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	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eventide Lutheran Home	1405 7th Street South Moorhead, MN 56560

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 49620

Based on observation, interview and document review, the facility failed to follow care planned interventions to ensure resident's safety for 1 of 3 residents (R1) who had a history of falls. This resulted in actual harm for R1 when he fell from the wheelchair, was sent to the emergency department (ED) and sustained a left humerus fracture. The facility implemented corrective action prior to the survey so the deficient practice was issued at past non-compliance.

Findings include:

R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderately impaired cognition with diagnoses of type two diabetes, dementia, anxiety and depression. Identified R1 required extensive assistance with activities of daily (ADL's) including transfers, bed mobility and toilet use.

R1's care plan undated, identified R1 had a potential for falls related to history of frequent falls, impaired mobility, unsteady gait, diabetes, acute encephalopathy, and dementia. Identified R1 had a closed three-part fracture of left proximal humerus. The staff were directed to remove foot pedals from R1's wheelchair when in room and to not leave R1 alone in wheelchair in room.

Review of R1's progress notes on 2/20/25, identified:

-At 4:45 p.m., licensed practical nurse (LPN)-A was called to R1's room and found R1 on the floor. The wheelchair was next to the bed facing the television. Catheter bag was in holder below the wheelchair and pedals were still on the wheelchair. R1's head was under roommate's bed. R1's feet were in front of his wheelchair. R1 stated he was trying to get back in the bed. R1 was complaining of pain to the left shoulder with limited range of motion to the shoulder. Call placed to provider and order received to send R1 to the emergency department (ED) for evaluation.

-At 7:45 p.m., ED informed facility R1 had a left acute, proximal left humerus fracture with some angulation and impaction (the top part of the upper arm bone, which was shaped like a ball, was broken).

Review of R1's progress notes from 2/12/25 to 2/22/25, identified the following:

-2/12/25 at 16:30 p.m., R1 was sent to ED for evaluation of stroke like symptoms. The progress noted lacked documentation about R1 having a fall.

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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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245461	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER: Eventide Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE: 1405 7th Street South Moorhead, MN 56560	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	-2/16/25 at 4:42 p.m., R1 had a fall on 2/12/25, not 2/16/25. The progress note further stated staff found R1 laying on the floor in his room at 3:50 p.m., with the wheelchair next to him. Staff had seen R1 in wheelchair in his room ten minutes before the fall occurred. R1 was unable to provide staff details on the fall and was sent to the ED for evaluation of altered mental status. -2/18/25 at 1:38 p.m., IDT reviewed R1's fall that occurred on 2/12/25 and the root cause was R1 experienced an acute change in health status. The progress note lacked documentation of interventions put in place. -2/21/25 at 12:35 a.m., R1 returned from the ED with orders provided to facility to ice left shoulder three times a day for the next three days and keep R1's left arm in a sling. -2/22/25 at 9:22 a.m., R1's fall on 2/20/25, reviewed during interdisciplinary team (IDT) meeting. Root cause of fall was that the resident stated he was wanting to get back into bed and fell trying to self-transfer. Resident had just gotten out of bed and into wheelchair with staff assist and seen in wheelchair 15 minutes prior to being on the floor. Resident had wheelchair pedals on wheelchair and also his catheter bag in the dignity bag under his wheelchair still at time of fall. Probable that resident could have tripped over one of them when trying to self-transfer. Foot pedals to be removed from wheelchair while resident is sitting in his room. R1's ED visit on 2/20/25, identified a closed fracture of proximal end of left humerus from a fall. R1's x-ray imaging order on 2/20/25 at 5:56 p.m., identified R1 had a fall with shoulder pain. Findings/Impression: Acute, proximal left humerus fracture with some angulation and impaction. During an observation on 3/11/25 at 9:31 a.m., R1 was laying in bed with a sling to the left arm, wheelchair over by dresser with foot pedals off. At 2:09 p.m., R1 was brought to his room after lunch and transferred to bed with a hoyer lift. R1's wheelchair was placed next to the bed, brakes on, his foot pedals were removed. The Facility Risk Predictive Factors assessment dated [DATE], identified R1 had poor recall, judgment and safety awareness. R1 required the use of assistive devices for mobility and three or more falls in the past three months. Fall risk score was 20 and indicated high risk for falls. Another Facility Risk Predictive Factors assessment dated [DATE], identified R1 had diminished safety awareness, required the use of assistive devices for mobility and one-two falls in the past three months. Fall risk score was 11 and indicated at risk for falls. Nursing assistant care plan dated 3/12/25, identified R1 was to have foot pedals removed from the wheelchair while in his room. Do not leave R1 alone in room in wheelchair. During an interview on 3/11/25 at 4:14 p.m., registered nurse (RN)-A stated R1 had a history of falls and a broken arm resulting from a recent fall. RN-A confirmed use of a care plan sheet with individual interventions for each resident for falls prevention and that he carried the care plan sheet with him each day of work. RN-A confirmed the care sheet identified R1 was to have foot pedals removed from the wheelchair when in his room. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/11/25 at 4:45 p.m., executive director confirmed R1 had a fall on 2/20/25. R1 fell from his wheelchair in his room, was taken to the ED, and returned to the facility with a left proximal humerus fracture. Executive director verified R1 had foot pedals on the wheelchair and tripped over the pedals or the catheter and fell . Executive director stated education for staff was provided immediately at shift change and education was sent out via email to staff. Executive director stated safety audits were being performed by the leadership team to ensure care plan interventions were being followed. On 3/12/25 at 9:49 a.m., the director of nursing (DON) returned a call to surveyor and verified R1 fell on [DATE], out of his wheelchair and at that time an intervention was put into place to remove pedals from R1's wheelchair while in his room. DON verified the pedals were on the wheelchair on 2/20/25, when R1 had an unwitnessed fall in his room from the wheelchair. DON verified R1 went to the ED on 2/20/25, after the fall and returned to the facility with a left proximal humerus fracture. DON stated care plan interventions included the keeping the pedals off R1's wheelchair while in his room were reviewed with staff at shift change and a mandatory meeting was completed with staff discussing falls and care plans. DON stated her expectations were staff would keep a resident safe if there was a fall, stay with the resident and call for help. DON confirmed the expectation staff would follow the care plan. DON would expect the nurse to assess the resident and surroundings and try to determine the root cause of the fall. The nurse would call the provider and family if a suspected injury resulted from the fall to determine further treatment. DON confirmed this was important to keep the resident safe after a fall and to prevent the fall from happening again. On 3/12/25 at 3:32 p.m., nurse practitioner (NP) returned a call to surveyor and verified R1 fell at the facility on 2/20/25, resulting in a left proximal humerus fracture. All nursing staff were sent out an email on 2/20/25 at 10:05 p.m., regarding R1's fall. All nursing staff were reminded that R1's foot pedals were to be removed from the wheelchair when R1 was sitting in his room. If staff were not transporting R1, foot pedals would be removed. Attached to the email was a copy of R1's ED report. Facility staff education meeting undated, identified education would be provided to employees on state prep, falls, and care plans. A facility policy titled Falls, revised 3/22, identified all residents would be assessed for fall risk and interventions implemented as appropriate. A comprehensive assessment would be completed with every fall to determine the root cause and to develop individualized interventions. A fall was identified as an unplanned descent to the floor with or without injury to the resident. A fall risk predictive factors assessment would be completed after each fall. If the fall score was 10 or greater the resident may be considered at high risk for potential falls and staff were to initiate the care plan for high risk for injury, list specific interventions based on assessment risk, identify interventions on the NA care plan.