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	11/13/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and document review, the facility failed to ensure orders were followed as prescribed by the physician for 1 of 3 residents (R1) reviewed for post-op care after a right great toe amputation. R1's quarterly Minimum Data Set (MDS) assessment dated [DATE], identified severely impaired cognition with physical behavioral symptoms towards others (hitting, kicking, pushing, scratching, grabbing) and verbal behavioral symptoms directed towards others (screaming, threatening others and cursing). Medical diagnoses included: non-traumatic brain dysfunction, peripheral vascular disease (PVD) (a circulation disorder where blood vessels outside the heart become narrowed, blocked, and can cause pain, cramping, numbness, and poor wound healing), diabetes mellitus (DM), and Alzheimer's. R1's care plan dated 11/12/25, identified a potential for skin breakdown related to dementia, urinary incontinence, history of stage 2 pressure ulcer to right buttock and seborrheic dermatitis, right great toe ulcers and left toe diabetic ulcers. Interventions directed staff to apply Prevalon boots (a cushioned bottom that floats the heel off the surface of the mattress, helping to reduce pressure) when going off the unit and to activities. Tubigrips (a brand of elastic tubular bandage used for providing compression and tissue support for conditions like sprains, strains, edema, and post-burn scarring) to bilateral lower extremities as ordered and wrapped bars around foot pedals of Rock n Go (type of wheelchair) with towel for protection. R1's post-op surgical shoe was not included in the care plan. Nursing assistant (NA) care plan dated 11/13/25, identified R1 transferred with assist of two and Hoyer (mechanical device used for transferring), non-ambulatory. Positioning: Prevalon boots when going off unit and to activities. Safety/Falls: gripper socks when in bed or room if not wearing shoes. R1's post-op surgical shoe was not included in the NA care plan. R1's post operative discharge instructions/orders dated 10/30/25, signed off by licensed practical nurse (LPN) on 10/30/25, identified weight bearing as tolerated in post-op shoe (a supportive medical shoe designed to protect and provide comfort for a foot recovering from surgery or injury), may gently wiggle toes within the dressings. R1's progress note dated 10/30/25 at 5:04 p.m., Provider Order: Ice to affected area for 48 to 72 hours and as needed (PRN). Avoid placing ice pack directly on skin. Place the ice pack under the knee of the surgical foot. Elevated leg for 72 hours. Keep dressing clean/dry/intact until follow up appointment on 11/12/25. May shower or bath. Wrap dressing with waterproof protection such as saran wrap or plastic bag. If dressing became soaked with water, contact the foot and ankle clinic. A telephone encounter returned phone call from wound clinic to nursing home dated 11/3/25, who needed a change in wound care order orders for patient's right great toe. He had a right partial hallux (big toe) amputation, hardware removal on 10/30/25. Orders were placed for post-surgery. Recommendations: discontinue wound clinic orders for the right great toe, continue with post-surgical orders placed by provider. R1's progress note dated 11/11/25 at 5:29 a.m. R1 kicked the wall by the secretary desk on 2nd floor before lunch. He had refused to move from that location. Looked at right foot earlier no injury and blood noted at the bottom on left gripper sock. He had a skin tear to tip of left forth toe 0.5 centimeters (cm) by 0.5 cm small amount of bleeding. R1's clinic visit dated 11/12/25, identified R1 with a history of type 2 diabetes with neuropathy, peripheral arterial disease (PAD) (narrowed arteries reduces blood flow to the arms and legs), atrial fibrillation and Alzheimer's. Two weeks post partial amputation of his great toe secondary to osteomyelitis (infection in the bone) and retained hardware. The incision was well coapted (edges of incision were closed) and no signs of dehiscence (splitting or opening) or erythema (redness of the skin). Healing was delayed but the wound edges are healthy and capillary refill to the flap was immediate. Sutures remained intact. During an observation on 11/12/25 at 2:03 p.m., R1 sat at nurse's station in Broda (allows the user to change angle of backrest to reduce pressure points and improve circulation) chair with blue lift sheet underneath him. R1 wore a blue pull-on gripper sock on the left foot and a black open toed post-op shoe on the right foot. The right foot and lower ankle were wrapped with a dressing and Tubigrip. During an observation on 11/13/25 at 8:07 a.m., R1 sat in Broda chair in dining room along with two other residents. He was well groomed and wore gripper socks on both feet. His left foot was placed on the floor in front of the Broad chair and right foot hung just above the floor. R1 did not have post-op shoe on his right foot. During an observation and interview on 11/13/25 at 11:12 p.m., NA-A and NA-B transferred R1 with a Hoyer lift from [NAME] chair onto his bed to off load him for a short period of time. R1's post-op shoe was not on his right foot and was observed on the floor in front of the recliner. R1 was transferred back to the Broda chair via Hoyer. R1's right foot was wrapped with cling/gauze on top of