

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  04/10/2024
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)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</b></p> <p>Based on observation, interview, and document review the facility failed to maintain wheelchairs in a clean and sanitary manner for 1 of residents (R68) reviewed who utilized wheelchairs. In addition, the facility failed to maintain a standing lift shared by residents in a clean and sanitary manner.</p> <p>Findings include:</p> <p>R68's annual Minimum Data Set (MDS) dated [DATE], identified R68 had moderate cognitive impairment and had diagnosis which included hypertension (elevated blood pressure), non traumatic brain dysfunction and arthritis. Identified R68 required staff assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Further identified R68 utilized a manual wheelchair for mobility.</p> <p>During an observation on 4/9/24 at 9:29 a.m., R68 was seated in his wheelchair at the nurses' station and the left foot pedal of his wheelchair contained a large dried brown food like substance of which covered half of the foot pedal.</p> <p>During an observation on 4/10/24 at 7:40 a.m., R68 was seated in his wheelchair at the nurses' station and left foot pedal continued to have a large dried brown food like substance.</p> <p>During an observation on 4/10/24 at 7:41 a.m., a standing lift which was located in the hallway on the second floor of the facility had a large area of dried brown food like substance on the lower end of the standing lift plate of the lift.</p> <p>During an interview on 4/10/24 at 7:50 a.m., nursing assistant (NA)-E confirmed the presence of a dried brown food like substance on R68's left wheelchair pedal and on the foot plate of the standing lift. NA-E stated she was unsure who was responsible for cleaning wheelchairs and lifts.</p> <p>During an interview on 4/10/24 at 7:52 a.m., housekeeper (HK) confirmed the presence of a dried brown food like substance on R68's left wheelchair pedal and the foot plate of the standing lift. HK stated he knew there was a process for cleaning wheelchairs however was unsure what the process was. HK indicated it was the responsibility of housekeeping to completed a deep clean of the lifts at least weekly.</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245461
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/24 at 10:56 a.m., director of nursing (DON) stated the night shift was responsible to clean resident wheelchairs on their bath day and in between as needed. DON indicated it was housekeeping's responsibility to clean the lifts.</p> <p>A facility policy on cleaning wheelchairs and lifts was requested however, one was not received.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45844</p> <p>Based on observation, interview, and document review, the facility failed to ensure food and beverages stored in the refrigerators and freezers were labeled, dated and discarded properly. This deficient practice had the potential to affect all 116 residents who received food and beverages from the refrigerators and freezers.</p> <p>Findings include :</p> <p>On 4/8/24 at 11:30 a.m., during the initial tour of the kitchen area with the culinary coordinator (CC), the following concerns were identified:</p> <p>Walk in produce cooler:</p> <ul style="list-style-type: none"> <li>-nine hard boiled eggs were in a Ziploc bag without a notation of a date.</li> <li>-1/2 large container of enchilada sauce with crusty black flakes around the lid with an open date of 1/1/24.</li> <li>-1/2 bottle of mustard with yellow crusty flakes around the lid and an open date of 10/3/23.</li> <li>-1/4 bag of whipped topping with no notation of an open date.</li> </ul> <p>Walk in egg and dairy cooler:</p> <ul style="list-style-type: none"> <li>-20 hard boiled eggs were in a Ziploc bag without a notation of a date.</li> <li>-1/4 bottle cherries with an open date of 1/16/24.</li> <li>-one open block of butter with no notation of an open date.</li> <li>-15 pieces of summer sausage in a Ziploc bag without notation of an open date.</li> <li>-20 slices of Swiss cheese in an opened Ziploc bag without notation of an open date.</li> <li>- four hard boiled eggs were in a Ziploc bag without notation of a date.</li> <li>- Fresh tray of twelve eggs in a container which contained spilled egg yolks.</li> <li>- four pieces of gluten free bread in a bag with an expiration date of 4/1/24.</li> <li>- 16 nectar thick ice cubes without notation of a date.</li> </ul> <p>Juice Cooler:</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-1/2 container thickened cranberry no notation of a date.</p> <p>Main freezer:</p> <p>-Several tator tots in a Ziploc bag with no notation of a date.</p> <p>-Peppers in a Ziploc bag with no notation of a date.</p> <p>-18 Pureed cinnamon rolls with large ice crystals and no notation of a date.</p> <p>- five breaded fish patties in a plastic bag with no notation of a date.</p> <p>Hall freezer:</p> <p>-one cupcake with no notation of a date</p> <p>-container of lefse with a moderate sized rip in the aluminum foil covering.</p> <p>Basement freezer:</p> <p>-28 pieces of breaded fish in a plastic bag without notation of a date.</p> <p>First floor Kitchen refrigerator:</p> <p>-one container of nectar thick water with no notation of a date.</p> <p>-one full container of orange juice without a cover.</p> <p>First floor kitchen freezer:</p> <p>-1/2 large container of vanilla ice cream without notation of an open date with ice crystals present around the cover.</p> <p>During an interview on 4/8/24 at 12:15 p.m., CC confirmed the above findings and indicated the residents had recently been served the above items. CC stated all the above items should have been discarded. CC indicated her expectation was that all items would have been dated when opened and discarded appropriately.</p> <p>During an interview on 4/9/24 at 2:33 p.m., registered dietician (RD) stated her expectation was that all food was dated when opened and discarded per facility policy.</p> <p>Review of a facility policy titled Cold Storage revised 1/18, indicated the facility was to ensure all perishable refrigerated and frozen items were stored according to state and federal regulations. In addition, it identified all food must be labeled, dated and properly sealed.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844</b></p> <p>Based on observation, interview and document review, the facility failed to ensure proper use of personal protective equipment (PPE) and hand hygiene per Centers for Disease Control and Prevention (CDC) to prevent and/or minimize further spread of COVID-19 for 2 of 3 residents (R45 and R59) reviewed for transmission based precautions. In addition, the facility failed to ensure catheter drainage bags were not placed on the floor for 1 of 1 residents (R62) reviewed for catheters.</p> <p>Findings include:</p> <p>Review of CDC guidance dated 3/18/24, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic indicated health care providers who entered the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH (National Institute for Occupational Safety &amp; Health) approved particulate respirator with N95 filters or higher (an N95 respirator is a respiratory protective device designed to achieve a very close facial fit and has very efficient filtration of airborne particles), gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face). Additionally, when transporting a resident who had suspected or confirmed SARS-CoV-2 infection, the transporter should continue to wear their respirator. The transporter should also continue to use eye protection if there was potential that the patient might not be able to tolerate their well-fitting source control device for the duration of transport.</p> <p>PPE USE</p> <p>Review of R45's and R59's Rapid Covid -19 lab results revealed the following:</p> <p>R45's Rapid Covid-19 test dated 4/1/24, indicated R45 was positive for Covid-19.</p> <p>R59's Rapid Covid -19 test dated 4/2/24, indicated R59 was positive for Covid-19.</p> <p>During an observation on 4/8/24 at 12:51 p.m., R45's and R59's door contained a sign that said Enhanced Droplet Precautions Everyone Must clean their hands, including before entering and when leaving the room. N95 mask, face shield, gown, and gloves are required when entering this room. Remove PPE and perform hand hygiene when exiting the room. In addition, the sign contained a picture of an N95 mask, face shield, gown, and gloves.</p> <p>During a continuous observation on 4/8/24 at 1:44 p.m., nursing assistant (NA)-A exited R45's room and removed (doffed) her N95 mask, put on a clean surgical mask, touched her hair and entered R45's room and placed a mask on R45. NA-A proceeded to wheel R45 down the length of the hallway to the tub room wearing only a surgical mask and no eye protection. At no time during the above observation did NA-A perform hand hygiene.</p> <p>- At 1:49 p.m., infection preventionist (IP) approached NA-A and informed her she should have worn an N95 and eye protection during transport and once she was in the tub room would need to additionally put on (don) a gown and gloves.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 4/10/24 at 7:11 a.m., NA-B exited R45's room, doffed her N95 and placed it directly on top of a box of clean gloves. NA-B proceeded to sanitize her eyewear with a disinfectant wipe then placed her eyewear on top of her head. At no time did NA-B sanitize her hands.</p> <p>During an interview on 4/10/24 at 7:13 a.m., NA-B verified she had placed her N95 on top of a clean box of gloves after exiting R45's room and had not sanitized her hands. NA-B stated her usual practice was to place her N95 in the garbage after exiting R45's room and then sanitize her hands.</p> <p>During an observation on 4/10/24 at 9:00 a.m., NA-C donned an N95 and placed the lower strap behind her head and left the lower strap in the front on top of the nose part of the N95. Surveyor intervened as NA-C was ready to enter R59's room and NA-C verified R59 her N95 was not being worn appropriately and placed the lower strap of the N95 behind her head before entering R59's room.</p> <p><b>CATHETER BAG</b></p> <p>R62's significant change MDS dated [DATE], identified R62 had severe cognitive impairment and diagnoses which included benign prostatic hyperplasia (enlarged prostate) (BPH), elevated blood pressure (HTN), and dementia. Indicated R62 required extensive assistance for activities of daily living (ADL's) which included toileting, transfers, and dressing. Identified R62 required the use of an indwelling catheter.</p> <p>R62's care plan dated 2/15/23, indicated R62 was at increased risk for infection related to foley catheter use. Directed staff to provide catheter cares per policy, keep drainage bag below the level of the bladder and monitor for signs of infection.</p> <p>During an observation on 4/9/24 at 5:15 p.m., R62 was lying on his back with bed in low position. R62's urinary catheter drainage bag which contained bright yellow urine was observed with the opening spout resting directly on the floor and was not covered.</p> <p>During an interview on 4/9/24 at 5:30 p.m., NA-D verified R62's urinary catheter drainage bag was lying directly on the floor. NA-D stated usual practice was to place R62's urinary catheter drainage bag in a dignity bag or in a basin so that the bag did not touch the floor when the bed was in low position.</p> <p>During an interview on 4/9/24 at 5:33 p.m., licensed practical nurse (LPN)-A verified R62's urinary catheter bag was lying directly on the floor. LPN-A stated her expectation was that R62's urinary drainage bag would have been placed in a dignity bag or in a basin so that the bag would not have touched the floor.</p> <p>During an interview on 4/10/24 at 10:42 a.m., infection preventionist (IP) verified R45 and R59 recently both had tested positive for COVID-19. IP verified NA-A had only worn a surgical mask while transporting R45 down the hallway for her bath. IP stated her expectation was that NA-A would have washed her hands when she exited R45's room and after she had removed her N95. IP stated NA-A should have worn an N95 and a face shield while transporting R45 down the hallway. IP stated urinary catheter drainage bags should have been placed in a dignity bag or a basin so they were not touching the floor. IP stated her expectation was all staff would don and doff PPE appropriately. IP indicated the facility followed CDC guideline for PPE usage regarding COVID -19.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/10/24 at 11:10 a.m., director of nursing (DON) verified R45 and R59 both currently tested positive for COVID-19. DON stated her expectation was all staff would don and doff PPE appropriately at all times. DON further stated hand hygiene should be performed appropriately and urinary catheter drainage bags should have been placed in a dignity bag or a basin off the floor to help prevent contamination of the urine drainage bag which could have caused a urinary tract infection.</p> <p>A facility policy titled Coronavirus (COVID-19) revised 5/23, indicated the facility was to follow recommendations for residents with COVID-19 set by the CDC and Minnesota Department of Health (MDH). Policy stated when working in a room with a resident who was positive for COVID-19, staff were to wear an N95 mask, gown, protective eyewear and gloves and that enhanced droplet precautions were followed. Policy identified hand hygiene was a necessary component of preventing the transmission with alcohol based hand rubs being the preferred method of hand hygiene.</p> <p>A facility policy titled Policy and Procedure: Catheter- Indwelling revised 1/24, indicated residents with indwelling catheters known as foley catheters were cared for by staff according to accepted practice. Identified the drainage bag of the catheter should never be placed on the floor, or the bag may become contaminated.</p>		