

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>245461</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>04/10/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>EVENTIDE LUTHERAN HOME</b>		STREET ADDRESS, CITY, STATE, ZIP <b>1405 7TH STREET SOUTH MOORHEAD, MN 56560</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Many</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p>Based on observation, interview and document review, the facility failed to ensure consistent social distancing, and failed to implement communal dining restrictions in common dining areas for residents reviewed at the time of the COVID-19 Focused Infection Control Survey, which had the potential to affect all 149 residents who currently resided at the facility. Findings include: Social Distancing During the facility tour on 4/8/2020, at 9:06 a.m. a small sitting area was located on the first floor of the south unit and to the left R1, R2, R3 and R4 were eating breakfast independently. R1 and R2 were seated approximately 2-3 feet apart while eating their breakfast. R1 sneezed occasionally without covering her face/mouth. R3 was seated approximately 5 feet straight across from R1 and R2 while eating breakfast independently. Registered nurse (RN)-A confirmed the four residents were seated together because they needed to be monitored while eating due to swallowing issues, except for R2 who had behaviors. - at 9:12 a.m. R1, R2, R3, R4 continued to be seating in the small sitting area located on the left side of the hallway eating independently and were not socially distanced from each other while eating. During observations on 4/8/2020, at 10:40 a.m. on the third floor commons area across from the nurses station, four residents were watching TV. Two female residents were seated in their wheel chairs and one female resident was seated in a chair with her wheelchair in front of her, next to a male resident seated in a chair. All the residents were seated approximately 3 to 4 feet apart, and were not socially distanced from each other. - at 11:14 a.m. one female resident remained seated in a chair with her wheelchair in front of her visiting with a male resident who was seated next to her. The two residents were not socially distanced from each other. At 11:41 a.m., four residents continued to be seated 3 to 4 feet apart from each other while they watched TV in the commons area. In addition, two residents were seated in front of the nurses station in their wheel chairs not socially distanced from each other. On 4/8/2020, at 11:31 a.m. on the second floor common area near the nursing desk, with unit secretary (US)-A seated behind the desk, R7 sat in a wheelchair less than a foot away from R8 who sat in a regular chair with a 4 wheeled walker in front of her. Multiple staff walked past R7 and R8, and did not attempt to provide social distancing. At that time, R8 attempted to stand independently, and nursing assistant (NA)-B approached R8, redirected her to sit back down in her wheelchair and immediately walked away with no attempt to provide social distancing for R7 and R8. - At 11:36 a.m. US-A remained seated behind the nursing desk, was not observed to provide social distancing for R7 and R8. Communal Dining During observation on 4/8/2020, at 9:28 a.m. in the second floor dining room, a total of 12 residents and staff were present in the common dining room, for the breakfast meal. During observation on 4/8/2020, at 9:29 a.m. on the third floor main dining room R5 and R6 were seated at a table located in the front of the dining room eating independently. R5 was seated approximately 3 to 4 feet away from R6 when trained medication aid (TMA)-A approached R5 and gave her medications to take. TMA-A proceeded to walk back to her medication cart. TMA-A was not observed to provide social distancing for R5, and 6 while they continued to eat their breakfast independently next to other. - at 9:41 a.m. R5 and R6 continued to be seated approximately 3 to 4 feet away from each other in the dining room area, eating independently. R5 and R6 were not observed to be socially distanced while they ate their breakfast. On 4/8/2020, at 11:04 a.m. registered nurse (RN)-B confirmed the residents who needed assistance/supervision with eating came to the main dining room for meals. RN-B indicated the facility had no restrictions on the number of residents and staff in the dining room, and staff were to space the residents out in the dining room so they were not close to each other while eating.</p> <p>On 4/8/2020, at 12:02 p.m. staff began serving the residents in second floor dining room. At this time a total of 13 residents and 8 dietary/nursing staff were observed in the common dining room. - At 12:13 p.m. at this time a total of 23 people were observed gathered in the second floor dining room, including 10 staff who were assisting 13 residents with various things during meal time. - At 12:25 p.m. a total of 10 staff and 13 residents remained in dining room. - At 12:30 p.m. a total 28 people including 15 staff, and 13 residents were observed to be gathered in the dining room. During observation on 4/8/2020, at 12:50 p.m. in the third floor dining room, 10 round tables had two place settings set at opposite ends of each table. 11 dietary/nursing staff were assisting residents with their plates of food, and 20 residents were seated in dining room with 2 residents at each table. Although the residents were socially distanced 6 feet across from each other, a total of 31 people were observed to be gathered in the communal dining room at the same time. On 4/8/2020, at 1:00 p.m. dietary aid (DA)-C confirmed they always served the residents in the third floor dining room this way and indicated nursing staff would bring residents into the dining room that need assistance with eating. On 4/8/2020, at 12:46 p.m. infection control registered nurse (ICRN) indicated residents were encouraged to remain in their rooms, and stated if residents were out of their rooms they were to be kept socially distanced as able. ICRN indicated if residents were seen closer than 6 feet apart, she would expect staff to try to separate them. The ICRN indicated the residents who ate in the dining rooms required assistance or supervision, and confirmed the facility had made no limitations on the number of people in the dining room at one time. On 4/10/2020, at 8:02 a.m. during a phone interview with the director of nurses (DON), she indicated the facility had stopped group activities, and indicated they had updated seating charts in the dining rooms to keep residents that needed assistance/supervision with eating 6 feet apart, and independent residents ate in their rooms. The DON stated she would expect staff to intervene and separate any residents who were not 6 feet apart. The DON verified she was aware of the large numbers of people gathered together in the dining rooms during meals, indicated she was unaware of how the number of residents/staff could be lowered and currently had no plan in place to ensure guidelines for provision of communal dining restrictions were followed. A review of the facility provided document titled COVID-19 Precaution Implementation Timeline, section dated 3/16/2020, indicated the facility had closed all communal gathering spaces.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.