Electronically Submitted
March 28, 2022

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

RE: CCN: 245461
Cycle Start Date: March 11, 2022

Dear Administrator:

On March 11, 2022, survey was completed at your facility by the Minnesota Department of Health and Public Safety 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On March 9, 2022, the situation of immediate jeopardy to potential health and safety cited at J was removed.

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 Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 12, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 12, 2022 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 12, 2022, (42 CFR 488.417 (b)).

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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 12, 2022. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/ or "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 11, 2022 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS DENIAL OF PAYMENT

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) 565-9462

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, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245461	A. BUILDING _____ B. WING _____	C 03/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/7/22, to 3/11/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 3/7/22, to 3/11/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5461074C (MN69785), with a deficiency cited at (F689). H5461078C (MN65201), with a deficiency cited at (F689). H5461080C (MN62557), with a deficiency cited at (F689). AND/OR The following complaints were found to be SUBSTANTIATED, however, NO deficiencies were cited due to actions implemented by the facility prior to survey: H5461075C (MN68124) H5461077C (MN65927) H5461079C (MN63063)	F 000		

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

Electronically Signed | 04/04/2022

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F 000	Continued From page 1 H5461081C (MN62055) H5461082C (MN60984) H5461083C (MN59197) H5461084C (MN55835) H5461086C (MN67366) AND/OR The following complaints were found to be UNSUBSTANTIATED: H5461072C (MN74613) H5461073C (MN71997) H5461076C (MN68036) H5461085C (MN51516) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each	F 550		4/15/22

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F 550	Continued From page 2 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to treat two of four residents (R 15 and R45) with dignity and respect reviewed for dignified treatment. This deficient practice created the potential for the residents to experience feelings of embarrassment or social isolation.	F 550	How corrective action will be accomplished for the resident(s) impacted: The Director of Life Enrichment, A-A□s supervisor, has met with R15 and R45 to ensure they feel comfortable and dignified	

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F 550	Continued From page 3 Findings include: R15 Review of R15's Admission Record revealed the resident was admitted to the facility on 3/19/20. Review of R15's diagnoses, located under the "Diagnosis" tab of her Electronic Medical Record (EMR) identified R15 had Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder, and anxiety disorder. On 3/08/22, at 9:45 a.m. during an interview in R15's room with the door closed, Activities (A)- A simultaneously knocked on R15's door, opened the door, and entered without waiting for R15 to respond. R15 looked at A-A and stated, "Don't come in. I'm busy." A-A stated, "I have to come in to tell you about the 10:00 activity." R15 stated, "Can't you see I have a visitor? I'm very busy and I didn't invite you in. That's very rude." A-A stated, "It's OK, I just have to come in and let you know about the activity." R15 stated, "No, you're being rude." A-A stated, "OK but legally I have to come in to try to tell you about the activity." R15 stated, "You're being rude. Right now, I don't want to hear about the activity. I have a visitor," and A-A exited the room. After A-A left the room, R15 continued to state how upset she was that A-A had entered without knocking. R15 stated, "The rest are good, but that one's rude." During an interview with registered nurse (RN)-A on 3/09/22, at 11:30 a.m., who was the Resident Care Manager for the third floor where R15 resided, stated staff were expected to knock and wait for a resident to respond before entering a resident room.	F 550	with their interactions with A-A going forward. R45 and R15 have been assessed and their psychosocial status remains at baseline. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. The Director of Life Enrichment or designee will interview 20 additional residents to ensure they feel comfortable and dignified with staff interactions. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Director of Life Enrichment provided education to A-A regarding treatment of residents with dignity and respect with an emphasis on knocking when entering resident rooms and respecting resident wishes and requests on 3/30/22. Education will be given to all staff to provide a reminder on the importance of treating residents with dignity and respect throughout all interactions. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Director of Life Enrichment or designee will perform five resident interviews weekly for one month and then ten resident interviews monthly for 11 months to monitor residents feelings of	

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F 550	Continued From page 4 On 3/10/22, at 10:10 a.m. R15 was observed entering a large activity room on the first floor in an electric wheelchair. R15 positioned herself to the left side of the group, more than six feet from the nearest resident. Three other residents were present, wearing face masks over their mouths however their noses were exposed. After settling in for the activity, R15 stated, "I can't breathe," and removed her face mask. A-A, who was conducting the activity, instructed R15 to replace her mask. R15 stated again, "I can't breathe." A-A stated, "If you want to participate you have to wear a mask." R15 pointed out the other residents were not wearing their masks over their noses and removed herself from the activity. An interview with R15 on 3/10/22, at 11:44 a.m. revealed she hurried to get to the activity and arrived late, which caused her to feel anxious and short of breath. R15 stated she made sure she was more than six feet from the other residents, and only needed to remove her mask for a few minutes until she was not "huffing and puffing anymore." R15 stated, "I was so embarrassed. Nobody else there was wearing their mask the way they should. I don't know why she singled me out." An interview with A-A on 3/10/22, at 11:55 a.m. revealed when she entered a resident's room, she typically knocked and waited for a response before entering unless the resident was hard of hearing. A-A stated she was aware she had upset R15 when she entered her room without waiting for the resident response however felt it was more important to let her know about the activity. A-A stated that for the activity where R15 left after being instructed to don a mask, all of the other residents were wearing their masks properly, so	F 550	dignity and respect when interacting with staff with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 550	Continued From page 5 she gave the resident the choice to either put hers on too or leave. A-A indicated she had not considered that doing so in front of the other residents may cause R15 to feel embarrassed. R45 Review of R45's Admission Record revealed the resident was most recently admitted to the facility on 9/16/20. Review of her "diagnoses," located under the "Diagnosis" tab of her EMR, identified R45 had dementia without behavioral disturbances, unspecified abnormalities of gait and mobility, and muscle weakness. Review of R45's quarterly Minimum Data Set (MDS) dated 12/23/21, identified R45 had a Brief Interview of Mental Status (BIMS) of five out of 15, indicating the resident was severely cognitively impaired. During an observation and interview on 3/07/22, at 3:31 p.m., A-A approached R45 in her room and asked her to attend an activity, to which the resident agreed. A-A began to apply foot pedals to R45's wheelchair. R45 stated, "I don't want those." A-A responded, "Well you have to have them if you want to go to the activity" as she pushed the resident down the hall in her wheelchair. A-A took R45 as far as the lobby near the third-floor elevator, then left to gather other residents. A-A returned approximately two minutes later and R45 asked to have her foot pedals removed. A-A stated, "I can't take you if I take those off. I'm not allowed to push you in your wheelchair if I take those off." R45 indicated she would use her feet to "walk" in her wheelchair, and she felt "trapped" with the foot pedals on. A-A stated, "It's a long way, and you'll have to walk the whole way if I take those off. I can't help you at	F 550		

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F 550	Continued From page 6	F 550		

all. I can't push you if I take those off." R45 stated, "You're mad at me because I won't do those things. I don't want to be trapped. I want to come under my own conditions," as A-A walked away. A-A did not offer a response. After A-A left, R45 stated, "I was fine until a few minutes ago. I was fine until I couldn't hold up the requirements of the job with her (referring to A-A) so I'm out. It required me wearing those foot pedals, which I don't like." At 3:42 p.m., A-A returned to the area where R45 was still sitting and assisted another resident to the activity. R45 watched with a frown on her face and stated, "See, she gets to go but I don't."

An observation on 3/07/22, at 3:46 p.m. revealed R45 was able to attend the activity when a different staff member agreed to remove her foot pedals as soon as the resident was settled in the activity.

An interview with RN-A on 3/09/22, at 11:30 a.m. revealed it was her expectation staff attempt to apply foot pedals for safety while assisting residents in their wheelchairs however should listen to resident objections and approach the charge nurse for further instructions if it means a care cannot be completed or a resident would be excluded from a meal or activity.

An interview with A-A on 3/10/22, at 11:57 a.m. revealed , "Legally I can only push her if she puts her foot pedals on. If she won't, then legally I can't take her. I tried to explain that to her, but she didn't want to put them on so I couldn't take her. I had someone else come up and they were able to get her to put them on, so she came." When informed of the concern that the interaction on 3/07/22, may not have met the requirement for

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

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F 550	Continued From page 7 dignified treatment, A-A stated, "OK." An interview with the administrator on 3/10/22, at 12:26 p.m. identified it was her expectation residents would be treated with dignity and respect. The administrator stated the facility had no requirement that residents had to be informed of upcoming activities even if it meant they were interrupted in the privacy of their own rooms. The administrator indicated that while it was her expectation foot pedals were used when staff were assisting residents in their wheelchairs, and masks would be used in group activities to reduce the risk of spreading COVID-19, she would expect any concerns with those expectations to be handled quietly and privately, and with dignity and respect. Policies were requested on dignity, foot pedal use with wheelchairs and mask use for group activities however were not provided. Review of facility policy titled "Minnesota Department of Health Combined Federal and State Bill of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities," revised 11/28/16, revealed, "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality."	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F 561		4/15/22

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F 561	Continued From page 8 through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor choices regarding daily routine for one of one resident (R64) reviewed for choices. Findings include: Review of R64's undated Admission Record revealed an admission date of 1/07/22, with medical diagnoses that included brown Seqard syndrome and congestive heart failure.	F 561	How corrective action will be accomplished for the resident(s) impacted: Upon learning of this situation, the Resident Care Manager immediately added a sign to the resident□s door stating hello, I am resting. Please do not disturb. R64 discharged from the facility on 3/14/22. How facility will identify other residents	

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F 561	Continued From page 9 Review of R64's admission Minimum Data Set (MDS) dated 1/13/22, revealed R64 had a "Brief Interview for Mental Status" (BIMS) score of 13 out of 15, which indicated R64 was cognitively intact. During an interview on 3/07/22, at 2:14 p.m., R64 stated he had requested quiet hours from 9:00 p.m. until 6:00 a.m. R64 stated staff entered his room at 2:00 a.m. to stock towels and gloves. R64 indicated he requested staff do their rounding without turning on his light. R64 stated he reported this concern to the social worker (SW), the nursing assistants (NA), and the nurses however it continued to happen on a daily basis. R64 stated, "I just need a good night's sleep." During an interview on 3/09/22, at 9:39 a.m. with the SW, she stated R64 requested quiet hour due to being awakened by staff several times throughout the night. During an interview on 3/09/22, at 9:54 a.m. licensed practical nurse (LPN)-C stated aides go into resident's rooms on the overnight shift to stock items and complete rounding. LPN-C stated R64 had requested staff not come in his room and turn on his light. LPN-C stated she did not know if staff were aware of the request. During an interview on 3/09/22, at 10:02 a.m. Resident Care Manager, registered nurse (RN)-A indicated the SW had informed her about R64's complaint. RN-A stated she had provided verbal education to the NAs regarding R64's request. RN-A indicated she informed the NAs to peek their heads into the room and to not turn on the light when rounding. RN-A stated this information	F 561	who have potential to be affected: All residents in the facility have the potential to be affected. The Director of Nursing or designee will interview 20 additional residents to ensure their choices are being honored. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education will be provided to all staff about residents□ right to make choices regarding their daily routine and our responsibility to honor those. 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 perform five resident interviews weekly for one month and then ten resident interviews monthly for 11 months to monitor residents□ choices being honored with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 561	Continued From page 10 should have been updated in the care plan because the NAs carry the care plan around in their pockets. RN-A indicated she had not followed up with the NAs to ensure they had followed the verbal education provided. Review of facility policy titled Resident Rights revised 12/2013, indicated resident rights were to be observed and promoted on an ongoing basis. A Minnesota Department of Health document, titled Combined Federal and State Bill of Rights, revised 11/28/16, identified residents had a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, plan of care and other applicable provision of this part.	F 561		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a	F 644		4/15/22

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F 644	Continued From page 11 related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Preadmission Screening and Resident Review (PASSAR) Level I was updated for one resident (R119) of five residents reviewed for PASARRs. This deficient practice resulted in R119 not receiving a PASSAR Level II evaluation to ensure R119 was receiving the appropriate care and services. Finding include: Review of R119's undated Admission Record located in R119's electronic medical record (EMR) under the "Profile" tab, indicated R119 was admitted to the facility on 11/14/21, with diagnoses which included schizoaffective disorder, post-traumatic stress disorder, major depressive disorder. Review of R119's admission Minimum Data Set (MDS) dated 11/20/21, revealed R119 had a "Brief Interview of Mental Status (BIMS)" score of 15 out of 15, which indicated R119 was cognitively intact. The MDS identified R119 was assessed as not exhibiting any behaviors and required extensive assistance with activities of daily living (ADLs), except for eating. Further review of the MDS indicated R119 was not receiving psychological treatment. Review of R119's PASARR Level I dated 11/12/21, identified R119 did not have a major mental disorder diagnosable as listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM Level I mental illness (MI)	F 644	How corrective action will be accomplished for the resident(s) impacted: R119□s Level I assessment was updated on 3/8/22 to include all correct psychiatric diagnoses. R119 discharged from the facility on 3/22/22. All current residents with psychiatric diagnoses have been reviewed. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education will be provided to all staff that any time a resident has a newly evident or possible serious mental illness, intellectual disability, or related condition, the facility would refer the resident to the appropriate state agency authority for a Level II evaluation and determination. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Director of Social Services and Admissions or designee will complete an	

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F 644	Continued From page 12 Result: Based on the information provided for the nursing home stay, it appeared R119 did not meet the criteria for MI. During an interview conducted with the social service director (SSD) on 3/08/22, at 2:20 p.m. stated she reviewed the PASARR's on admission. SSD confirmed R119 had diagnoses of schizoaffective disorder, major depressive disorder, and post-traumatic stress disorder and stated these diagnoses were major mental illnesses and were qualifiers for a referral for PASSAR Level II evaluation. The SSD indicated she would need to look and see if one was completed or not. During a follow-up interview conducted with the SSD on 3/08/22, at 3:51 p.m. the SSD confirmed a PASSAR Level II evaluation was not completed for R119. SSD reviewed R119's PASSAR Level I and confirmed the screening did not identify R119 had a major mental illness and verified another PASSAR Level I should have been completed. Review of the facility's policy titled Preadmission Screening and Resident Review dated 11/2021, indicated if a resident had a negative Level I preadmission screening, and later was identified with a newly evident or possible serious mental illness (MI), intellectual disability (ID), or related condition (RC), the facility would refer the resident to the appropriate state agency authority for a Level II evaluation and determination.	F 644	audit of 10 PASARR assessments each month for three months and 5 each month for 9 months to ensure the PASARR is updated as required with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
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 -	F 689		4/15/22

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F 689	Continued From page 13 §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 ensure residents were free from accident and hazards as possible for three of 10 residents (R47, R45 and R118) reviewed for accidents. The facility failed to provide adequate supervision to prevent falls for R47 and R45; and failed to assess R118 for smoking safety measures. This deficient practice resulted in actual harm for R47 who suffered a scalp laceration and hematoma which required medical intervention. Findings include: FALLS R47 Review of R47's undated Admission Record identified she had been admitted to the facility on 09/23/19. Review of her diagnoses indicated R47 had a history of falling upon admission, adult failure to thrive, other symptoms and signs involving cognitive functions and awareness, anxiety disorder, other abnormalities of gait and mobility, macular degeneration, and dizziness and giddiness. Review of R47's quarterly Minimum Data Set (MDS) dated 4/01/20, identified R47 was cognitively intact. The MDS indicated R47 required limited assistance of one staff for	F 689	How corrective action will be accomplished for the resident(s) impacted: Care plans for R47 and R45 have been reviewed to ensure that fall interventions are appropriate and up-to-date. Nursing staff have been educated on the fall interventions for R47 and R45 and the necessity of reading/following care plans. A smoking assessment has been completed with R118. How facility will identify other residents who have potential to be affected: All residents in the facility who are at-risk for falls have the potential to be affected. DON or designee will review care plans for residents at-risk for falls to ensure that interventions are appropriate and up-to-date. Any additional residents who smoke have the potential to be affected. The facility has determined that no additional residents currently smoke and will enforce the no smoking policy with new residents moving forward.	

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F 689	Continued From page 14 transfers and walking in her room; extensive assistance of one staff for toilet use and personal hygiene; was not steady but able to stabilize herself when moving from a seated to standing position and moving on and off the toilet. Review of R47's care plan revealed a care plan intervention of mat on the floor next to bed, initiated on 09/23/19, and resolved on 03/08/20. The care plan indicated R47 was at high risk for falls due to history of falls and history of self transferring. The care plan identified R47 required stand by assist of one with transfers. Review of R47's form titled Fall Risk Predictive Factors, dated 3/26/20, revealed R47 scored 15, indicating she was at high risk for falls. Specifically, the resident triggered for diminished safety awareness, impaired mobility, balance problems while standing and walking, being legally blind, taking medications with known adverse reactions of falls, and having disease processes which contributed to falls. Review of R47's progress notes from 6/11/20, to 6/12/20, revealed the following: -6/11/20, at 8:00 p.m. indicated R47 was found on the floor in her room with "a cut and swelling to the back of the head." -6/12/20, at 10:34 a.m., late entry identified staff found resident lying on the floor with head facing the closet. A laceration and swelling of three cm (centimeters) by two cm was noted to the back of the left lower part of her head. Resident was being toileted, and nursing assistant (NA) left resident in the bathroom and went to assist another resident. R47 attempted to self-transfer	F 689	What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education will be provided to all nursing staff regarding following care plans and fall interventions. Education will be provided to all staff regarding completing quarterly and PRN smoking assessments for R118. Education will include that smoking materials must be kept secured in the medication room and that R118 must sign in and out of the facility when going outside to smoke. Education will be provided to R118 of the same. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: DON or designee will perform 10 audits a month for three months and 5 audits a month for 9 months on care plan adherence with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting. DON or designee will perform 10 audits a month for three months and 5 audits a month for 9 months on R118□s sign in/outs and having smoking materials locked up when not in use. DON or	

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F 689	Continued From page 15 to her bed and she tripped over the fall mat that was placed in front of her bed. The root cause of the fall was determined to be the resident had been left unattended and a fall mat created obstruction of movement for R47. R47 described a throbbing pain of 8/10 to the back of her head. R47 was assisted into a stretcher by two emergency response staff. The fall mat was removed from R47's room and education had been provided to NA by nursing staff. Review of an undated and untitled document included in the folder titled Final Report for R47's 6/11/20, fall identified by registered nurse (RN)-A as the pocket care plan in use by the NAs at the time the fall, instructed staff to not leave R47 alone in the bathroom. Further review of the document indicated no fall mat was planned for the resident. Review of the investigation summary for R47's 6/11/20, fall identified R47 was not to be left alone in the bathroom. The summary indicated previous fall interventions (low bed and fall mat) were discontinued in March due to R47 beginning to self-transfer in the evening hours as a fall mat and low bed would place R47 at increased risk for falls. On the evening of 6/11/20, R47 was noted to be self-transferring from her bed to the bathroom, direct care staff intervened and assisted her to the toilet. R47 was left alone in the bathroom while the direct care staff left to attend to another resident in the hallway. During that time, R47 attempted to get herself off of the toilet and transfer with her walker back to her bed. While doing so, R47 tripped over a fall mat that was on the floor and fell backwards hitting her head on the ground. Charge nurse performed a physical assessment and noted a deep laceration to her	F 689	designee will audit to ensure that smoking assessments are completed for R118 quarterly and PRN with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 689	Continued From page 16	F 689		

skull that was bleeding large amounts of blood. Order was obtained to transfer R47 to the ER (Emergency Room) for further assessment of the head injury. Charge nurse noticed immediately the floor mat was on the ground and asked direct care staff to review the care plan. It was noted the care plan was not followed by that specific staff member. Areas of the care plan that were not followed included: resident was left unattended in the bathroom and the floor mat was put down. Upon further interviewing, it was noted the direct care staff member stated she had not reviewed R47's care plan and put interventions in place she recalled from the previous time she worked with R47. R47 was admitted for observation in the hospital and was diagnosed with a scalp hematoma. Staples were placed in her head and she was sent back to facility.

An interview with RN-A on 3/09/22, at 11:11 a.m. revealed she did not recall the incident per se, however after reviewing R47's EMR stated the facility determined the resident's fall and subsequent injury were the result of the staff not following R47's care plan. RN-A indicated the facility determined the NA had not read the resident's care plan prior to providing care, which did not meet her expectation in terms of fall prevention.

The NA determined to have not followed R47's care plan no longer worked at the facility at the time of the survey and was unavailable for interview.

An interview with the administrator on 3/10/22, at 12:26 p.m. identified she had not been in her current role at the time of R47's fall, however it was her expectation staff would follow the care

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F 689	Continued From page 17 plans written for the residents, to include adequate supervision to prevent falls and structuring the resident's environment to minimize accident hazards. R45 Review of R45's Admission Record revealed she was most recently admitted to the facility on 9/16/20. Review of her diagnoses identified R45 had dementia without behavioral disturbances, a need for assistance with personal care, unspecified abnormalities of gait and mobility, and muscle weakness. Review of R45's quarterly MDS dated 12/23/21, revealed R45 was severely cognitively impaired. The MDS indicated R45 had no rejection of care or other behaviors; required extensive assistance of one staff person for transfers and toilet use; and was not steady and only able to stabilize with human assistance with moving on and off the toilet. The MDS identified R45 had two or more falls since the prior assessment and one of the falls resulted in an injury. Review of R45's care plan identified R45 was at risk for falls related to history of falls and dementia and instructed staff to offer the toilet every hour beginning on 9/16/20. The care plan indicated R45 transferred with stand by assistance of one staff. Review of form titled Third Floor Care Plan printed on 3/8/22, instructed staff to offer toileting every hour and as needed due to frequent attempts to self-transfer. Review of R45's Progress Notes from 9/29/21, to 3/8/22, revealed the following:	F 689		

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F 689	Continued From page 18	F 689		

R45 had falls with no injury attempting to get on or off the toilet on 9/29/21, at 11:30 a.m., 10/05/21, at 5:15 a.m., 12/03/21, at 7:40 p.m., 1/20/22, at 11:22 a.m. and 2/10/22, at 9:53 p.m.

A continuous observation of R45 on 3/08/22, between 2:26 p.m. and 5:00 p.m. (two and a half hours) revealed:

On 3/08/22, at 2:26 p.m. R45 was in her room. Her wheelchair was next to her bed, and she transferred without assistance from her bed to her wheelchair. At 2:28 p.m., R45 was seated in her wheelchair in the doorway to her room, peering out into the hallway. R45 remained there until 2:30 p.m., then stated to no one in particular she was going back into her room to watch a movie.

On 3/08/22, at 2:52 p.m. NA-B entered R45's room to freshen her water. NA-B did not offer R45 assistance to the toilet. At 2:54 p.m., NA-C entered R45's room looking for NA-B. R45 asked NA-C about items on her activity calendar. NA-C stated she would find out and NA-B and NA-C exited R45's room. NA-C returned to R45's room at 2:56 p.m. with the response to R45's question about activities and exited the room. NA-C was not observed to offer R45 assistance to the toilet.

On 3/08/22, at 3:01 p.m., NA-B, NA-A, and NA-C were noted to be outside R45's room. NA-B provided shift to shift report to NA-A and NA-C. NA-B stated R45 had been toileted.

On 3/08/22, at 3:56 p.m. R45 came to the door of her room in her wheelchair, saw NA-C and motioned her to her room. R45 asked NA-C what

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F 689	Continued From page 19	F 689		

time it was and what was for dinner. NA-C responded to R45's questions and left the room without offering the toilet.

On 3/08/22, at 5:00 p.m. licensed practical nurse (LPN)- B approached R45 as she sat in the doorway to her room in her wheelchair and offered to take her to dinner. R45 agreed and LPN-B wheeled R45 to the dining room. LPN-B was not observed to offer R45 the toilet.

An interview with NA-D on 3/09/22, at 11:00 a.m. NA-D stated she was one of the NAs responsible for R45's care that day and was familiar with R45's care needs. NA-D verified she had not offered R45 the toilet every hour because the resident took herself independently. NA-D stated she was unaware R45 had fallen getting to and from the toilet.

An interview with NA-E on 3/09/22, at 11:05 a.m. identified she was one of the NAs responsible for R45's care that day and was familiar with R45's care needs. NA-E confirmed she had not offered R45 the toilet every hour because she believed R45 took herself independently. NA-E stated she was unaware R45 had fallen getting to and from the toilet. NA-E indicated she became aware of each resident's care needs via verbal report from the previous shift, and from reading the care plan document the NAs received at the beginning of each shift. NA-E removed the days' care plan from her uniform pocket, and after reviewing it stated, "Oh, I guess I am supposed to help her. To be honest, I get a verbal report from the previous shift but because I know this resident, I don't always read the care plan."

An interview with RN-A on 3/9/22, at 11:11 a.m.

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F 689	Continued From page 20 who was the Resident Care Manager (RCM) for the third floor, identified it was her expectation the NAs working with R45 "follow the care plan. 100 percent. The only time they can do anything differently is if they think a resident needs more help than the care plan says. Then they can provide the help they think the resident needs, but they have to tell the charge nurse afterwards. They can never provide less, though." RN-A stated she was familiar with R45 and her fall history and had taken place in the Interdisciplinary Team (IDT) discussion where the determination was made to assist R45 to the toilet every hour. RNA stated, "She falls in the bathroom a lot. This was our plan to prevent further falls." When informed of the surveyor observation that the resident was not offered or assisted to use the toilet for two and a half hours, RNA stated, "That absolutely does not meet my expectation in any way, shape, or form." An interview with the administrator on 3/10/22, at 12:26 p.m. revealed it was her expectation the NAs would follow the resident care plans for fall prevention, and if the care plan was not followed the expectation was not met. Review of the facility's policy titled Falls revised 03/22, identified all residents would be assessed for fall risk and interventions implemented as appropriate. Review of the facility's policy titled Standards of Care revised 04/2021, identified each staff member providing direct nursing care would have in their possession throughout their shift the written plan of care for each resident and would perform specific cares.	F 689		

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F 689	Continued From page 21 SMOKING R118 Review of R118's annual MDS dated 2/03/22, indicated R118 was cognitively intact, and used tobacco products. Review of the 1/24/20, facility form titled Diagnosis revealed R118 had hemiplegia, unspecified affecting right dominant side, unspecified convulsions, tremor unspecified, and personal history of traumatic brain injury. Review of R118's care plan dated 1/24/20, revealed a focus area for a potential for safety concerns due to R118 going outside off property to smoke cigarettes. Education had been provided to R118 regarding the risks associated with this in which he reported he understood. The focus area identified a smoking assessment had been completed upon admission. R118 was able to light his own cigarette and able to handle the mechanics of smoking safely. Cigarettes and lighters were to be kept in the med [medication] cart and locked up. R118 was educated that staff needed to be present with him when he left to smoke and he needed to sign out with the nurses prior to leaving the building. Review of the 1/24/20, to 3/08/22, "Assessments" tab located in the EMR revealed no smoking or safety assessment to assess if resident was able to keep his smoking materials on his person. Review of the 1/30/20, admission note identified staff met with R118's wife to review admission paperwork. R118's wife handled business affairs and R118 was able to make day to day decisions but due to a brain injury wife handled finances.	F 689		

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F 689	Continued From page 22 R118 was a smoker and was aware the facility was a non-smoking campus. Wife had talked to R118 about that and she stated he understood. The staff reminded R118's wife to make sure the nurses kept his cigarettes and lighters. Review of the 12/28/21, communication note located in the EMR under the progress note revealed staff had a conversation with resident regarding smoking outside of facility. Staff discussed Eventide was a Smoke free facility and he could not smoke on Eventide property. Discussed that he had been observed smoking near building. R118 acknowledged he had been closer to building. Staff reiterated to R118 he could not do that. R118 verbalized understanding and then explained where he went to smoke, which was an accepted location not on property or in front of resident windows on 8th street. Staff stated it was getting colder, and he needed to wear appropriate clothing to go outside. R118 showed staff his hat, gloves, and coat. Staff encouraged R118 to limit his time outside when it was very cold and he verbalized understanding. Staff encouraged him to keep his phone on him when going outside and ensured wheelchair was powered. Staff strongly educated him that he needed to alert staff when going out, so staff were aware to check on him if needed. R118 verbalized understanding of the education. Review of the 6/15/21, communication note located in the EMR under the progress note revealed R118 was at 8th and 16th streets and was waving at cars to honk at him. Staff walked out and he was further down on 16th street away from busy traffic. When asked where he went to smoke, R118 stated 8th and 16th or 7th and 16th. Staff asked him to use the 7th and 16th streets	F 689		

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F 689	Continued From page 23 since it was less busy. R118 agreed. Review of the facility form titled List of Residents Who Smoke, located in the facility survey book, revealed "Designated Smoking Times, & Locations Eventide on 8th is a non-smoking campus and we don't have any residents who smoke." On 3/09/22, at 9:55 a.m., RN-B stated R118 went outside to smoke on a sidewalk off premises along the main street. RN-B stated R118 signed himself out and carried his cell phone. RN-B walked the surveyor close to the location and pointed R118 out as he sat in his electric wheelchair on the sidewalk by himself. On 3/09/22, at 1:05 p.m., R118 was observed in his electric wheelchair in his room placing a pack of cigarettes in his coat pocket. On 3/09/22, at 12:48 p.m., RN-A asked about a smoking assessment for R118. She confirmed there was not a smoking assessment for R118. During an interview on 3/09/22, at 3:12 p.m., RN-C stated R118 kept the smoking materials, cigarettes and lighter, on him. RN-C indicated she was unaware of any safety assessment for R118 except checking his clothes for burn marks. At 3:40 p.m., RN-C approached the surveyor and stated, "we don't do smoking assessments on R118 because we are a non-smoking facility and that's his business." "He goes off the property and keeps his cigarettes and lighter on his person." When asked to see R118's smoking materials, she stated "oh no, that's his business. You'll have to ask him."	F 689		

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F 689	Continued From page 24 On 3/09/22, at 3:42 p.m., R118 was observed in his room sitting in his electric wheelchair. R118 showed his pack of cigarettes and lighter to the surveyor after he was asked if he kept them. He stated his lighter was a "BIC lighter" (Pocket lighter made with isobutane fuel) and did not use matches. On 3/10/22, at 9:25 a.m., the sign-out book was reviewed again and the last sign-out day/time for R118 was 3/04/22, when R118's wife signed. Review of the facility's smoking policy, revised 11/2014, revealed it was Eventide's policy that all buildings and grounds were smoke-free. Purpose: To promote and maintain a safe and healthy environment for all residents, visitors, and employees. Procedure: 1. Residents and visitors may not smoke in the apartments, hallways, common areas, or on Eventide grounds. Anyone seen smoking would be asked to put their cigarette out immediately and be informed of the policy. 2. Residents/representatives were informed of the policy prior to signing a reservation agreement and again when signing a lease. 3. Failure of a resident to abide by the policy would result in an eviction notice.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		4/15/22

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F 690	Continued From page 25 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate catheter care for 1 of 2 (R5) residents reviewed for catheter cares. Findings include: R5's significant change Minimum Data Set (MDS) dated 2/18/22, identified R5 was cognitively intact and had a diagnosis of neuromuscular bladder dysfunction (urinary bladder problems due to	F 690	How corrective action will be accomplished for the resident(s) impacted: Nursing staff have been educated that R5□s catheter bag needs to remain below the level of the bladder at all times. How facility will identify other residents who have potential to be affected:	

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F 690	Continued From page 26 disease or injury of the central nervous system or peripheral nerves involved in the control of urination). The MDS indicated R5 required assistance with bed mobility, dressing, toileting, and personal hygiene. Additionally, the MDS identified R5 had an indwelling catheter. R5's care plan revised 11/6/20, identified R5 was at risk for infection related to suprapubic (SP) catheter placement due to neuromuscular bladder dysfunction. The care plan directed staff to maintain patency of the catheter and to keep the bag below the level of R5's bladder. Additionally, the care plan directed staff to provide catheter care per facility policy. During an observation on 3/8/22, at 2:52 p.m. R5 was observed lying in bed with the head of her bed elevated to 45 degrees. R5 lifted her left pants leg to show her catheter leg bag and stated the nursing assistants had emptied the bag "a little bit ago". There was approximately 100 milliliter (ml) of clear yellow urine. The foot of R5's bed was elevated which caused R5's leg bag to be above the level of her bladder. R5 stated she always wore her leg bag while in bed and was unaware the catheter bag should have been positioned below the level of her bladder to promote drainage. During an observation on 3/8/22, at 4:54 p.m. nursing assistant (NA)-Q was observed to empty R5's catheter leg bag after assisting R5's transfer from her bed to her wheelchair. NA-Q obtained a graduated cylinder from R5's bathroom and cleaned the port of R5's catheter leg bag with an alcohol swab. After draining the bag and measuring the urine, NA-Q disposed of the urine in R5's toilet. NA-Q then rinsed the graduated	F 690	All residents who have catheters in the facility have the potential to be affected. The DON or designee has determined all residents who have catheters and provided education to nursing staff regarding catheter bag placement. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education will be completed for nursing staff regarding the need for catheters to be placed below the level of the bladder at all times. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: DON or designee will perform 10 audits a month for three months and 5 audits a month for 9 months on appropriate catheter bag placement with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 690	Continued From page 27 cylinder and placed it on the back of the toilet to dry. During an interview at 4:47 p.m. NA-Q stated she did not know if R5's leg bag had been below the level of R5's bladder when she was lying in bed. NA-Q indicated she began working at the facility a few months prior and had been trained by her fellow nursing assistants to lay R5 down with the catheter leg bag attached to her leg. NA-Q indicated she had not received education on ensuring R5's catheter leg bag was below the level of the bladder. During an interview on 3/8/22, at 5:48 p.m. licensed practical nurse (LPN)-G stated nursing had not been removing or ensuring R5's catheter leg bag was below the level of the bladder when lying down. During an interview on 3/9/22, at 3:22 p.m. LPN-D stated it was her expectation the staff should always change R5's catheter leg bag to a catheter bed bag whenever she laid down because the catheter leg bag would not be maintained below the level of the bladder which had the potential to cause the urine to flow back into R5's bladder. During an interview on 3/9/22, at 3:27 p.m. registered nurse (RN)-B stated when R5 was assisted to bed, the nursing assistant was expected to change the catheter leg bag to a catheter bed bag and ensure the bag was below the level of R5's bladder. RN-B indicated R5's care plan directed staff to maintain R5's catheter bag below the level of the bladder and staff were expected to follow R5's care plan.	F 690		

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F 690	Continued From page 28 During an interview on 3/11/22, at 11:54 a.m. the director of nursing (DON) stated staff were expected to maintain all catheter bags below the level of the bladder to promote drainage and, additionally, were expected to follow the care plan for catheter care. During an interview on 3/11/22, at 12:04 p.m. the administrator stated she expected staff to follow the care plan for catheter care. The facility policy Catheter - Suprapubic revised 6/2021, directed staff to maintain a clean and patent catheter drainage system and to continuously drain the bladder.	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers'	F 700		4/15/22

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F 700	Continued From page 29 recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete all required components of the side rail assessments for one of one resident reviewed for side rails (R25). This deficient practice had the potential to create an accident and hazard for R25. Findings include: Review of R25's quarterly Minimum Data Set (MDS) dated 12/11/21, revealed R25 was admitted on 09/26/17, had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which identified R25 was moderately cognitively impaired. The MDS identified R25 required extensive assistance of one staff for bed mobility, transfers, and toileting, and side rails were not used. Review of R25's care plan revised 2/10/22, identified R25 had skin breakdown related to impaired mobility and indicated R25 required assist of one staff with bed mobility. The care plan revealed R25 had bilateral half side rails in place for R25 to use to assist with bed mobility and transfers. On 3/07/22, at 2:05 p.m. R25 was observed sitting in her wheelchair in her room eating popcorn. R25's bed was observed with 1/4 length size side rails up on both sides of the head of the bed. On 3/10/22, at 12:15 a.m. R25 was observed in bed asleep with 1/4 length size side rails up on	F 700	How corrective action will be accomplished for the resident(s) impacted: Eventide has created a new half side rail policy and a new half side rail assessment that includes missing elements. The half side rail assessment will be completed on all residents who currently use half side rails. The facility has identified all residents who currently use half side rails and adjustments will be made as needed based off of new assessments. How facility will identify other residents who have potential to be affected: All residents in the facility who utilize half side rails have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education will be provided for all nursing staff on the new half side rail policy and assessment. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: DON or designee will perform 10 audits a month for three months and 5 audits a month for 9 months on appropriate use of	

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F 700	Continued From page 30 both sides of the head of the bed. Review of R25's facility form titled Half Side Rail Evaluation & Consent dated 6/07/21, revealed a top section with Yes or No questions for: Bed Mobility that included: Turning side to side- Yes, Moving up and down in bed- Yes, Holding self to one side- Yes, Pulling self from lying to sitting position- No, Transfer- No, Improving Balance- Yes, Supporting Self- Yes, Exiting Bed- No, and Entering Bed- No Review of R25's facility form titled Half Side Rail Evaluation & Consent dated 3/07/22, revealed a top section with Yes or No questions for: Bed Mobility that included: Turning side to side- Yes, Moving up and down in bed- No, Holding self to one side- Yes, Pulling self from lying to sitting position- No, Transfer- No, Improving Balance- Yes, Supporting Self- Yes, Exiting Bed- No, and Entering Bed- Yes The bottom section included consent for half side rails, and indicated benefits, & alternatives had been discussed with the resident/resident representative & they consented to placement. The side rail evaluations lacked documentation of the following required components: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical	F 700	half side rails and half side rail assessments with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 700	Continued From page 31	F 700		

interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication, or risk of falling.

Review of R25's progress notes from 6/07/21, to 3/07/22, lacked documented alternatives to side rails as well as an evaluation of: medical diagnosis, conditions, symptoms, and/or behavioral symptoms, size and weight, sleep habits, medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication, or risk of falling.

Review of R25's fall risk assessment dated 3/07/22, identified R25 scored an 11, which indicated R25 was at high risk for falls.

During an interview on 3/09/22, at 12:48 p.m. registered nurse (RN)-A stated no copies of side rail documents were kept. RN-A indicated the evaluation document was scanned and included the consent as well as risks and benefits which were located on the bottom of the form. RN-A confirmed the evaluation only included a bed mobility evaluation. RN-A stated the risks and benefits and alternatives were provided to the person giving consent however, no alternatives were documented. RN-A indicated she was not aware of the other requirements listed above.

During an interview on 3/11/22, at 10:20 a.m. RN-D stated the decision to use side rails was based on the resident's care plan, the side rail evaluation, and BIMS. RN-D confirmed she was unaware of other requirements for side rail assessment which included: medical diagnosis, conditions, symptoms, and/or behavioral symptoms; size and weight, sleep habits,

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F 700	Continued From page 32 medication(s), acute medical or surgical interventions, underlying medical conditions, existence of delirium, ability to toilet self safely, communication, or risk of falling. During an interview on 3/11/22, at approximately 5:30 p.m. the director of nursing (DON) confirmed the facility's side rail evaluation lacked the required components as specified above. Review of the facility's policy titled Restraint Utilization policy, revised March 2017, revealed if the resident did not use the half side rail(s) as a means of improving or assisting their mobility, then the half side rail(s) would be considered a restraint and the procedure for restraints would be followed. The policy identified a potential risk of using half side rails included: skin bruising, cuts, and scrapes and strangling suffocating, bodily injury, or death when residents or part of their body were caught between rails or between the rails and the mattress.	F 700		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/15/22

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F 880	Continued From page 33 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 34 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors; and failed to conduct an annual review of its Infection Prevention and Control Program. This deficient practice had the potential to affect all 134 residents residing in the facility. Findings include: During an interview on 3/10/22, at 2:23 p.m. the director of nursing (DON) who was also the interim infection preventionist (IP) stated the facility did not have a surveillance system, infection log or line listing of infections in the building to track and trend infections. Additionally, the DON stated staff had to go into the electronic medical record and search through progress notes in order to see if a resident had tested positive for COVID-19. During an interview on 3/10/22, at 3:28 p.m. the administrator confirmed the facility lacked	F 880	How corrective action will be accomplished for the resident(s) impacted: We have an infection tracking system in our electronic medical record for residents that helps, identify, report and investigate infections. This has been updated to capture current information. The Infection Prevention and Control program has been reviewed and updated as needed in April of 2022. The Infection Preventionist or designee will monitor and follow up as needed. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 880	Continued From page 35 documentation of a line listing, infection or surveillance log for COVID-19 positive infections or for any other infections for 2021, or 2022. During a follow-up interview on 3/10/22, at 3:43 p.m. with DON, she confirmed she had not been tracking or trending any infections in the facility. During a follow-up interview on 3/10/22, at 5:15 p.m. with the administrator, she stated she was not aware the facility wide Infection Control Policy was required to be updated annually. The administrator confirmed the "Infections, Monitoring, and Surveillance Plan" had last been revised May 2017. Review of facility policy titled, Infections, Monitoring, and Surveillance Plan, revised May 2017, identified the facility was to ensure infections were monitored, and data collected for the purpose of identifying baseline information regarding frequency, type of infection, and organism involved in an effort to permit rapid identification of appropriate treatment, identify potential outbreaks and institute control measures.	F 880	Education was provided to the administrator and DON or designee on using the electronic medical record to track current and potential infections. The orientation checklist for the Infection Preventionist was reviewed and updated as needed and it was ensured that all tasks were assigned. Education has been provided to nursing staff on the Infection Prevention and Control feature of our electronic medical record. A root cause analysis was completed on F880 and the causes of this deficiency were identified and interventions have been put into place to prevent future reoccurrence. The Infection Monitoring and Surveillance policy was reviewed in May of 2021, but was not revised, so the revision date was not changed. This policy was reviewed in April 2022 and was updated with the revision date. The infection prevention and control program was reviewed and updated as needed in April of 2022. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Infection Preventionist or designee will audit all infection tracking for one month, ten infections for three months,	

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F 880	Continued From page 36	F 880	and five infections for 8 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program with established protocols to help in reducing unnecessary antibiotic use and resulting in the potential of drug resistance. The program also lacked documentation of appropriate antibiotic use along with education provided to staff and residents on antibiotic stewardship. The deficient practice had the potential to affect all 134 residents who resided in the facility. Findings include: During an interview on 3/11/22, at 10:42 a.m., with licensed practical nurse (LPN)-E identified if	F 881	How corrective action will be accomplished for the resident(s) impacted: Additional signs and symptoms and appropriate lab and diagnostic testing cannot be completed for infections that occurred during the survey. All residents with current infections will be reviewed to ensure prescribed antibiotics have signs and symptoms documented and, if appropriate, all diagnostic testing and labs were performed. How facility will identify other residents who have potential to be affected:	4/15/22

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F 881	Continued From page 37 a resident developed signs/symptoms (S/S) of a potential infection, between the hours of 8:00 a.m. - 5:00 p.m. the primary provider was contacted with an update and to obtain orders, however if it was after 5:00 p.m., staff were to contact the on call provider, communicate the resident's S/S and request input/or direction and proceed from that point. LPN-E stated when a resident received orders for an antibiotic it was logged in a book which was maintained at the nursing station and highlighted once the ordered antibiotic was completed. LPN-E indicated staff were expected to complete a daily note in Point Click Care (PCC) which was titled antibiotic and included a resident's S/S, vital signs, the medication, and the rationale for the medication, if the resident was improving and any suspected reactions to the medication. LPN-E stated documentation continued on a daily basis until the medication regime was completed. LPN-E reported the log was kept to remind staff of the need for daily documentation and nothing was done with the information following completion of the medication. LPN-E identified the facility did not have specific criteria that was to be met prior to obtaining orders for an antibiotic. LPN-E stated with regard to treatment of a urinary tract infection (UTI), staff would attempt to offer cranberry juice and push fluids, however she was not aware of any specific criteria that was to be met prior to use of an antibiotic. During an interview on 3/11/22,at 10:54 a.m. with registered nurse (RN)-A when a resident developed S/S of a UTI, the provider was contacted and it was based on their decision if an antibiotic was ordered. RN- identified she was not aware of any specific criteria that was to be met prior to an antibiotic being prescribed.	F 881	All residents in the facility who develop symptoms of an infection have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to all staff about documenting and communicating current signs and symptoms of a potential infection, updating providers, and requesting pertinent diagnostic labs and testing prior to ordering an antibiotic. Infection Preventionist or designee will monitor documentation of signs and symptoms of infection in the medical record and ensure appropriate lab or diagnostic testing was completed. Providers will be updated with lab or diagnostic results to facilitate an appropriate course of treatment. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Infection Preventionist or designee will audit criteria for infections and appropriate antibiotic use for one month, ten infections for three months, and five infections for 8 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the	

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F 881	Continued From page 38 During an interview on 3/11/22, at 11:12 a.m. with the director of nursing (DON), identified McGeers criteria was utilized by the provider to determine if an antibiotic was indicated for S/S of a UTI. DON indicated nursing staff were expected to update the provider and it was up to them if they wanted to order additional tests, or an antibiotic. The DON stated the facility did not have a format or process that was utilized prior to contacting the provider with a resident's S/S and it was the decision of the provider if they wanted to request additional testing or order an antibiotic. The DON who is the acting Infection Preventionist (IP), identified the only tracking being completed was the documentation that was done daily in PCC. The DON indicated she had provided education to the nursing staff on documentation points as to what and when to document when the provider was updated and if orders were received. During an interview on 3/11/22, at 12:59 p.m. with the NP identified a resident needed to meet criteria before an antibiotic was ordered, however there was not a policy or procedure in writing that she was aware of. NP stated she would expect the IP or DON to be responsible for following up on the process, however she was not aware of what was being done at the current time in the facility. Review of the facility policy on Antibiotic Stewardship identified the medical director the physician champion for antibiotic stewardship. Nursing was expected to evaluate and communicate clinical signs and symptoms when a resident was suspected of having an infection while encouraging diagnostic testing. The infection preventionist was to be responsible for	F 881	monitoring results to the QA committee at the quarterly meeting.	

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F 881	Continued From page 39 infection surveillance and tracking in addition to collecting and review of data. Education opportunities would be provided for clinical staff in addition to residents and families on appropriate use of antibiotics.	F 881		
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to inform residents, resident representatives, and families of suspected or	F 885	How corrective action will be accomplished for the resident(s) impacted:	4/15/22

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F 885	Continued From page 40 confirmed COVID-19 cases in the facility when they were identified for 13 of 26 notification opportunities. This failure had the potential to affect all 134 residents and resident representatives of the facility. Findings include: During an interview on 3/10/22, at 2:23 PM with the director of nursing (DON) who was also the Interim Infection Preventionist (IP), she stated the nursing staff were responsible for notifying residents and representative of positive COVID-19 cases in the facility and add a note to the residents' medical record. The DON indicated the administrator sent an email request to the Department of Health Operations Center to have an Everbridge (an enterprise software company that offers applications which provide information about critical events to help with personal safety and business continuity) notification sent. Review of a National Healthcare Safety Network (NHSN) report, provided by the facility to the survey team on 3/10/22, revealed seven incidences of positive COVID-19 results for residents during the month of January 2022. Review of the administrator's emails to The Department of Health Operations Center revealed the facility did not report two of those incidences within the required timeframe. A review of a list of staff who had tested positive for COVID-19 was reviewed 3/10/22, for the months of January 2022 and February 2022. During those months, there were 19 incidences of positive COVID-19 results. Review of the administrator's emails to The Department of Health Operations Center revealed the facility did not report 11 of those incidences within the	F 885	An updated notice was sent to residents' representatives on 4/4/22 indicating COVID-19 case counts in the facility for January, February, and March 2022. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education was provided to administrator or designee explaining that residents and representatives need to be notified by 5pm the next calendar day of a single occurrence of COVID-19 or if there are three or more residents or staff who develop symptoms of COVID-19 within 72 hours of each other. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The administrator or designee will conduct an audit of staff and resident COVID-19 case notifications after each positive test result for one month with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly	

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F 885	Continued From page 41 required timeframe for the notifications to be sent out to residents and their representatives. During an interview on 3/10/22, at 5:49 p.m. with the administrator, she stated she sent on email to The Department of Health Operations Center, requesting an Everbridge notification to be sent to resident and representatives when there were positive cases at the facility. The administrator confirmed she had not requested notifications to be sent out to the residents and their families/representatives for all positive COVID-19 cases. Review of Center for Medicare and Medicaid Services QSO-20-29-NH Memo titled, " Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes", dated May 6, 2020, stated the facility must inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.	F 885	meeting.	
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886		4/15/22

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F 886	Continued From page 42 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the	F 886		

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	245461	A. BUILDING _____ B. WING _____	C 03/11/2022

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F 886	Continued From page 43 transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure unvaccinated staff were tested as required for COVID-19 for seven of seven unvaccinated staff reviewed. This deficient practice had the potential to affect all 134 residents residing in the facility and staff and increased their risk of COVID-19 exposure. Findings include: Review of a list of facility unvaccinated staff, provided to the survey team by the facility on 3/09/22, was completed. The list included the following staff: licensed practical nurse (LPN)-B, nursing assistant (NA)-P, NA-N, and facilities technician (FT)-C. During an interview on 3/10/22, at 2:23 p.m. the director of nursing (DON) who was also the Interim Infection Preventionist (IP) and confirmed she was responsible tracking required testing of employees. DON stated the community transmission rate was high. The DON indicated unvaccinated staff were tested for COVID-19	F 886	How corrective action will be accomplished for the resident(s) impacted: The facility is unable to go back and collect specimens from unvaccinated employees to test according to community transmission rates. Once this practice was noticed, all unvaccinated staff were tested prior to their next shift. How facility will identify other residents who have potential to be affected: All residents in the facility have the potential to be affected. Residents were monitored for symptoms of COVID-19 and providers were updated as needed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A COVID-19 testing spreadsheet has	

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F 886	Continued From page 44 twice a week at an offsite location of their choice. The DON stated the unvaccinated staff were expected to send their results to the facility. The DON stated the staffing coordinator (SC) then filed the results in the staff's personnel file. The DON indicated nothing further was done with those results and confirmed the facility did not keep track of how often the unvaccinated staff tested to ensure they were tested twice weekly. The DON stated LPN-B and NA-N sent their COVID-19 testing results to the staff phone however was unsure if these unvaccinated staff were being tested twice per week as required. When asked if NAP had been tested twice per week because she had worked intermittently while on leave, the DON stated this staff was on maternity leave. When asked if FTC had been testing twice per week, the DON stated his results were sent to a different department and she would retrieve those testing results. During an interview on 3/10/22, at 3:32 p.m. with the SC, she stated the nursing staff were required to send COVID-19 testing results to the staffing phone. The SC indicated after she had received the results, she printed and filed them in the staff's personnel file. The SC stated she was trained to file the results however did not track the results. The SC indicated she had only received results for LPN-B and NA-N however could not confirm if they had been tested twice a week. During a follow-up interview on 3/10/22, at 3:43 p.m. with the DON, she confirmed she had not been tracking to ensure unvaccinated staff, with exemptions, were tested twice per week for COVID-19 as required. During a follow-up interview on 3/10/22, at 4:23 p.m. with the DON, she stated she reviewed all	F 886	been implemented to track the testing frequency and compliance of all staff who are not up-to-date with their COVID-19 vaccination. The Infection Preventionist or designee is responsible for test tracking. If the employee does not complete testing according, the employee□s supervisor will be notified and the employee will be removed from the schedule until testing is completed and results are received by the facility. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Infection Preventionist or designee will audit each testing event tracking for one month, four test events per month for 3 months, and one test event for 8 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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F 886	Continued From page 45 documentation and NA-P had never sent in testing results. During an interview on 3/10/22, at 5:49 p.m. with the administrator, she stated unvaccinated staff had been sending in their results however she had just been made aware the facility was not tracking those results. The administrator indicated she had instructed SC to retrieve testing results for LPN-B, NA-N, and FTC. The administrator confirmed the facility had not tracked NA-P's testing results. The administrator stated FTC and NA-N should have been tested twice per week due to not having received any doses of the vaccine. The administrator indicated NA-P had received one dose of the COVID-19 vaccine and tested positive for COVID-19 on 11/22/21, and was no longer in the 90-day window. The administrator stated LPN-B had not received any doses of the COVID-19 vaccine and should have been tested twice per week. The administrator indicated LPN-B had tested positive on 12/06/21, and was no longer in the 90-day window. The administrator confirmed the facility could not verify LPN-B and NA-P were being tested for COVID-19 per the requirements. The administrator confirmed there was no process in place at the time for tracking the testing of unvaccinated staff. Review of facility's unvaccinated staff's COVID-19 testing results, provided to the survey team by the facility, for the period of November 2021, to March 2022, revealed the following: 1. The facility was able to provide documentation LPN-B submitted testing results to the facility six times (five submissions in November 2021, and one submission in December 2021). Per the	F 886		

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administrator, LPN-B tested positive for COVID-19 on 12/06/21. LPN-B should have submitted test results nine times during the month of November 2021 and should have begun testing again in March 2022.

2. The facility was able to provide documentation FTC submitted testing results to the facility twice in February 2022. The facility was unable to provide any additional testing results for FTC. The FTC should have submitted testing results 39 times during the review period (nine submissions in November 2021; nine submissions in December 2021; nine submissions in January 2022; eight submissions in February 2022; four submissions in March 2022) however, there was no documented evidence this occurred.

3. The facility was able to provide documentation NA-N submitted testing results to the facility nine times during the review period (one submission in November 2021; three submissions in December 2021; one submission in January 2022; three submissions in February 2022; one submission in March 2022.) NA-N should have submitted testing results 39 times during the review period however, there was no documented evidence this had occurred.

4. The facility was unable to provide any documentation of testing results for NA-P.

During an interview on 3/11/22, at 10:30 a.m. with NA-N, he stated he was unvaccinated with a religious exemption. NA-N indicated the facility had instructed him to wear an N95 mask, face shield, and to test twice weekly. NAN stated he was tested at an offsite location and sent the test

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results to a staffing phone number. NA N confirmed he had tested twice weekly due to working ten-hour shifts and the offsite location was not open during his available hours.

During an interview on 3/11/22, at 10:46 a.m. with NA-P, she stated she received one dose of the COVID-19 vaccine however then became pregnant and did not receive the second dose of the vaccine. NA-P stated she had not tested positive for in November 2021, however instead she had been positive in November 2020. NA-P indicated she had been instructed to test only before her shift due to working as needed. NA-P stated she had tested as she had been instructed however had not submitted her test results due to no longer having the staffing phone number that had been provided by her supervisor. NA-P indicated she had never requested an exemption for the vaccine.

Review of a list of facility's unvaccinated contract staff, provided to the survey team by the administrator on 3/10/22, revealed the following:

The list included the following staff: occupational therapist (OT)-G, speech therapist (ST)-H, and nurse practitioner (NP)-F. At the time the list was provided, the administrator confirmed the facility did not maintain the test results for contracted staff.

During an interview on 3/11/22, at 11:54 a.m., OT-G stated she had not been vaccinated and had a medical exemption. OT-G indicated the facility instructed her she would need to be tested twice a week, on Mondays and Thursdays. OT-G stated she had tested positive for COVID-19 on 11/2/21 and was told she did not have to test for

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90 days. OT-G stated prior to her positive COVID-19 results, she tested twice per week at an offsite location and sent her results to the facility's admissions office. OT-G indicated she was supposed to begin testing twice a week in February however did not test until last week. OTG stated she had forgotten about the testing and had not been reminded by the facility. OT-G indicated she worked about six hours per day, Monday - Friday.

During an interview on 3/11/22, at 12:11 p.m., therapy director (TD)-I, stated OT-G worked daily, Monday- Friday and ST-H worked approximately twice per month. TD-I stated both OT-G and ST-H were unvaccinated and should have been tested twice per week.

During an interview on 3/11/22, at 12:50 p.m. with Vice President of Human Resources (VPHR) of Blue Stone Therapy, he stated OT-G and ST-H both were unvaccinated and had exemptions. VPHR stated OT-G and ST-H were expected to follow facility policies and wear N95 masks, face shields and test twice per week.

During an interview on 3/11/22, at 12:55 p.m. with ST-H, she stated she was unvaccinated and had a medical exemption. ST-H indicated she had been instructed to wear a N95 mask, face shield, test twice per week, and send testing results to TD-I. ST-H confirmed she had not been testing twice weekly as required.

Review of timecards of unvaccinated facility staff, for the period of November 2021, to March 2022, provided to the survey team by the facility on 03/11/22, revealed the following:

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F 886	Continued From page 49 1. The facility provided documentation LPN-B had worked 11 days in November 2021; four days in December 2021; eight days in January 2022; three days in February 2022; and four days in March 2022. 2. The facility provided documentation FTC had worked 20 days in November 2021; 22 days in December 2021; 21 days in January 2022; 21 days in February 2022; and six days in March 2022. 3. The facility provided documentation NA-N had worked 14 days in November 2021; 20 days in December 2021; 21 days in January 2022; 20 days in February 2022; and seven days in March 2022. 4. The facility provided documentation NA-P had worked three days in November 2021; five days in December 2021; one day in January 2022. NAP did not work in February or March 2022. Review of timecards of unvaccinated contract staff, for the period of November 2021, to March 2022, provided to the survey team on 03/11/22, revealed the following: 1. The facility provided documentation OTG had worked 20 days in November 2021; 24 days in December 2021; 17 days in January 2022; 18 days in February 2022; and nine days in March 2022. 2. The facility provided documentation ST-H had worked seven days in November 2021; five days in December 2021; two days in January 2022; three days in February 2022. STH did not work in March 2022	F 886		

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F 886	Continued From page 50 The facility was unable to provide testing results for unvaccinated contract staff OT-G or ST-H. The facility did not provide testing results or timecards for unvaccinated contract staff NP-F. Review of facility policy titled Eventide COVID-19 Testing Policy revised May 2021, identified if an employee had completed COVID-19 testing outside of Eventide's mass employee testing (i.e.: through another job or at a clinic), the employee would discuss with their manager in advance to ensure appropriate testing was completed as required by the MN/ND Department of Health and CMS. The employee would be required to provide documentation of the test result from the other facility to Eventide.	F 886		
F 888 SS=F	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:	F 888		4/15/22

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F 888	Continued From page 51 (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the	F 888		

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F 888	Continued From page 52 transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the	F 888		

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F 888	Continued From page 53 recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unvaccinated staff adhered to additional precautions that were intended to mitigate the spread of COVID-19. This deficient practice had the potential to affect all 134 residents residing within the facility. Findings include: Review of a list of unvaccinated contract staff provided by the facility identified occupational therapist (OT)-G as unvaccinated.	F 888	How corrective action will be accomplished for the resident(s) impacted: OT-G was notified by Blue Stone that her N-95 exemption was denied and OT-G was instructed to wear an N-95 and eye protection while in the facility. All other unvaccinated staff were educated on additional precautions they need to take while working in the facility. How facility will identify other residents	

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F 888	Continued From page 54 Review of the timecards of unvaccinated contract staff, for the period of November 2021, to March 2022, was completed on 3/11/22. The facility provided documentation OT-G worked 18 days in February 2022; and nine days in March 2022. The facility was unable to provide testing results for unvaccinated contract staff OT-G. During an observation and interview on 3/11/22, at 11:54 a.m., OT-G was observed to wear a face shield and a blue surgical mask. OT-G stated she was not vaccinated; however, she had a medical exemption. OT-G stated the facility instructed her she would need to be tested twice a week, on Mondays and Thursdays. OT-G indicated she tested positive for COVID-19 on 11/02/21 and was told she did not have to test for 90 days. OT-G stated she was supposed to start testing twice a week back in February 2022, however did not begin testing until last week. OT-G indicated she had forgotten about testing and had not been reminded by the facility. OT-G stated the facility instructed her to wear a face shield and an N95 mask. OT-G stated she requested an exemption for the N95 mask through her employer (Blue Stone Therapy) however was not aware if the exemption for the mask had been approved. OT-G stated, "I decided to wear the surgical mask for my own health reasons, and I haven't been told otherwise." OT-G indicated she worked about six hours per day, Monday through Friday. During an interview on 3/11/22, at 12:11 p.m., the therapy director (TD)-I stated OT-G had requested an exemption for the N95 masks, however she was not aware if the request had been approved. TD-I confirmed OT-G wore a surgical mask instead of the required N95 mask.	F 888	who have potential to be affected: All residents in the facility have the potential to be affected. Residents were monitored for symptoms of COVID-19 and providers were updated as needed. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Education has been provided to all staff who are not vaccinated regarding the additional precautions they need to take to be compliant. How the facility will monitor its corrective actions to ensure that the deficient practice is corrected and will not recur: The Infection Preventionist or designee will audit to ensure unvaccinated staff adhere to additional precautions three times per week for one month, once a week for three months, and 4 observations per month for 8 months with additional audits as recommended by the QA committee. If concerns are identified, immediate corrective action will be implemented. The Infection Preventionist or designee will submit a report of the monitoring results to the QA committee at the quarterly meeting.	

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	245461	A. BUILDING _____ B. WING _____	C 03/11/2022

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

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F 888	Continued From page 55 During an interview on 3/11/22, at 12:50 p.m. with Vice President of Human Resources (VPHR) of Blue Stone Therapy, he stated OT-G was expected to follow facility policies and wear N95 masks, face shields and test twice per week. The VPHR indicated OT-G had requested an accommodation on 11/09/21, for the N95 mask however had not been approved. Review of facility policy titled, COVID-19 Vaccine-Employee, revised 11/21, identified if an employee had been granted an exemption, they would be required to wear a N95 and eye protection until the public health emergency ended. The policy indicated all employees were required to be fully vaccinated with the COVID-19 vaccine.	F 888		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2022

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

Re: State Nursing Home Licensing Orders
Event ID: IN3111

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 11, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Rd., Suite 300
Fergus Falls, Mn. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00072	A. BUILDING: _____ B. WING _____	C 03/11/2022

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/7/22, to 3/11/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued:	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5461074C (MN69785), with a licensing order issued at 0830. H5461078C (MN65201), with a licensing order issued at 0830. H5461080C (MN62557), with a licensing order issued at 0830. AND/OR The following complaints were found to be SUBSTANTIATED, however, NO licensing orders were issued: H5461075C (MN68124) H5461077C (MN65927) H5461079C (MN63063) H5461081C (MN62055) H5461082C (MN60984) H5461083C (MN59197) H5461084C (MN55835) H5461086C (MN67366) AND/OR The following complaints were found to be UNSUBSTANTIATED: H5461072C (MN74613) H5461073C (MN71997) H5461076C (MN68036) H5461085C (MN51516) Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. 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	2 000		

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2 000	Continued From page 2 appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors 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 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. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		4/15/22

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2 830	Continued From page 3 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents were free from accident and hazards as possible for three of 10 residents (R47, R45 and R118) reviewed for accidents. Additionally, the facility failed to provide adequate supervision to prevent falls for R47 and R45; and failed to assess R118 for smoking safety measures. Findings include: FALLS R47 Review of R47's undated Admission Record identified she had been admitted to the facility on 09/23/19. Review of her diagnoses indicated R47 had a history of falling upon admission, adult failure to thrive, other symptoms and signs involving cognitive functions and awareness, anxiety disorder, other abnormalities of gait and mobility, macular degeneration, and dizziness	2 830	Corrected	

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2 830	Continued From page 4 and giddiness. Review of R47's quarterly Minimum Data Set (MDS) dated 4/01/20, identified R47 was cognitively intact. The MDS indicated R47 required limited assistance of one staff for transfers and walking in her room; extensive assistance of one staff for toilet use and personal hygiene; was not steady but able to stabilize herself when moving from a seated to standing position and moving on and off the toilet. Review of R47's care plan revealed a care plan intervention of mat on the floor next to bed, initiated on 09/23/19, and resolved on 03/08/20. The care plan indicated R47 was at high risk for falls due to history of falls and history of self transferring. The care plan identified R47 required stand by assist of one with transfers. Review of R47's form titled Fall Risk Predictive Factors, dated 3/26/20, revealed R47 scored 15, indicating she was at high risk for falls. Specifically, the resident triggered for diminished safety awareness, impaired mobility, balance problems while standing and walking, being legally blind, taking medications with known adverse reactions of falls, and having disease processes which contributed to falls. Review of R47's progress notes from 6/11/20, to 6/12/20, revealed the following: -6/11/20, at 8:00 p.m. indicated R47 was found on the floor in her room with "a cut and swelling to the back of the head." -6/12/20, at 10:34 a.m., late entry identified staff found resident lying on the floor with head facing the closet. A laceration and swelling of three cm	2 830		

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2 830	Continued From page 5 (centimeters) by two cm was noted to the back of the left lower part of her head. Resident was being toileted, and nursing assistant (NA) left resident in the bathroom and went to assist another resident. R47 attempted to self-transfer to her bed and she tripped over the fall mat that was placed in front of her bed. The root cause of the fall was determined to be the resident had been left unattended and a fall mat created obstruction of movement for R47. R47 described a throbbing pain of 8/10 to the back of her head. R47 was assisted into a stretcher by two emergency response staff. The fall mat was removed from R47's room and education had been provided to NA by nursing staff. Review of an undated and untitled document included in the folder titled Final Report for R47's 6/11/20, fall identified by registered nurse (RN)-A as the pocket care plan in use by the NAs at the time the fall, instructed staff to not leave R47 alone in the bathroom. Further review of the document indicated no fall mat was planned for the resident. Review of the investigation summary for R47's 6/11/20, fall identified R47 was not to be left alone in the bathroom. The summary indicated previous fall interventions (low bed and fall mat) were discontinued in March due to R47 beginning to self-transfer in the evening hours as a fall mat and low bed would place R47 at increased risk for falls. On the evening of 6/11/20, R47 was noted to be self-transferring from her bed to the bathroom, direct care staff intervened and assisted her to the toilet. R47 was left alone in the bathroom while the direct care staff left to attend to another resident in the hallway. During that time, R47 attempted to get herself off of the toilet and transfer with her walker back to her bed. While	2 830		

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2 830	Continued From page 6	2 830		

doing so, R47 tripped over a fall mat that was on the floor and fell backwards hitting her head on the ground. Charge nurse performed a physical assessment and noted a deep laceration to her skull that was bleeding large amounts of blood. Order was obtained to transfer R47 to the ER (Emergency Room) for further assessment of the head injury. Charge nurse noticed immediately the floor mat was on the ground and asked direct care staff to review the care plan. It was noted the care plan was not followed by that specific staff member. Areas of the care plan that were not followed included: resident was left unattended in the bathroom and the floor mat was put down. Upon further interviewing, it was noted the direct care staff member stated she had not reviewed R47's care plan and put interventions in place she recalled from the previous time she worked with R47. R47 was admitted for observation in the hospital and was diagnosed with a scalp hematoma. Staples were placed in her head and she was sent back to facility.

An interview with RN-A on 3/09/22, at 11:11 a.m. revealed she did not recall the incident per se, however after reviewing R47's EMR stated the facility determined the resident's fall and subsequent injury were the result of the staff not following R47's care plan. RN-A indicated the facility determined the NA had not read the resident's care plan prior to providing care, which did not meet her expectation in terms of fall prevention.

The NA determined to have not followed R47's care plan no longer worked at the facility at the time of the survey and was unavailable for interview.

An interview with the administrator on 3/10/22, at

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2 830	Continued From page 7 12:26 p.m. identified she had not been in her current role at the time of R47's fall, however it was her expectation staff would follow the care plans written for the residents, to include adequate supervision to prevent falls and structuring the resident's environment to minimize accident hazards. R45 Review of R45's Admission Record revealed she was most recently admitted to the facility on 9/16/20. Review of her diagnoses identified R45 had dementia without behavioral disturbances, a need for assistance with personal care, unspecified abnormalities of gait and mobility, and muscle weakness. Review of R45's quarterly MDS dated 12/23/21, revealed R45 was severely cognitively impaired. The MDS indicated R45 had no rejection of care or other behaviors; required extensive assistance of one staff person for transfers and toilet use; and was not steady and only able to stabilize with human assistance with moving on and off the toilet. The MDS identified R45 had two or more falls since the prior assessment and one of the falls resulted in an injury. Review of R45's care plan identified R45 was at risk for falls related to history of falls and dementia and instructed staff to offer the toilet every hour beginning on 9/16/20. The care plan indicated R45 transferred with stand by assistance of one staff. Review of form titled Third Floor Care Plan printed on 3/8/22, instructed staff to offer toileting every hour and as needed due to frequent attempts to self-transfer.	2 830		

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2 830	Continued From page 8 Review of R45's Progress Notes from 9/29/21, to 3/8/22, revealed the following: R45 had falls with no injury attempting to get on or off the toilet on 9/29/21, at 11:30 a.m., 10/05/21, at 5:15 a.m., 12/03/21, at 7:40 p.m., 1/20/22, at 11:22 a.m. and 2/10/22, at 9:53 p.m. A continuous observation of R45 on 3/08/22, between 2:26 p.m. and 5:00 p.m. (two and a half hours) revealed: On 3/08/22, at 2:26 p.m. R45 was in her room. Her wheelchair was next to her bed, and she transferred without assistance from her bed to her wheelchair. At 2:28 p.m., R45 was seated in her wheelchair in the doorway to her room, peering out into the hallway. R45 remained there until 2:30 p.m., then stated to no one in particular she was going back into her room to watch a movie. On 3/08/22, at 2:52 p.m. NA-B entered R45's room to freshen her water. NA-B did not offer R45 assistance to the toilet. At 2:54 p.m., NA-C entered R45's room looking for NA-B. R45 asked NA-C about items on her activity calendar. NA-C stated she would find out and NA-B and NA-C exited R45's room. NA-C returned to R45's room at 2:56 p.m. with the response to R45's question about activities and exited the room. NA-C was not observed to offer R45 assistance to the toilet. On 3/08/22, at 3:01 p.m., NA-B, NA-A, and NA-C were noted to be outside R45's room. NA-B provided shift to shift report to NA-A and NA-C. NA-B stated R45 had been toileted. On 3/08/22, at 3:56 p.m. R45 came to the door of her room in her wheelchair, saw NA-C and	2 830		

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2 830	Continued From page 9	2 830		

motioned her to her room. R45 asked NA-C what time it was and what was for dinner. NA-C responded to R45's questions and left the room without offering the toilet.

On 3/08/22, at 5:00 p.m. licensed practical nurse (LPN)- B approached R45 as she sat in the doorway to her room in her wheelchair and offered to take her to dinner. R45 agreed and LPN-B wheeled R45 to the dining room. LPN-B was not observed to offer R45 the toilet.

An interview with NA-D on 3/09/22, at 11:00 a.m. NA-D stated she was one of the NAs responsible for R45's care that day and was familiar with R45's care needs. NA-D verified she had not offered R45 the toilet every hour because the resident took herself independently. NA-D stated she was unaware R45 had fallen getting to and from the toilet.

An interview with NA-E on 3/09/22, at 11:05 a.m. identified she was one of the NAs responsible for R45's care that day and was familiar with R45's care needs. NA-E confirmed she had not offered R45 the toilet every hour because she believed R45 took herself independently. NA-E stated she was unaware R45 had fallen getting to and from the toilet. NA-E indicated she became aware of each resident's care needs via verbal report from the previous shift, and from reading the care plan document the NAs received at the beginning of each shift. NA-E removed the days' care plan from her uniform pocket, and after reviewing it stated, "Oh, I guess I am supposed to help her. To be honest, I get a verbal report from the previous shift but because I know this resident, I don't always read the care plan."

An interview with RN-A on 3/9/22, at 11:11 a.m.

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2 830	Continued From page 10 who was the Resident Care Manager (RCM) for the third floor, identified it was her expectation the NAs working with R45 "follow the care plan. 100 percent. The only time they can do anything differently is if they think a resident needs more help than the care plan says. Then they can provide the help they think the resident needs, but they have to tell the charge nurse afterwards. They can never provide less, though." RN-A stated she was familiar with R45 and her fall history and had taken place in the Interdisciplinary Team (IDT) discussion where the determination was made to assist R45 to the toilet every hour. RNA stated, "She falls in the bathroom a lot. This was our plan to prevent further falls." When informed of the surveyor observation that the resident was not offered or assisted to use the toilet for two and a half hours, RNA stated, "That absolutely does not meet my expectation in any way, shape, or form." An interview with the administrator on 3/10/22, at 12:26 p.m. revealed it was her expectation the NAs would follow the resident care plans for fall prevention, and if the care plan was not followed the expectation was not met. Review of the facility's policy titled Falls revised 03/22, identified all residents would be assessed for fall risk and interventions implemented as appropriate. Review of the facility's policy titled Standards of Care revised 04/2021, identified each staff member providing direct nursing care would have in their possession throughout their shift the written plan of care for each resident and would perform specific cares. SMOKING	2 830		

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2 830	Continued From page 11 R118 Review of R118's annual MDS dated 2/03/22, indicated R118 was cognitively intact, and used tobacco products. Review of the 1/24/20, facility form titled Diagnosis revealed R118 had hemiplegia, unspecified affecting right dominant side, unspecified convulsions, tremor unspecified, and personal history of traumatic brain injury. Review of R118's care plan dated 1/24/20, revealed a focus area for a potential for safety concerns due to R118 going outside off property to smoke cigarettes. Education had been provided to R118 regarding the risks associated with this in which he reported he understood. The focus area identified a smoking assessment had been completed upon admission. R118 was able to light his own cigarette and able to handle the mechanics of smoking safely. Cigarettes and lighters were to be kept in the med [medication] cart and locked up. R118 was educated that staff needed to be present with him when he left to smoke and he needed to sign out with the nurses prior to leaving the building. Review of the 1/24/20, to 3/08/22, "Assessments" tab located in the EMR revealed no smoking or safety assessment to assess if resident was able to keep his smoking materials on his person. Review of the 1/30/20, admission note identified staff met with R118's wife to review admission paperwork. R118's wife handled business affairs and R118 was able to make day to day decisions but due to a brain injury wife handled finances. R118 was a smoker and was aware the facility was a non-smoking campus. Wife had talked to	2 830		

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2 830	Continued From page 12 R118 about that and she stated he understood. The staff reminded R118's wife to make sure the nurses kept his cigarettes and lighters. Review of the 12/28/21, communication note located in the EMR under the progress note revealed staff had a conversation with resident regarding smoking outside of facility. Staff discussed Eventide was a Smoke free facility and he could not smoke on Eventide property. Discussed that he had been observed smoking near building. R118 acknowledged he had been closer to building. Staff reiterated to R118 he could not do that. R118 verbalized understanding and then explained where he went to smoke, which was an accepted location not on property or in front of resident windows on 8th street. Staff stated it was getting colder, and he needed to wear appropriate clothing to go outside. R118 showed staff his hat, gloves, and coat. Staff encouraged R118 to limit his time outside when it was very cold and he verbalized understanding. Staff encouraged him to keep his phone on him when going outside and ensured wheelchair was powered. Staff strongly educated him that he needed to alert staff when going out, so staff were aware to check on him if needed. R118 verbalized understanding of the education. Review of the 6/15/21, communication note located in the EMR under the progress note revealed R118 was at 8th and 16th streets and was waving at cars to honk at him. Staff walked out and he was further down on 16th street away from busy traffic. When asked where he went to smoke, R118 stated 8th and 16th or 7th and 16th. Staff asked him to use the 7th and 16th streets since it was less busy. R118 agreed. Review of the facility form titled List of Residents	2 830		

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2 830	Continued From page 13 Who Smoke, located in the facility survey book, revealed "Designated Smoking Times, & Locations Eventide on 8th is a non-smoking campus and we don't have any residents who smoke." On 3/09/22, at 9:55 a.m., RN-B stated R118 went outside to smoke on a sidewalk off premises along the main street. RN-B stated R118 signed himself out and carried his cell phone. RN-B walked the surveyor close to the location and pointed R118 out as he sat in his electric wheelchair on the sidewalk by himself. On 3/09/22, at 1:05 p.m., R118 was observed in his electric wheelchair in his room placing a pack of cigarettes in his coat pocket. On 3/09/22, at 12:48 p.m., RN-A asked about a smoking assessment for R118. She confirmed there was not a smoking assessment for R118. During an interview on 3/09/22, at 3:12 p.m., RN-C stated R118 kept the smoking materials, cigarettes and lighter, on him. RN-C indicated she was unaware of any safety assessment for R118 except checking his clothes for burn marks. At 3:40 p.m., RN-C approached the surveyor and stated, "we don't do smoking assessments on R118 because we are a non-smoking facility and that's his business." "He goes off the property and keeps his cigarettes and lighter on his person." When asked to see R118's smoking materials, she stated "oh no, that's his business. You'll have to ask him." On 3/09/22, at 3:42 p.m., R118 was observed in his room sitting in his electric wheelchair. R118 showed his pack of cigarettes and lighter to the surveyor after he was asked if he kept them. He	2 830		

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2 830	Continued From page 14 stated his lighter was a "BIC lighter" (Pocket lighter made with isobutane fuel) and did not use matches. On 3/10/22, at 9:25 a.m., the sign-out book was reviewed again and the last sign-out day/time for R118 was 3/04/22, when R118's wife signed. Review of the facility's smoking policy, revised 11/2014, revealed it was Eventide's policy that all buildings and grounds were smoke-free. Purpose: To promote and maintain a safe and healthy environment for all residents, visitors, and employees. Procedure: 1. Residents and visitors may not smoke in the apartments, hallways, common areas, or on Eventide grounds. Anyone seen smoking would be asked to put their cigarette out immediately and be informed of the policy. 2. Residents/representatives were informed of the policy prior to signing a reservation agreement and again when signing a lease. 3. Failure of a resident to abide by the policy would result in an eviction notice. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review and revise applicable policies and procedures pertaining to comprehensive fall assessments; then educate staff on ensuring timely completion of such assessments; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff to ensure comprehensive smoking assessments are completed to ensure safety for any resident identified to be smoking who are	2 830		

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2 830	Continued From page 15 admitted to the facility. TIME PERIOD FOR CORRECTION: Ten days (10) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors; and failed to conduct an annual review of its Infection Prevention and Control Program. This deficient practice had the potential to affect all 134 residents residing in the facility. Findings include: During an interview on 3/10/22, at 2:23 p.m. the director of nursing (DON) who was also the interim infection preventionist (IP) stated the facility did not have a surveillance system, infection log or line listing of infections in the building to track and trend infections. Additionally, the DON stated staff had to go into the electronic medical record and search through progress notes in order to see if a resident had tested positive for COVID-19.	21375	Corrected	4/15/22

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21375	Continued From page 16 During an interview on 3/10/22, at 3:28 p.m. the administrator confirmed the facility lacked documentation of a line listing, infection or surveillance log for COVID-19 positive infections or for any other infections for 2021, or 2022. During a follow-up interview on 3/10/22, at 3:43 p.m. with DON, she confirmed she had not been tracking or trending any infections in the facility. During a follow-up interview on 3/10/22, at 5:15 p.m. with the administrator, she stated she was not aware the facility wide Infection Control Policy was required to be updated annually. The administrator confirmed the "Infections, Monitoring, and Surveillance Plan" had last been revised May 2017. Review of facility policy titled, Infections, Monitoring, and Surveillance Plan, revised May 2017, identified the facility was to ensure infections were monitored, and data collected for the purpose of identifying baseline information regarding frequency, type of infection, and organism involved in an effort to permit rapid identification of appropriate treatment, identify potential outbreaks and institute control measures. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise, as necessary, policy and procedures related to the tracking and trending of communicable diseases. The DON could monitor and develop an audit system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		

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21880	Continued From page 17	21880		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section	21880		4/15/22

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21880	Continued From page 18 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to treat two of four residents (R 15 and R45) with dignity and respect reviewed for dignified treatment. This deficient practice created the potential for the residents to experience feelings of embarrassment or social isolation. Findings include: R15 Review of R15's Admission Record revealed the resident was admitted to the facility on 3/19/20. Review of R15's diagnoses, located under the "Diagnosis" tab of her Electronic Medical Record (EMR) identified R15 had Chronic Obstructive Pulmonary Disease (COPD), major depressive disorder, and anxiety disorder. On 3/08/22, at 9:45 a.m. during an interview in R15's room with the door closed, Activities (A)- A simultaneously knocked on R15's door, opened the door, and entered without waiting for R15 to respond. R15 looked at A-A and stated, "Don't come in. I'm busy." A-A stated, "I have to come in to tell you about the 10:00 activity." R15 stated, "Can't you see I have a visitor? I'm very busy and I didn't invite you in. That's very rude." A-A stated, "It's OK, I just have to come in and let you know about the activity." R15 stated, "No, you're being rude." A-A stated, "OK but legally I have to come	21880	Corrected	

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in to try to tell you about the activity." R15 stated, "You're being rude. Right now, I don't want to hear about the activity. I have a visitor," and A-A exited the room. After A-A left the room, R15 continued to state how upset she was that A-A had entered without knocking. R15 stated, "The rest are good, but that one's rude."

During an interview with registered nurse (RN)-A on 3/09/22, at 11:30 a.m., who was the Resident Care Manager for the third floor where R15 resided, stated staff were expected to knock and wait for a resident to respond before entering a resident room.

On 3/10/22, at 10:10 a.m. R15 was observed entering a large activity room on the first floor in an electric wheelchair. R15 positioned herself to the left side of the group, more than six feet from the nearest resident. Three other residents were present, wearing face masks over their mouths however their noses were exposed. After settling in for the activity, R15 stated, "I can't breathe," and removed her face mask. A-A, who was conducting the activity, instructed R15 to replace her mask. R15 stated again, "I can't breathe." A-A stated, "If you want to participate you have to wear a mask." R15 pointed out the other residents were not wearing their masks over their noses and removed herself from the activity.

An interview with R15 on 3/10/22, at 11:44 a.m. revealed she hurried to get to the activity and arrived late, which caused her to feel anxious and short of breath. R15 stated she made sure she was more than six feet from the other residents, and only needed to remove her mask for a few minutes until she was not "huffing and puffing anymore." R15 stated, "I was so embarrassed. Nobody else there was wearing their mask the

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way they should. I don't know why she singled me out."

An interview with A-A on 3/10/22, at 11:55 a.m. revealed when she entered a resident's room, she typically knocked and waited for a response before entering unless the resident was hard of hearing. A-A stated she was aware she had upset R15 when she entered her room without waiting for the resident response however felt it was more important to let her know about the activity. A-A stated that for the activity where R15 left after being instructed to don a mask, all of the other residents were wearing their masks properly, so she gave the resident the choice to either put hers on too or leave. A-A indicated she had not considered that doing so in front of the other residents may cause R15 to feel embarrassed.

R45
Review of R45's Admission Record revealed the resident was most recently admitted to the facility on 9/16/20. Review of her "diagnoses," located under the "Diagnosis" tab of her EMR, identified R45 had dementia without behavioral disturbances, unspecified abnormalities of gait and mobility, and muscle weakness.

Review of R45's quarterly Minimum Data Set (MDS) dated 12/23/21, identified R45 had a Brief Interview of Mental Status (BIMS) of five out of 15, indicating the resident was severely cognitively impaired.

During an observation and interview on 3/07/22, at 3:31 p.m., A-A approached R45 in her room and asked her to attend an activity, to which the resident agreed. A-A began to apply foot pedals to R45's wheelchair. R45 stated, "I don't want those." A-A responded, "Well you have to have

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them if you want to go to the activity" as she pushed the resident down the hall in her wheelchair. A-A took R45 as far as the lobby near the third-floor elevator, then left to gather other residents. A-A returned approximately two minutes later and R45 asked to have her foot pedals removed. A-A stated, "I can't take you if I take those off. I'm not allowed to push you in your wheelchair if I take those off." R45 indicated she would use her feet to "walk" in her wheelchair, and she felt "trapped" with the foot pedals on. A-A stated, "It's a long way, and you'll have to walk the whole way if I take those off. I can't help you at all. I can't push you if I take those off." R45 stated, "You're mad at me because I won't do those things. I don't want to be trapped. I want to come under my own conditions," as A-A walked away. A-A did not offer a response. After A-A left, R45 stated, "I was fine until a few minutes ago. I was fine until I couldn't hold up the requirements of the job with her (referring to A-A) so I'm out. It required me wearing those foot pedals, which I don't like." At 3:42 p.m., A-A returned to the area where R45 was still sitting and assisted another resident to the activity. R45 watched with a frown on her face and stated, "See, she gets to go but I don't."

An observation on 3/07/22, at 3:46 p.m. revealed R45 was able to attend the activity when a different staff member agreed to remove her foot pedals as soon as the resident was settled in the activity.

An interview with RN-A on 3/09/22, at 11:30 a.m. revealed it was her expectation staff attempt to apply foot pedals for safety while assisting residents in their wheelchairs however should listen to resident objections and approach the charge nurse for further instructions if it means a

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21880	Continued From page 22	21880		

care cannot be completed or a resident would be excluded from a meal or activity.

An interview with A-A on 3/10/22, at 11:57 a.m. revealed , "Legally I can only push her if she puts her foot pedals on. If she won't, then legally I can't take her. I tried to explain that to her, but she didn't want to put them on so I couldn't take her. I had someone else come up and they were able to get her to put them on, so she came." When informed of the concern that the interaction on 3/07/22, may not have met the requirement for dignified treatment, A-A stated, "OK."

An interview with the administrator on 3/10/22, at 12:26 p.m. identified it was her expectation residents would be treated with dignity and respect. The administrator stated the facility had no requirement that residents had to be informed of upcoming activities even if it meant they were interrupted in the privacy of their own rooms. The administrator indicated that while it was her expectation foot pedals were used when staff were assisting residents in their wheelchairs, and masks would be used in group activities to reduce the risk of spreading COVID-19, she would expect any concerns with those expectations to be handled quietly and privately, and with dignity and respect.

Policies were requested on dignity, foot pedal use with wheelchairs and mask use for group activities however were not provided.

Review of facility policy titled "Minnesota Department of Health Combined Federal and State Bill of Rights for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities," revised 11/28/16, revealed, "A facility must treat each resident with

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	00072	A. BUILDING: _____ B. WING _____	C 03/11/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 23 respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality." SUGGESTED METHOD OF CORRECTION:The administrator or designee could review, and/or revise policies and procedures to ensure resident/family grievances were appropriately addressed in a timely manner. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21880		

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	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/09/2022**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/09/2022. At the time of this survey, Eventide Lutheran Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 04/04/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The facility was surveyed as one building, with all construction being a type II. Eventide Lutheran Home is a 3-story building with a partial basement. The building was constructed at four different times. The original building was constructed in 1961, is one-story without a basement, and was determined to be of Type II(222) construction. In 1977, a 3-story addition, without a basement, was constructed north of the	K 000		

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	245461	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/09/2022**

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K 000	Continued From page 2 original building and was determined to be of Type II (222) construction. In 1978 an administrative office building that is one story with a basement was constructed to the east of the original building for administrative offices, is separated with a 2-hour fire barrier, does not have any resident use, and is a business occupancy. In 1992 an addition was constructed to the north of the 1977 building, which is 3-stories, with a basement, was determined to be a Type II (222) building and was separated with at least a 2-hour fire barrier. The facility is divided into sixteen smoke zones by 30 minute and 90-minute fire barriers. In 2013 a PT/ Wellness building was added to the northwest of the original building. It is 1-story, has no basement, and is Type II (111). The building is fully sprinkler protected in accordance with NFPA 13, The Standard for the Installation of Sprinklers. The facility has a fire alarm system with corridor smoke detection and smoke detection in common areas installed in accordance with NFPA 72, The National Fire Alarm and Signaling Code. The fire alarm system is monitored for automatic fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system. The facility has a capacity of 164 beds and had a census of 133 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance	K 345		4/8/22

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K 345	Continued From page 3 A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of the available documentation and staff interview, the facility failed to inspect the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.5 and NFPA 72 (2010 edition), The National Fire Alarm and Signaling Code, section 14.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 03/09/2022 at 11:00 AM, it was revealed by a review of available documentation the semi-annual fire alarm testing documentation was not available at the time of the survey. An interview with the Director of Maintenance Facilities verified this deficient finding at the time of discovery.	K 345	A detailed description of the corrective action taken or planned to correct the deficiency. Summit Fire Protection completed the first semi-annual inspection of Eventide's fire alarms on 3/21/22. Summit has been contacted about scheduling the second semi-annual fire alarm inspection for September 2022. Address the measures that will be put into place to ensure the deficiency does not reoccur. Our annual inspections calendar has been updated to include semi-annual fire alarm inspections in March and September each year. Summit has a reoccurring appointment with Eventide to complete these inspections. Eventide will collect documentation from Summit at the end of each inspection and add this documentation to our compliance binder. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring	

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K 345	Continued From page 4	K 345	of compliance. The Director of Facilities and Maintenance or designee will complete an audit at the end of each month from April 2022 through December 2022 to cross-check our annual inspections calendar with inspection documentation received from vendors and filed in our compliance binder.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct inspections of all fire-rated doors required per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.15.2 and 7.2.1.15.4 and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 5.2.1. This deficient finding could have a widespread impact on the	K 761	A detailed description of the corrective action taken or planned to correct the deficiency. A 13-point inspection will be used for fire door inspections going forward. Annual fire door inspections will take place in April of each year.	4/8/22

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K 761	Continued From page 5 residents within the facility. Findings include: On 03/09/2022 at 11:15 AM, it was revealed by a review of available documentation the annual fire-rated doors were not conducted, and appropriate documentation was not available at the time of the survey. An interview with the Director of Maintenance Facilities verified this deficient finding at the time of discovery.	K 761	Address the measures that will be put into place to ensure the deficiency does not reoccur. Our annual inspections calendar has been updated to include annual fire door inspections in April of each year. Our work order system has been updated to initiate this inspection annually. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The Director of Facilities and Maintenance or designee will complete an audit at the end of each month from April 2022 through December 2022 to cross-check our annual inspections calendar with inspection documentation completed by our internal maintenance team and filed in our compliance binder.	
K 781 SS=J	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 781	A detailed description of the corrective	4/8/22

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K 781	Continued From page 6 facility failed to prohibit the use of portable electric space heaters in resident sleeping rooms per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8, resulting in a risk of serious harm or death due to the high likelihood of space heaters to cause a fire in 2 resident sleeping rooms which could affect 2 out of 20 residents. An immediate jeopardy began on 02/22/2022 when the heating system failed to provide adequate heating, causing two rooms to drop in temperature. The facility placed portable electric space heaters in resident rooms 176 and 177. The Executive Director was notified of the immediate jeopardy at 10:50 AM on 03/09/2022. The immediate jeopardy was removed, and the deficient practice was corrected on 03/09/2022. Findings include: On 03/09/2022 at 9:05 AM, during an interview with an MDH Health Surveyor, it was revealed that patient rooms 176 and 177 had portable space heaters in them. On 03/09/2022 at 9:20 AM, during an interview with the resident in room 177, she stated her room was cold and needed the portable space heater. On 03/09/2022 at 9:21 AM, an observation by the Life Safety Surveyor revealed that a portable space heater was placed within one foot of a fabric recliner and was turned on in Room 177. On 03/09/2022 at 9:45 AM, during an interview with the resident in Room 176, she stated her room was cold and needed the portable space heater on all day.	K 781	action taken or planned to correct the deficiency. Space heaters were removed from rooms 176 and 177 immediately following notification of this deficiency on 3/9/22. All space heaters were removed from storage in the Assisted Living building on 3/10/22 to ensure they are no longer accessible. Address the measures that will be put into place to ensure the deficiency does not reoccur. Education will be provided to all staff explaining that space heaters are prohibited in our building. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Identify who is responsible for the corrective actions and monitoring of compliance. The Director of Facilities and Maintenance will perform 10 audits per month for three months and 5 audits per month for 9 months to ensure space heaters are not in the facility.	

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K 781	Continued From page 7 On 03/09/2022 at 9:46 AM, an observation by the Life Safety Surveyor revealed that a portable space heater was placed on the refrigerator and was turned on in Room 176. On 03/09/2022 at 10:50 AM, during an interview with the Executive Director, she stated she received an email from the Director of Nursing on 02/22/2022 stating that two portable space heaters were taken from the assisted living and brought to resident rooms 176 and 177. On 03/09/2022 at 10:52 AM, during an interview with the Director of Facilities, it was revealed that he believed that a heating valve might be stuck in the closed position, making it cooler than normal in Room 176, and that is why the portable space heater was placed in that room. The immediate jeopardy that began on 02/22/2022 was removed, and the deficient practice was corrected on 03/09/2022 when the facility removed all portable space heaters from resident rooms 176 and 177.	K 781		
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920		4/4/22

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K 920	Continued From page 8 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that powerstrips were used per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.4 through 10.2.4.2.3 and UL 1363, Standard for Relocatable Power Taps. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1) On 03/09/2022 between 11:00 AM to 3:00 PM, observation revealed that resident room 306 had a daisy-chained power strip and medical devices plugged into the powerstrip. 2) On 03/09/2022, between 11:00 AM to 3:00 PM, observation revealed that in resident room 320, a wheelchair and a refrigerator were plugged into a powerstrip. 3) On 03/09/2022 between 11:00 AM to 3:00 PM, observation revealed that In resident room 178, a nebulizer was plugged into a powerstrip.	K 920	Past noncompliance: no plan of correction required.	

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K 920	Continued From page 9 An interview with the Director of Maintenance Facilities verified these deficient findings at the time of discovery.	K 920		