| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245461 | A. Building<br>B. Wing | 06/25/2025 |

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 1 of 1 residents (R4) who received assistance with eating in the dining room.<br><br>Findings include:<br><br>R4's quarterly Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment and had diagnoses which included: hypertension (elevated blood pressure), dementia, and anemia. Identified R4 required staff assistance to eat.<br><br>R4's care plan dated 11/9/22, identified R4 had self-care performance deficit related to weakness and dementia.<br><br>R4's interventions included assistance with hygiene, bathing and dressing. Identified R4 required total staff assistance with eating. Identified R4 had a terminal prognosis and received hospice care.<br><br>During an observation on 6/24/25 at 12:35 p.m., R4 sat in a reclining wheelchair in the dining room at a table. Hospice registered nurse (H-RN) stood near R4's right side, and provided R4 with food from a spoon.<br><br>-at 12:43 H-RN continued to stand near R4's side while assisting R4 to eat from a spoon.<br><br>During a phone interview on 6/24/25 at 12:50 p.m., family member (FM)-A stated she did not feel it was a dignified practice for staff to stand while feeding R4. FM-A stated she would have expected staff to sit while assisting R4 to eat.<br><br>During an interview on 6/24/25 at 12:56 p.m., H-RN verified he had stood up while assisting R4 to eat. H-RN stated R4's chair was big and it was not convenient for him to sit so he stood to assist R4 with her meal. RN-A further stated it was not a dignified practice to stand while assisting residents to eat.<br><br>During an interview on 6/24/25 at 1:08 p.m., RN-A verified H-RN stood while assisting R4 to eat. RN-A stated her expectation was H-RN would have sat down while feeding R4 to maintain dignity.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/25/25 at 9:18 a.m., director of nursing (DON) stated staff were expected to be seated by residents while assisting with eating as it was important to maintain dignity and promote safety.<br><br>Review of a facility policy titled Standards of Care revised 8/24, identified standards of care were followed when providing care to all residents. Identified all residents would receive safe, dignified care. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 residents (R5) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications.<br><br>Findings include:<br><br>R5's admission Minimum Data Set (MDS) dated [DATE], indicated R5 was cognitively intact and had diagnoses which included pneumonia, hip fracture, and respiratory failure. R5 was dependent on staff for transfers and toileting hygiene.<br><br>R5's care plan dated 5/30/25, identified R5 as having an activity of daily living (ADL) self-care performance deficit related to a fracture of the right ankle. R5's care plan interventions included assistance with dressing and grooming and being able to feed self after staff assisted with tray set up.<br><br>Review of the care plan dated 5/30/25, lacked information regarding the self-administration of medications.<br><br>Review of R5' s electronic health record (EHR) revealed Formoterol Fumarate inhalation nebulization solution ( a medication prescribed for asthma) 20 micrograms (mcg)/2 milliliters (ml) two times a day for asthma, Ipratropium-Albuterol inhale orally every six hours as needed for shortness of breath. EHR lacked information regarding the self-administration of medications.<br><br>Review of R5's Order summary Report Dated 6/4/24 directed staff to administer Formoterol Fumarate inhalation nebulization solution 20mcg/2ml two times a day for asthma, Ipratropium-Albuterol inhale orally every six hours as needed for shortness of breath. The order summary report lacked an order to self-administer medications.<br><br>Review of assessments located in the assessment tab of the EHR lacked an assessment of self-medication assessment.<br><br>During an observation on 6/23/25 at 12:15 p.m., R5 was sitting in a wheelchair next to the bed with a nebulizer mask on her and a nebulizer machine turned on. No staff were present in the room or outside of the room.<br><br>During an observation on 6/24/25 at 9:41 a.m., R5 was sitting in a wheelchair next to the bed with a nebulizer mask on her face and the nebulizer machine on. No staff were present in the room or outside of the room.<br><br>(continued on next page) |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/24/25 at 11:09, licensed practical nurse (LPN) indicated self-administration assessment of medication were charted under the administration tab in the EHR. LPN looked and was unable to find a self-administration of medication assessment. LPN located an assessment for brief interview for mental status (BIMS). LPN indicated if a resident had a high BIMS score that indicated the resident as cognitively intact. LPN indicated the procedure for a resident to self-administer medications was to ensure a resident was cognitively intact and the resident could demonstrate they could self-administrate medication safely. LPN did not believe the facility needed to obtain a physician order for self-administration of medications. LPN verified that R5 administered her nebulizer independently after being set up by staff.<br><br>During an interview on 6/25/25 at 7:42 a.m., resident care manager (RCM) indicated the nurses would do an assessment for the self-administration of medication, the facility would obtain a physician order, and would place the self-administration of medication in the care plan. RCM verified that R5 did not have a self-administration medication assessment. RCM also verified that R5 did not have self-administration of medications care planned.<br><br>During an interview on 6/25/25 at 12:00 p.m., director of nursing (DON) indicated the facility had a self medication policy. The nurse would complete a BIMS assessment of the resident throughout the day. The nurse would assess the resident's performance with holding or keeping the mask on during the nebulizer treatment, if the resident could shut off the nebulizer appropriately, and discuss with the provider. The facility would review self-administrations quarterly or as needed. The DON would expect nurses to follow the policy on self-medication administration to ensure a resident could safely administer the medications.<br><br>Review of a facility policy titled Medications Self-Administration of Medications dated 3/25, identified if deemed appropriate the resident may participate in the self-administration of medication process. A provider's order was required. The standing order may be utilized but the resident's primary provider must be informed. Medication administration will be monitored and the resident's ability to self-administer medications would be reviewed quarterly, prior to discharging home, and with a significant change in condition or as needed. Procedure: 1. The resident will be asked if they would like to self-administer medications. 2. If the resident declined, documentation would be made in the resident's medical record. 3. If the resident wanted to self-administer medications, the nurse would complete the Self-Administration of Medication Assessment to determine appropriateness. Inhalants or inhalers: The resident must demonstrate competency of use(timing of breathing, depressing the atomizer, position of the mouth for medication administration, length of time to wait between doses, etc.) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R95) had adequate hydration within reach.<br><br>Findings include:<br><br>R95's quarterly Minimum Data Set (MDS) dated [DATE], indicated R95 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. R95 required partial assistance with eating and extensive assistance with dressing and personal hygiene. R95 had a diagnosis of cerebral infection (stroke), hemiparesis (weakness of one side of the body), anxiety, and depression.<br><br>R95's care plan was revised on 3/12/25, indicating that R95 could feed herself after staff assisted with tray setup. Staff to encourage R95 to use her right hand to feed herself, and place the tray in the far-right visual felid. Dysphasia mechanically altered with nectar thick liquids, on 4/3/25 per speech therapy changed to pureed with nectar thick liquids with hopes of improving intakes. Dislikes strawberries. The family prefers that R95 be given cranberry juice to drink instead of any other flavored juices or milk. No water mug with thin liquids.<br><br>R95's physician order dated 6/10/25, indicated R95 had a Dysphasia mechanically altered texture and nectar thick consistency.<br><br>During an interview on 6/23/25 at 11:56 a.m., a family member indicated that R95's water mug had been across the room multiple times when visiting. The family member indicated that R95 could not move her wheelchair across the room to get her water mug. If the water mug was beside R95, then she would have been able to take a drink independently.<br><br>During an observation on 6/24/25 at 9:43 a.m., R95 was sitting in a wheelchair looking out the window. The side table with the water mug was behind R95 next to the bed, out of reach.<br><br>During an observation/interview on 6/25/25 at 7:28 a.m., R95 was in bed wake, and R95's nightstand was across the room next to the wall out of reach. NA-E verified that R95 was unable to reach the water mug. NA-E indicated staff normal practice was to keep the water mug next to her. NA-E indicated R95 was able to drink fluids independently, but at times did need assistance.<br><br>During an observation/interview on 6/25/25 at 11:11 a.m., R95 was in her wheelchair next to the bed and the side table with the water mug was aginst the wall on the left side about three feet away. NA-C confirmed R95 could not reach her side table and water mug on the left side. NA-C confirmed R95 she had left-sided weakness from a stroke. R95 confirmed she was unable to reach the water mug. The water mug was moved to the right side of the wheelchair and R95 was able to demonstrate she could pick up the water mug and bring it to her mouth.<br><br>During an interview on 6/25/25 at 10:11 a.m., R95 indicated staff did not always leave the water mug within reach. R95 indicated she would get thirsty and would be unable to reach her water mug.<br><br>During an interview on 6/254/25 at 6:47 p.m., NA-D indicated R95 was able to drink water independently depending on R95's mood that day.<br><br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/24/25 at 7:13 p.m., trained medical assistant (TMA)-A indicated R95 could hold her water mug when in reach.<br><br>During an interview on 6/25/25 at 7:51 a.m., resident care manager (RCM)-A indicated R95 was able to drink independently if the water mug was placed on her right side.<br><br>During an interview on 6/25/25 at 12:07 p.m., director of nursing (DON) indicated her expectations would have been for staff to place the water within reach to prevent dehydration.<br><br>Review of the policy titiled: Stnadards of Care dated 8/2024, directed staff to offer fluids when completing scheduled cares (toileting, turning, etc.) Policy lacked information of having water within reach when apporpirate. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and observation, the facility failed to honor a resident's right to make choices about food choices at meals for 1 of 1 residents (R95) reviewed for choices.<br><br>Findings include:<br><br>R95's quarterly Minimum Data Set (MDS) dated [DATE], indicated R95 had a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. R95 required partial assistance with eating and extensive assistance with dressing and personal hygiene. R95 had diagnoses of cerebral infection (stroke), hemiparesis (weakness of one side of the body), anxiety, and depression.<br><br>R95's care plan revised on 3/12/25, indicated R95 could feed herself after staff assisted with tray setup. Staff to encourage R95 to use her right hand to feed herself and place the tray in the far-right visual felid. R95's diet was changed on 4/3/25, per speech therapy to pureed (smooth blended foods) with nectar thick liquids with hopes of improving intakes. The family preferred that R95 be given cranberry juice to drink instead of any other flavored juices or milk. No water mug with thin liquids.<br><br>R95's physician order dated 6/10/25, indicated R95 had a Dysphagia (difficulty swallowing) mechanically altered texture and nectar thick consistency.<br><br>During an interview on 5/23/25 at 11:55 a.m., family member (FM)-A indicated staff would ask other residents what they wanted for the meal but would not ask R95 what she wanted for her meal; staff would not give her options.<br><br>During an interview/observation on 6/23/25 at 3:10 p.m., nursing assistant (NA)-C went to each resident's room and asked residents which meal choice for supper they wanted however, did not provide R95 options for supper. NA-C indicated there was only one choice for mechanical soft diets and pureed diets.<br><br>During an interview on 6/25/25 at 7:28 a.m., NA-E indicated all the mechanical soft diets and pureed diets get the same meal and because of this staff did not ask R95 what she wanted to eat each meal. NA-E indicated that R95 was able to verbalize what she liked to eat.<br><br>During an interview on 6/24/25 at 6:47 p.m., NA-D indicated the kitchen chose what meal option R95 would receive. NA-D indicated the kitchen staff would puree the food in the kitchen before it was brought up to the dining room to be served.<br><br>During an interview on 6/25/25 at 7:51 a.m., resident care manager (RCM)-A stated an expectation would be for staff to give all residents options for meals.<br><br>During an interview on 6/25/25 at 10:11 a.m., R95 verified staff did not ask her what she wanted for meals. R95 indicated she normally did not like what was for lunch. At times some staff would make her something else to eat, however, not consistently.<br><br>(continued on next page) |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/25/25 at 10:15 a.m., NA-F indicated residents on a dysphasia mechanical diet or food that needed to be ground up, were not provided meal options. NA-F indicated staff had not been asking R95 what she wanted to eat for meals as the kitchen would bring the food already ground up.<br><br>During an interview on 6/25/25 at 10:29 a.m., DA-A indicated the food was blended in the kitchen and then brought up to the kitchenette for the residents who received a pureed diet. Residents who did not have mechanically altered diets would have two meal choices. Which meal choice was blended was predetermined by the cook.<br><br>During an interview on 6/24/25 at 5:25 p.m., Cook-B indicated residents who received a pureed or mechanical soft diet would receive the first option on the menu.<br><br>During an interview on 6/25/25 at 10:37 a.m., Cook-A indicated staff would puree the first meal choice, otherwise the facility was wasting a lot of food. A lot of residents who received a pureed diet were incapable of making a meal choice. Cook-A indicated the normal process was to puree the first meal choice.<br><br>During an interview on 6/25/25 at 10:38 a.m., dietary manager (DM) indicated if a resident was able to express preferences the facility would try to honor their preferences. The kitchen would keep a record of foods a resident did not like if they were able to verbalize that. If a resident could not verbalize what they did not like the staff would watch for symptoms such as turning the head away when being fed. DM verified that residents who received a pureed diet did not receive meal choice options.<br><br>During an interview on 6/25/25 at 12:07 a.m., director of nursing (DON) indicated her expectation would be for staff to offer an alternative food option if a resident was not eating their meal. Having choices would be important for nutritional intake and the prevention of dehydration.<br><br>A policy titled Liberal Geriatric Diets, textures and Consistencies dated 8/24, indicated Eventide uses non-therapeutic (regular) diets to enhance the quality of life for our residents. All therapeutic diet orders such as general adult, diabetic, salt restrictions, heart-healthy, renal, etc. will be changed to a regular diet upon admission, Diets may be adjusted by a registered dietician based on the resident's individual needs and preferences. All orders for high-calorie/high-protein nutritional supplements, snacks, and calorie counts will be discontinued upon admission. The registered dietitian would implement high-calorie/high-portion nutritional supplements and snacks based on the resident individual needs and preferences. Eventide follows texture/liquid modifications as ordered. Texture modifications/liquid consistencies may be downgraded by the dietician and/or nursing as needed. The policy lacked information regarding meal choices. |

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| F 0637<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assess the resident when there is a significant change in condition<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) using the Resident Assessment Instrument (RAI) process, following the initiation of hospice services for 1 of 1 resident (R117) reviewed for hospice.<br><br>Findings include:<br><br>R117's quarterly Minimum Data Set (MDS) dated [DATE], identified R117 had severe cognitive impairment and diagnoses which included Alzheimer's disease, dementia, and traumatic brain injury. Identified R117 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting.<br><br>R117's progress notes dated 3/31/25 to 5/19/25, identified R117 was admitted to Ethos Hospice on 4/28/25.<br><br>R117's electronic medical record (EMR) identified a quarterly MDS was completed on 2/28/25, and a death MDS was completed on 5/19/25. R117 EMR lacked a significant changed MDS was completed when R117 was admitted to hospice.<br><br>During an interview on 6/25/25 at 11:11 a.m., MDS coordinator confirmed R117 passed away on 5/19/25. MDS coordinator further indicated the significant MDS was missed because the MDS coordinator counted the days wrong.<br><br>During an interview on 6/25/25 at 11:54 a.m., director of nursing (DON) confirmed the above findings. DON stated that her expectations were to have MDS's completed timely.<br><br>Review of facility policy titled Resident Assessment Instrument (RAI) process - MDS 3.0 revised 2/25, The RAI was a method for assessing functional capacity and needs, identify problems, needs, and strengths developing intervention. If the interdisciplinary team determined there was a significant change in condition, the MDS Coordinator would notify all disciplines and initiate the significant change in status. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a pressure relieving device was implemented to prevent skin breakdown for 1 of 3 residents (R22) reviewed for pressure ulcers.<br><br>Findings include:<br><br>R22's quarterly Minimum Data Set (MDS) dated [DATE], identified R22 had severe cognitive impairment and diagnoses which included hemiplegia (paralysis on one side of the body), aphasia (disorder that affects the ability to communicate), and Parkinson's Disease. Identified R22 required extensive assistance with activities of daily living (ADL's) which included bed mobility, transfers, and toileting. Identified R22 was at risk for pressure ulcers.<br><br>R22's annual Care Area Assessment (CAA) dated 10/19/24, identified R22 required total assistance from staff with repositioning and was at risk for skin breakdown. Identified R22 was incontinent of bowel and bladder.<br><br>R22's care plan dated 10/14/2016, identified R22 had self care deficits and was at risk for skin breakdown related to stroke and right sided hemiparesis and dependence on staff for repositioning in bed and wheelchair. Identified R22 was to wear Prevalon boots when in bed.<br><br>R22's Braden Scale for Predicting Pressure Ulcer Risk dated 4/12/25, identified R22 was at moderate risk of developing a pressure ulcer.<br><br>R22's treatment administration record (TAR) for the month of June 2025, identified R22 was to have Prevalon boots when in bed on every shift.<br><br>Third floor nursing assistant (NA) care sheet undated, identified R22 was to have Prevalon boots on while in bed.<br><br>During an observation on 6/23/25 at 12:29 p.m., R22 was lying in bed on her back wearing gripper socks on her feet. Blue Prevalon boots were on a bedside table across the room.<br><br>During an observation on 6/24/25 at 1:22 p.m., nursing assistant (NA)-A and NA-B sanitized hands and applied gloves, hooked R22 up to the hoyer lift and lifted R22 into bed. NA-A and NA-B rolled R22 onto her side and pulled her pants down to check her incontinent product then turned R22 onto her left side. Blue Prevalon boots continued to be on the bedside table across the room. NA-A- and NA-B removed gloves sanitized hands, and exited R22's room. At no time did NA-A or NA-B offer to place the blue Prevalon boots onto R22's feet.<br><br>During a joint interview on 6/24/25 at 1:34 p.m., NA-A and NA-B stated they had not offered to put the blue Prevalon boots on R22's feet because R22 only required the blue Prevalon boots on her feet when she went to bed at night.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Eventide Lutheran Home | 1405 7th Street South<br>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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 6/24/25 at 1:40 p.m., registered nurse (RN)-A verified R22 was at risk for developing pressure ulcers. RN-A stated R22 was to have blue Prevalon boots at all times while she is in bed per the care plan. RN-A placed the blue Prevalon boots on R22's feet and stated her expectation was the staff placed the blue Prevalon boots on any time R22 was in bed to prevent skin breakdown.<br><br>During an interview on 6/25/25 at 9:16 a.m., director of nursing (DON) verified R22 was at risk for skin breakdown. DON stated her expectation was that staff would have applied the blue Prevalon boots on R22's feet when in bed per the care plan to prevent skin breakdown.<br><br>Review of a facility policy titled Skin Assessment revised 12/23, identified the purpose of the skin assessment was to identify current and potential problems. Identified a resident admitted to the facility was to receive the necessary treatment and services to promote healing, prevent infection, and prevent new pressure ulcers, Further identified the goal was that residents who entered the facility without pressure ulcers do not develop pressure ulcers unless their clinical condition demonstrates the pressure ulcer was unavoidable. |