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	04/02/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on observation, interview, and document review the facility failed to ensure appropriate hand hygiene and personal protective equipment (PPE) practices were performed during a high contact care activity for 2 of 3 residents (R1, R5) in enhanced barrier precautions (EBP) with an indwelling device. Findings include: Primary provider visit dated 2/4/25 at 8:00 p.m. identified assessment/plan: neurogenic bladder - continue with suprapubic catheter (a flexible tube placed through an incision in the abdomen instead of from the urethra to empty urine from the bladder into a collection bag) (SP), Mirabegron 25 milligrams (mg) (medication for bladder spasms). Nursing was responsible for catheter cares. No recent urinary tract infection (UTI) concerns. R1's annual Minimum Data Set (MDS) dated [DATE], identified intact cognition without behaviors. She had upper impairment on one side, lower impairment on both sides and used a wheelchair for mobility. She required partial/moderate assistance with upper body dressing, personal hygiene, roll left and right, substantial/maximum assistance with toileting hygiene, shower/bathe, lower body dressing, and dependent upon staff for putting on and taking off footwear and all transfers. She had an indwelling urinary catheter and always incontinent of bowel. Medical diagnoses included congestive heart failure (CHF), neurogenic bladder, arthritis, osteoporosis, multiple sclerosis, anxiety, and depression. R1's current care plan identified R1 was at risk for infection related to SP catheter placement and chronic/long term use due to a neuromuscular dysfunction of the bladder. Staff were instructed to have provided EBP for all catheter cares and emptying, good hand hygiene, catheter cares per policy, monitor for signs/symptoms (s/sx) of UTI, encourage fluids, and position catheter bag and tubing below the level of the bladder. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's significant change MDS dated [DATE], identified severely impaired cognition, altered level of consciousness and inattention (easily distractible or had difficulty keeping track of what was said) that fluctuated. She had behaviors symptoms every one to three days that included: physical directed toward others (hitting, kicking, pushing, scratching, grabbing), verbal directed towards others (threatening, screaming, cursing at others), and other symptoms not directed towards others (hitting or scratching self, disrobing in public, throwing or smearing food or body wastes, or verbal/vocal symptoms like screaming, disruptive sounds). She required substantial/maximal assistance with toileting hygiene, shower/bathe, upper and lower body dressing, roll left and right, sit to lying, lying to sitting on side of bed, sit to stand, and all transfers. Used a manual wheelchair for mobility. She had an indwelling urinary catheter and frequently incontinent of bowel. Medical diagnoses included CHF, neurogenic bladder, arthritis, osteoarthritis, and epilepsy (seizure disorder). R5's current care plan identified she was at risk for infection related to indwelling urinary catheter due to neurogenic bladder. She is on EBP. Staff were directed to use good hand hygiene, catheter cares per policy, observe for signs of catheter associated urinary tract infection (CAUTI), and encourage fluids. During an observation on 4/1/25 at 1:15 p.m. nursing assistant (NA)-A pushed R1 in her wheelchair from dining room back to her room. Located on the wall in the hallway on right side of R1's door was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room, and gown and gloves be placed on for all high-risk activities (dressing, bathing/showering, transferring in room or tub room, providing hygiene, changing briefs, and toileting, changing linens, device care and use of the urinary catheters, central lines, feeding tubes, and tracheostomies, wound care and dressing changes). NA-A walked back out into the hallway and grabbed the total lift machine, sanitized her hands, applied an isolation gown and gloves. She entered R1's bathroom and carried an empty graduate pitcher and alcohol swabs. She placed a paper towel onto the floor and the graduate pitcher on top. She removed the urinary catheter collection bag from the privacy bag and hooked it on the lower bar of the lift machine. She pulled the end of the drainage tube out of the holder, wiped off the end of the tubing with the alcohol swab, unclamped the tubing and drained 400 milliliters (ml) of yellow urine with a strong odor into the collection container, and clamped the tubing. The end of the tubing was wiped with an alcohol swab and placed back into the holder. She emptied the urine into the toilet in the bathroom, rinsed out the container with water and placed it back into a clear bag that hung by the toilet on the wall. She removed her gloves and without sanitizing her hands placed a pair of clean gloves on. NA-A and NA-B connected he loops from the lift sheet onto the lift machine, transferred R1 back to bed, and removed the loops from the machine. Together they turned R1 over onto her side and removed the lift sheet from underneath her. NA-A used her gloved hands and lowered the head of the bed with the remote control, covered R1 with a blanket, and moved the bedside table over R1's abdomen. She removed her gown, placed it in the hamper located in R1's room, removed her gloves, exited the room, and sanitized her hands in the hallway. During an interview on 4/1/25 at 2:45 p.m. NA-B stated staff were expected to follow the facility policy EBP while they provided cares and worked with the urinary catheters to help prevent the spread of infection. Staff were expected to have applied a gown and gloves, removed gloves after completing cares, gloves became soiled, and/or emptying a urinary catheter, wash or sanitize their hands prior to the placement of a clean pair of gloves to help prevent infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/1/25 at 3:09 p.m. NA-A stated R1 was placed in EBP because she had a urinary catheter. She had placed a gown and gloves on prior to entering the room and emptied urinary catheter while R1 sat in the wheelchair. There was 400 ml of yellow urine in the graduate pitcher, dumped the urine in the toilet and rinsed the container out. She removed her gloves and without sanitizing her hands placed a clean pair of gloves on. She left the bathroom and continued to work with the resident, then removed her gloves and gown, and sanitized her hands. She stated would have been really important to have washed her hands after she removed the dirty gloves and applied a clean pair to help prevent the spread of germs. She had forgotten to wash her hands. During an interview on 4/1/25 at 4:05 p.m. licensed practical nurse (LPN)-A stated staff were expected to have placed a gown and gloves on prior to entering an EBP room when planned to complete cares and emptying a urinary catheter. Staff would be expected to remove their gloves after working with a resident's catheter and urine, wash their hands, prior to when clean gloves were applied. Those steps were expected, especially when staff went from dirty to clean, would have helped prevent the transfer of bacteria and infection. During an observation on 4/2/25 at 9:57 a.m. NA-C entered R5's room. Located on the wall in the hallway on right side of R5's doorway was a STOP sign titled EBP and instructed providers and staff to perform hand hygiene upon entering and exiting the room and placed gown and gloves on before all high-risk activities were completed. NA-C entered R5's room, gown and gloves were not applied. She explained the indwelling catheter would be emptied and applied a pair of clean gloves. She placed a paper towel on the floor, graduate pitcher retrieved from the bathroom was placed on top of the paper towel and opened an alcohol swab. She removed end of the catheter tube from the holder and wiped off the end port with an alcohol swab. She unclicked the clamp on the tubing and emptied the urine from the collection bag into the graduate pitcher. She clicked the clamp closed, wiped off the end port with an alcohol swab, and placed the end in the holder located on the front of the collection bag. She emptied 400 ml of clear yellow urine into the toilet and without rinsing out the collection container placed it on the back side of the toilet. She removed her gloves and washed her hands with soap and water, flushed the toilet, grabbed a tied bag of garbage, and exited R5's room. During an interview on 4/2/25 at 10:05 a.m. NA-C stated R5 was placed in EBP due to her urinary catheter, infection, and helped prevent the spread of germs. Staff were expected to wear a gown and gloves when they provided any type of care, including emptying the urinary catheter to help prevent the spread of germs. She stated she did not wear an isolation gown while she worked with R5's urinary catheter and it was a mistake; she had forgotten to put on one. The graduate pitcher should have been rinsed out after the urine was dumped in the toilet to keep it clean, disinfected, and for infection control. She had gone back later and rinsed it. During an interview on 4/2/25 at 11:14 a.m. registered nurse (RN)-A director of quality and infection prevention stated residents with indwelling urinary catheters are placed in EBP to help prevent the spread of infection. Hand hygiene should be completed prior and after resident contact, when hands were visibly soiled, before every clean procedure, before and after gloving, take off gloves appropriately without getting the hands solid, to help prevent the spread of infection. Staff would be expected to wear an isolation gown and gloves when entering a resident's room placed in enhanced barrier precautions when cares were to be completed and emptying the indwelling urinary catheter to help prevent the spread of infection. She would have promoted staff to have rinsed out the collection container once the urine was disposed of in the toilet to have helped prevent odor and hopefully inhibit the growth of bacteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/2/25 at 1:28 p.m. director of nursing (DON) stated EBP are used with those residents that had indwelling urinary catheters to prevent the spread of germs and multi-drug-resistant organisms (MDRO) (organisms that are resistant to typical antibiotic treatments and can cause infection). Staff would be expected to have completed hand hygiene prior to the application of the gloves and once they completed working with the indwelling urinary catheter gloves should have been removed, hand hygiene completed prior to a new application of clean gloves. This would have helped spread the germs and protected staff and residents. When a resident was placed in enhance barrier precautions staff were expected to wear a gown and gloves during prolonged exposure such as catheter cares and/or transfers of the resident to help prevent the spread of germs and MDROs. Facility policy Hand Hygiene dated 11/2024, identified proper hand hygiene will be followed before and after resident contact (before you leave the room), before every clean procedure, after every dirty procedure, and as needed. Purpose: hand hygiene is a general term that applied to either hand washing or alcohol-based hand rub (ABHR). The purpose was to prevent the spread of infection.