



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 20, 2025

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

RE: CCN: 245461
Cycle Start Date: March 12, 2025

Dear Administrator:

On March 12, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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 listed below to the CMS location.

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

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

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.

The CMS location may notify you of their determination regarding any imposed remedies.

Eventide Lutheran Home

March 20, 2025

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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:

LeAnn Huseth, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, MN 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

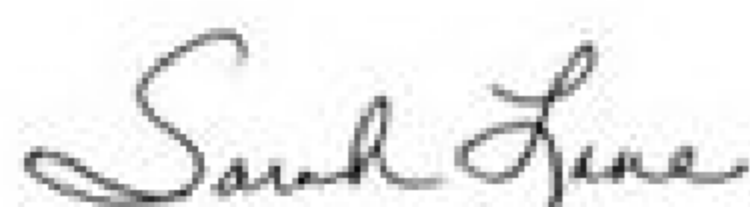
INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

Sincerely,



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



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March 20, 2025

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

Re: Event ID: 559R11

Dear Administrator:

The above facility survey was completed on March 12, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in 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

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

PRINTED: 03/20/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/12/2025
NAME OF PROVIDER OR SUPPLIER EVENTIDE LUTHERAN HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH MOORHEAD, MN 56560		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 3/11/25 to 3/12/25, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed: H54619067C (MN00110936) and a deficiency was issued at F689 at Harm, PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, harm was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow care planned interventions to ensure resident's safety for 1 of 3 residents (R1) who had a history of falls. This resulted in actual harm for R1 when he fell from the wheelchair, was sent to the emergency	F 689	Past noncompliance: no plan of correction required.		

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

TITLE

(X6) DATE

Electronically Signed

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

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F 689	<p>Continued From page 1</p> <p>department (ED) and sustained a left humerus fracture. The facility implemented corrective action prior to the survey so the deficient practice was issued at past non-compliance.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated 1/10/25, identified R1 had moderately impaired cognition with diagnoses of type two diabetes, dementia, anxiety and depression. Identified R1 required extensive assistance with activities of daily (ADL's) including transfers, bed mobility and toilet use.</p> <p>R1's care plan undated, identified R1 had a potential for falls related to history of frequent falls, impaired mobility, unsteady gait, diabetes, acute encephalopathy, and dementia. Identified R1 had a closed three-part fracture of left proximal humerus. The staff were directed to remove foot pedals from R1's wheelchair when in room and to not leave R1 alone in wheelchair in room.</p> <p>Review of R1's progress notes on 2/20/25, identified:</p> <p>-At 4:45 p.m., licensed practical nurse (LPN)-A was called to R1's room and found R1 on the floor. The wheelchair was next to the bed facing the television. Catheter bag was in holder below the wheelchair and pedals were still on the wheelchair. R1's head was under roommate's bed. R1's feet were in front of his wheelchair. R1 stated he was trying to get back in the bed. R1 was complaining of pain to the left shoulder with limited range of motion to the shoulder. Call placed to provider and order received to send R1 to the emergency department (ED) for evaluation.</p>	F 689		

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F 689	<p>Continued From page 2</p> <p>-At 7:45 p.m., ED informed facility R1 had a left acute, proximal left humerus fracture with some angulation and impaction (the top part of the upper arm bone, which was shaped like a ball, was broken).</p> <p>Review of R1's progress notes from 2/12/25 to 2/22/25, identified the following:</p> <p>-2/12/25 at 16:30 p.m., R1 was sent to ED for evaluation of stroke like symptoms. The progress noted lacked documentation about R1 having a fall.</p> <p>-2/16/25 at 4:42 p.m., R1 had a fall on 2/12/25, not 2/16/25. The progress note further stated staff found R1 laying on the floor in his room at 3:50 p.m., with the wheelchair next to him. Staff had seen R1 in wheelchair in his room ten minutes before the fall occurred. R1 was unable to provide staff details on the fall and was sent to the ED for evaluation of altered mental status.</p> <p>-2/18/25 at 1:38 p.m., IDT reviewed R1's fall that occurred on 2/12/25 and the root cause was R1 experienced an acute change in health status. The progress note lacked documentation of interventions put in place.</p> <p>-2/21/25 at 12:35 a.m., R1 returned from the ED with orders provided to facility to ice left shoulder three times a day for the next three days and keep R1's left arm in a sling.</p> <p>-2/22/25 at 9:22 a.m., R1's fall on 2/20/25, reviewed during interdisciplinary team (IDT) meeting. Root cause of fall was that the resident stated he was wanting to get back into bed and fell trying to self-transfer. Resident had just gotten</p>	F 689		

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F 689	<p>Continued From page 3</p> <p>out of bed and into wheelchair with staff assist and seen in wheelchair 15 minutes prior to being on the floor. Resident had wheelchair pedals on wheelchair and also his catheter bag in the dignity bag under his wheelchair still at time of fall. Probable that resident could have tripped over one of them when trying to self-transfer. Foot pedals to be removed from wheelchair while resident is sitting in his room.</p> <p>R1's ED visit on 2/20/25, identified a closed fracture of proximal end of left humerus from a fall.</p> <p>R1's x-ray imaging order on 2/20/25 at 5:56 p.m., identified R1 had a fall with shoulder pain. Findings/Impression: Acute, proximal left humerus fracture with some angulation and impaction.</p> <p>During an observation on 3/11/25 at 9:31 a.m., R1 was laying in bed with a sling to the left arm, wheelchair over by dresser with foot pedals off. At 2:09 p.m., R1 was brought to his room after lunch and transferred to bed with a hooyer lift. R1's wheelchair was placed next to the bed, brakes on, his foot pedals were removed.</p> <p>The Facility Risk Predictive Factors Assessment dated 2/22/25, identified R1 had poor recall, judgment and safety awareness. R1 required the use of assistive devices for mobility and three or more falls in the past three months. Fall risk score was 20 and indicated high risk for falls. Another Facility Risk Predictive Factors Assessment dated 2/21/25, identified R1 had diminished safety awareness, required the use of assistive devices for mobility and one-two falls in the past three months. Fall risk score was 11 and</p>	F 689		

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F 689	<p>Continued From page 4 indicated at risk for falls.</p> <p>Nursing assistant care plan dated 3/12/25, identified R1 was to have foot pedals removed from the wheelchair while in his room. Do not leave R1 alone in room in wheelchair.</p> <p>During an interview on 3/11/25 at 4:14 p.m., registered nurse (RN)-A stated R1 had a history of falls and a broken arm resulting from a recent fall. RN-A confirmed use of a care plan sheet with individual interventions for each resident for falls prevention and that he carried the care plan sheet with him each day of work. RN-A confirmed the care sheet identified R1 was to have foot pedals removed from the wheelchair when in his room.</p> <p>During an interview on 3/11/25 at 4:45 p.m., executive director confirmed R1 had a fall on 2/20/25. R1 fell from his wheelchair in his room, was taken to the ED, and returned to the facility with a left proximal humerus fracture. Executive director verified R1 had foot pedals on the wheelchair and tripped over the pedals or the catheter and fell. Executive director stated education for staff was provided immediately at shift change and education was sent out via email to staff. Executive director stated safety audits were being performed by the leadership team to ensure care plan interventions were being followed.</p> <p>On 3/12/25 at 9:49 a.m., the director of nursing (DON) returned a call to surveyor and verified R1 fell on 2/12/25, out of his wheelchair and at that time an intervention was put into place to remove pedals from R1's wheelchair while in his room. DON verified the pedals were on the wheelchair on 2/20/25, when R1 had an unwitnessed fall in</p>	F 689		

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F 689	<p>Continued From page 5</p> <p>his room from the wheelchair. DON verified R1 went to the ED on 2/20/25, after the fall and returned to the facility with a left proximal humerus fracture. DON stated care plan interventions included the keeping the pedals off R1's wheelchair while in his room were reviewed with staff at shift change and a mandatory meeting was completed with staff discussing falls and care plans. DON stated her expectations were staff would keep a resident safe if there was a fall, stay with the resident and call for help. DON confirmed the expectation staff would follow the care plan. DON would expect the nurse to assess the resident and surroundings and try to determine the root cause of the fall. The nurse would call the provider and family if a suspected injury resulted from the fall to determine further treatment. DON confirmed this was important to keep the resident safe after a fall and to prevent the fall from happening again.</p> <p>On 3/12/25 at 3:32 p.m., nurse practitioner (NP) returned a call to surveyor and verified R1 fell at the facility on 2/20/25, resulting in a left proximal humerus fracture.</p> <p>All nursing staff were sent out an email on 2/20/25 at 10:05 p.m., regarding R1's fall. All nursing staff were reminded that R1's foot pedals were to be removed from the wheelchair when R1 was sitting in his room. If staff were not transporting R1, foot pedals would be removed. Attached to the email was a copy of R1's ED report.</p> <p>Facility staff education meeting undated, identified education would be provided to employees on state prep, falls, and care plans.</p>	F 689		

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F 689	Continued From page 6 A facility policy titled Falls, revised 3/22, identified all residents would be assessed for fall risk and interventions implemented as appropriate. A comprehensive assessment would be completed with every fall to determine the root cause and to develop individualized interventions. A fall was identified as an unplanned descent to the floor with or without injury to the resident. A fall risk predictive factors assessment would be completed after each fall. If the fall score was 10 or greater the resident may be considered at high risk for potential falls and staff were to initiate the care plan for high risk for injury, list specific interventions based on assessment risk, identify interventions on the NA care plan.	F 689			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2025
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NAME OF PROVIDER OR SUPPLIER EVENTIDE LUTHERAN HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1405 7TH STREET SOUTH MOORHEAD, MN 56560
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 3/11/25 to 3/12/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was reviewed: H54619067C (MN00110936). NO licensing</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00072	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/12/2025
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2 000	<p>Continued From page 1</p> <p>orders were issued.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		