and brings them to appointment. DON could not confirm if First In Line transportation service stayed with R2 for R2's appointment. DON stated the facility sends paperwork with each resident and that is to be handed off during the appointment and returned to the facility after the appointment. DON could not confirm if R2 had paperwork sent with R2 for R2's appointment on 3/4/26. On 6/24/26 at 7:35 a.m., email received from FPD stating no police report containing R2's name was found for 3/4/26. During a phone interview on 6/24/26 at 8:02 a.m., Nursing supervisor Essentia Health (NSEH) stated nursing staff found R2 sitting alone in the lobby and brought R2 back to R2's appointment on 3/4/26. NSEH indicated FILT did not stay with R2 during his appointment. NSEH stated R2 did not have any documentation or paperwork with R2 from the facility providing any direction for nursing staff. Nursing staff were not aware R2 lived in a nursing home and had cognitive impairments. NSEH stated R2 told staff R2's son was going to pick R2 up after the appointment. NSEH indicated nursing staff assumed this was correct as R2 as R2 did not have any other information with R2. NSEH stated once the appointment was finished, staff brought R2 down to the pickup area for R2 to wait for his ride. HSEH stated nursing staff were not aware they needed to call FILT for a ride back to the facility for R2. HSEH further stated staff continued to check on R2 for			20830			07/10/2026

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 11 approximately two hours in the pick-up area. NSEH indicated during this time, nursing staff attempted to contact R2's daughter but never received a call back. HSEH stated the last time nursing staff went to check on R2, R2 was no longer sitting in the pick-up area so nursing staff assumed R2's son picked R2 up. HSEH indicated on the morning of 3/5/26 the department received a telephone message from 3/4/26 from Eventide. HSEH stated the message was requesting information about R2's appointment. HSEH further stated nursing staff called Eventide back and spoke with LPN-B. HSEH indicated LPN-B stated R2 had been seen at the clinic on 3/4/26. HSEH stated nursing staff told LPN-B that R2 did not come with any paperwork so NSEH were unaware res lived in a nursing home or that R2 did not have a return ride to the facility, LPN-B indicated there was a mix up with R2's daughters who were usually with R2 for appointments. HSEH stated nursing staff told LPN-B that R2 was picked up by R2's son and LPN-B indicated R2 did not have a son. HSEH further stated LPN-B told nursing staff that R2 had been brought back to the facility by the police department. HSEH indicated LPN-B apologized for the mix up and nursing staff faxed paperwork from the appointment to Eventide. The past noncompliance that began on 6/12/26. The deficient practice was corrected by 6/19/26, after the facility implemented a systemic plan. Verification of corrective action was confirmed and interviewed with facility staff and review of training documentation. The nursing assistant involved verified she was promptly re-educated on the importance of following the nursing assistant care sheets. Documentation showed the facility had developed, implemented, and completed a plan to ensure that any staff responsible for providing cares were trained. This was confirmed by review of training records and staff interview. Observation of care in bed observed and verified that staff were following the nursing assistant care sheets. Facility was able to demonstrate monitoring of the corrective action and sustained compliance. Facility Policy titled Care Plans dated 2/10/26, to develop a person-centered care plan in conjunction with the interdisciplinary team and resident/resident representative that reflects the actual care, condition and preferences of each resident. Any changes made to the comprehensive care plan will also be updated in the NAR/CNA care plan. Facility policy titled Falls – Resident dated 2/13/26, all resident will be assessed for fall risk and			20830			07/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/24/2026	
NAME OF PROVIDER OR SUPPLIER Eventide Lutheran Home				STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH , MOORHEAD, Minnesota, 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
20830	Continued from page 12 individualized interventions will be implemented as appropriate to minimized the all risk and reduce injury. Facility policy titled wander guard dated 2/17/26, a wander guard is used to minimize potential resident elopement. Facility policy titled resident medical appointments dated 2/17/26, to arrange a safe transport and escort procedure for those residents whose families are unavailable to transport and/or accompany them to appointments and to provide the provider with appropriate information. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee should review policies and procedures, train staff, and implement measures to ensure appropriate adequate supervision for cognitively impaired residents at appointments. The director of nursing or designee, should conduct measurable audits of supervision at appointments to ensure that process are followed. The DON or designee should educate staff to those intervention. The results of audits should be taken to QAPI to determine compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			20830			07/10/2026