DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3H0B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245259**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER HAVEN**
(L4) **1109 EAST HIGHWAY 7**
(L5) **MONTEVIDEO, MN** (L6) **56265**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/08/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/12/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/17/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245259

November 13, 2014

Mr. Jim Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, Minnesota 56265

Dear Mr. Flaherty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B. Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid Programs.

Effective October 12, 2014 the above facility is certified for:

90 skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 13, 2014

Mr. Jim Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, Minnesota 56265

RE: Project Number S5259021

Dear Mr. Flaherty:

On September 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. This survey found the most serious deficiencies to be isolated deficie widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 20, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 12, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 12, 2014 and therefore remedies outlined in our letter to you dated Septemeber 22, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5259r14

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245259	A. Building B. Wing	10/28/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/07/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** MM/mm	**Date:** 11/13/2014	**Signature of Surveyor:** 28034	**Date:** 10/28/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/11/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245259	A. Building 01 - MAIN BUILDING 01 B. Wing	10/20/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 10/12/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/mm	Date: 11/13/2014	Signature of Surveyor: 19251	Date: 11/20/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/17/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3H0B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245259**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER HAVEN**
(L4) **1109 EAST HIGHWAY 7**
(L5) **MONTEVIDEO, MN** (L6) **56265**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/11/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 10/03/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 11/14/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/17/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3H0B

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

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(L1) **245259**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677040100**

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(L3) **LUTHER HAVEN**
(L4) **1109 EAST HIGHWAY 7**
(L5) **MONTEVIDEO, MN** (L6) **56265**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/28/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
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FISCAL YEAR ENDING DATE: (L35)
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And/Or Approved Waivers Of The Following Requirements:
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___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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Gail Anderson, Unit Supervisor 11/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 12/08/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible (L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/12/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/17/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245259

November 13, 2014

Mr. Jim Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, Minnesota 56265

Dear Mr. Flaherty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B. Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid Programs.

Effective October 12, 2014 the above facility is certified for:

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If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

November 13, 2014

Mr. Jim Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, Minnesota 56265

RE: Project Number S5259021

Dear Mr. Flaherty:

On September 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 11, 2014. This survey found the most serious deficiencies to be isolated deficie widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 20, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 11, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 12, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 11, 2014, effective October 12, 2014 and therefore remedies outlined in our letter to you dated Septemeber 22, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5259r14

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245259	A. Building B. Wing	10/28/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/07/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **10/07/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **10/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** MM/mm	**Date:** 11/13/2014	**Signature of Surveyor:** 28034	**Date:** 10/28/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/11/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245259	01 - MAIN BUILDING 01	10/20/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	10/12/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	11/13/2014	19251	11/20/2014
CMS RO				

Followup to Survey Completed on: 9/17/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 22, 2014

Mr. Jim Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Project Number S5259021

Dear Mr. Flaherty:

On September 17, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

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Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 21, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 21, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 11, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	**1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to speak to residents in a manner which promoted dignity for 3 of 5 residents (R28,R52, R75) who received meals in the west dining room of the facility. Findings include: R28's annual Minimum Data Set (MDS) dated 8/6/14, identified R28 had moderate cognitive impairment, and required extensive assistance for areas of daily living (ADL) which included eating. R28's care plan reviewed 8/27/14,	F 241	F 241: Luther Haven must promote care for Residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. All Luther Haven department Managers were notified and instructed to remind staff of dignity issues involving terms of endearment. This notification was completed while the survey team was present at Luther Haven. Individual coaching and education was given to CNA (NA)-F who was specifically identified by	10/7/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/30/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	09/11/2014

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F 241	Continued From page 1 identified R28 had diagnosis of dementia and had impaired decision making skills. The care plan listed various interventions which included to respect resident's rights to make decisions, adjust tome of voice and speak directly to resident or directly into good ear when communicating, and to repeat communication to resident as needed. However, the care plan did not identify R28 preferred to be called a nickname or pet name instead of her given name. R52's quarterly MDS dated 6/3/13, identified R52 had severe cognitive impairment, and required extensive assistance for ADL'S which included eating. R52's care plan reviewed 3/12/14, identified R52 had dementia, difficulty comprehending what is said to her, and difficulty expressing what she needs. The care plan listed various interventions which included adjust tome of voice and speak directly to resident when communicating, and to repeat communication as needed. However, the care plan did not identify R52 preferred to be called a nickname or pet name instead of her given name. R75's significant change MDS dated 8/4/14, identified R75 had severe cognitive impairment, and required extensive assistance for transferring, toileting and personal hygiene. Further, the MDS identified R75 had difficulty focusing attention, disorganized thoughts, and altered level of consciousness. R75's care plan reviewed 6/11/14, identified R75 had anxiety, depression, and visual impairment. The care plan listed various interventions which included to provide information necessary to make health care decisions, and explain procedures. However, R75's care plan did not identify R75 preferred to be called a nickname or pet name	F 241	the survey team. Written notification was also distributed to all staff with payroll checks on 09/25/2014. This will also be discussed at Resident Council on 9/30/2014. Random daily audits will continue indefinitely. Results of these audits will be discussed/reviewed at the next QI/QA meeting (10/7/2014) and until necessary. This will also be reviewed, discussed, and results summarized at an All Staff In-service Oct. 23rd, 2014. Responsible Person: Director of Nursing and/or Designee	

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F 241	Continued From page 2 instead of her given name. During continuous observation of the evening meal on 9/8/14, from 6:39 p.m. to 7:19 p.m. whiled seated together in the dining room R28, R52 and R75 were observed to be repeatedly called pet names such as honey, sweetheart and dear. At 6:39 p.m. nursing assistant (NA)-F stood beside R52's wheel chair and assisted R52 to eat food items from her plate. When R52's refused to open her mouth for the bite of food, NA-F called R52 by name followed by "honey." When R52 did not answer, NA-F immediately moved to a stationary chair next to R28. R28 was assisted to eat bites of food while NA-F repeatedly addressed her as "honey," and stated "there you go sweetheart," as she spooned bites of food into R28's mouth. At 6:48 p.m. NA-F addressed R75 by her first name followed by "honey do you want juice?" and immediately walked from the room. At 6:50 p.m. NA-F returned to the table with a glass of milk, placed the glass on the table in front of R75 and stated "there you go sweetheart." At 7:04 p.m. NA-F was seated next to R52 and a offered a drink of juice to R52 and addressed R52's name followed by "honey." At 7:09 p.m. again NA-F offered R52 food choices as she used R52's name followed by "honey." At 7:10 p.m. again NA-F offered R52 a bite of food, and stated "here you go honey." At 7:13 p.m. NA-F approached R28, offered her a drink from her glass and stated "there you go honey."	F 241		

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F 241	Continued From page 3 At 7:15 p.m. NA-F called across the table to R52 and stated "what's wrong Honey?" At 7:19 p.m. NA-F stated to R52 "would you like a ride back to your room, dear?" During interview on 9/8/14, 7:23 p.m. NA-F confirmed she routinely called residents by pet names such as honey and sweetheart. NA-F stated she had been told not to speak to residents in this manner and stated "but it is my personality." During an interview on 9/10/14, at 3:03 p.m. the assistant director of nursing (ADON) confirmed it was not dignified for residents to have been called names like honey, and sweety. The ADON further explained if residents chose to be called anything besides their given name, that would be addressed on the individual care plan, face sheet and electronic record. Review of the undated facility policy titled Quality of life Policy identified residents would receive care in a manner to enhance respect and dignity. The policy identified "Our staff shall display respect for residents when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		10/7/14

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F 282	Continued From page 4 by: Based on observation, interview, document review the facility failed to implement the care plan intervention to float heels for 1 of 2 residents (R114) with a current pressure ulcers in the facility. Findings include: R114's care plan dated 8/27/14, identified R114 was at risk for skin breakdown related to impaired mobility, surgical incision to right hip, and also had an open area on the right heel. R114's care plan listed various interventions which included: to reposition every 2 hours and as needed, observe skin with cares and licensed staff to complete a body audit weekly, provide measures to decrease pressure/irritation to skin as needed and alternating pressure mattress overlay applied to R114's mattress. The undated care sheet (form used by direct care staff which was used as a daily guide for directing care needs for residents), directed staff to utilize various interventions for R114 which included "*Float Heels*" On 9/10/14, 7:06 a.m. R114 was observed lying in bed on right side with both heels resting on the mattress. There was no pillow near R114's legs or feet, nor near end of bed on or off of the bed. Two pillows were observed under R114's head. During continuous observation from 7:06 a.m. to 7:49 a.m. R114 remained lying in bed on right side with both heels resting on the bed. At 7:49 a.m. licensed practical nurse (LPN-A) entered R114's room to check his vital signs. LPN-A asked R114 to turn from right side to lay on his back in order to obtain his blood pressure. While	F 282	F 282: Luther Haven must provide services by qualified persons in accordance with each resident□s written plan of care. Surveyor questioned and reported non-compliance of plan of care regarding floating of heels for Resident 114 during the survey process. Nursing staff caring for Resident 114 was immediately coached and educated regarding the plan of care for floating of heels as well as the policy. Floating of heels policy and procedure was then reviewed during each shift report . Floating of heels for all Residents with the intervention to float heels will now be monitored every shift by Nursing staff and documented in the TAR to ensure policy and procedure compliance to prevent pressure ulcers and breakdown. Plan of Care (floating of heels) audits for all facility Residents was initiated immediately and will continue weekly for 1 month and randomly thereafter. Results of audits will be discussed/reviewed at the next QI/QA meeting (10/7/2014) and until necessary. This will also be reviewed, discussed, and results summarized at an All Staff In-service Oct. 23rd, 2014. Responsible Person: Director of Nursing and/or Designee	

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F 282	Continued From page 5	F 282		

turning in bed, R114 pushed on the mattress with his right heel to aid in turning. R114 hollered out, "Oh my God, my heel hurts!" R114 clenched both hands on the bottom sheet and had a strong grimace on his face. R114 stated his right heel hurt terribly and rated the pain a 10/10 on a numeric pain scale (0 being no pain and 10 being the worst pain possible). LPN-A offered to assist R114 to utilize a pillow for comfort and briefly exited R114's room to obtain a pillow. Upon return, LPN-A assisted R114 to lift legs and placed a pillow under R114's lower legs which allowed both heels to float over the bed and offered R114 an oral pain medication. R114 expressed relief from pain with pressure relief from floating the right heel and declined the medication at that time. LPN-A confirmed R114's heels had been resting on the mattress upon entry to R114's room. LPN-A indicated R114 should have had a pillow under his legs so both heels could be floated over the bed.

On 9/10/4, at 8:09 a.m. registered nurse (RN)-A confirmed R114's heels were to be floated at all times when in bed due to the presence of the pressure ulcer. RN-A confirmed R114's care sheet directed staff to float R114's heels and confirmed she would expect staff to follow care plan and care sheet interventions at all times.

On 9/10/14, 8:30 a.m. the director of nursing (DON) verified R114's physician orders directed staff to float heels when in bed. The DON indicated she expected staff to follow R114's interventions listed on the care plan and care sheets.

On 9/10/14, 12:18 p.m., the assistant director of nursing (ADON) confirmed R114 had a current

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F 282	Continued From page 6 pressure ulcer to the right heel. The ADON verified R114's heels were to be floated when in bed to aid in healing the pressure ulcer. The ADON further confirmed the that pressure on the heel could impair healing of the pressure ulcer. On 9/11/14, at 12:18 p.m. R114 stated "sometimes" staff put pillows under legs to keep his heels off of the bed. R114 stated he experienced pain briefly at the pressure ulcer site when the area was touched. Review of the policy provided by the facility titled Pressure Ulcer Prevention and Treatment Interventions and Guidelines, dated 2007, directed staff to avoid positioning resident on a pressure ulcer and to elevate heels off bed and directed to place pillows under calf to raise heels off the bed or utilize foam heel lift boots. Review of the policy provided by the facility titled Policy and Procedure for Prevention and Treatment of Skin Breakdown, dated 2007, revealed residents would be routinely assessed to identify those at increased risk for pressure ulcers, preventative measures implemented and appropriate interventions implemented for treatment of pressure ulcers.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		10/7/14

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 314	Continued From page 7 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to promote the healing of a current pressure ulcer for 1 of 2 residents (R114) reviewed with a current pressure ulcer. Findings include: R114's admission Minimum Data Set (MDS) dated 8/20/14, identified R114 had diagnoses which included right hip fracture with surgical repair, heart failure and peripheral vascular disease. The MDS identified R114 had intact cognition, and required extensive assistance with all activities of daily living (ADL's). Further, the MDS identified R114 was at risk for the development of pressure ulcers and required a pressure reducing device in chair and in bed. The MDS identified R114 did not have a current pressure ulcer at the time of assessment. R114's Care Area Assessment (CAA) dated 8/26/14, identified R114 required extensive assistance with ADL's, was able to slightly shift weight but was unable to fully move position without staff assistance. The CAA further identified R114 had very dry, calloused feet that were open due to calluses had fallen off. The CAA revealed staff decision to implement a plan of care for R114 to prevent pressure ulcers and breakdown. R114's care plan dated 8/27/14, identified R114	F 314	F 314: Luther Haven must provide services by qualified persons in accordance with each resident□s written plan of care. Surveyor questioned and reported non-compliance of plan of care regarding floating of heels for Resident 114 during the survey process. Nursing staff caring for Resident 114 was immediately coached and educated regarding the plan of care for floating of heels as well as the policy. Floating of heels policy and procedure was then reviewed during each shift report . Floating of heels for all Residents with the intervention to float heels will now be monitored every shift by Nursing staff and documented in the TAR to ensure policy and procedure compliance to prevent pressure ulcers and breakdown. Plan of Care (floating of heels) audits for all facility Residents was initiated immediately and will continue weekly for 1 month and randomly thereafter. Results of audits will be discussed/reviewed at the next QI/QA meeting (10/7/2014) and until necessary. This will also be reviewed, discussed, and results summarized at an All Staff In-service Oct. 23rd, 2014. Responsible Person: Director of Nursing and/or Designee	

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	245259	A. BUILDING _____ B. WING _____	09/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

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F 314	Continued From page 8 was at risk for skin breakdown related to impaired mobility, surgical incision to right hip, and also had an open area on the right heel. R114's care plan listed various interventions which included: to reposition every 2 hours and as needed, observe skin with cares and licensed staff to complete a body audit weekly, provide measures to decrease pressure/irritation to skin as needed and alternating pressure mattress overlay applied to R114's mattress. The undated care sheet (form used by direct care staff which was used as a daily guide for directing care needs for residents), directed staff to utilize various interventions for R114 which included "*Float Heels*" On 9/10/14, 7:06 a.m. R114 was observed lying in bed on right side with both heels resting on the mattress. There was no pillow near R114's legs or feet, nor near end of bed on or off of the bed. Two pillows were observed under R114's head. During continuous observation from 7:06 a.m. to 7:49 a.m. R114 remained lying in bed on right side with both heels resting on the bed. At 7:49 a.m. licensed practical nurse (LPN-A) entered R114's room to check his vital signs. LPN-A asked R114 to turn from right side to lay on his back in order to obtain his blood pressure. While turning in bed, R114 pushed on the mattress with his right heel to aid in turning. R114 hollered out, "Oh my God, my heel hurts!" R114 clenched both hands on the bottom sheet and had a strong grimace on his face. R114 stated his right heel hurt terribly and rated the pain a 10/10 on a numeric pain scale (0 being no pain and 10 being the worst pain possible). LPN-A offered to assist R114 to utilize a pillow for comfort and briefly exited R114's room to obtain a pillow. Upon	F 314		

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F 314	Continued From page 9	F 314		

return, LPN-A assisted R114 to lift legs and placed a pillow under R114's lower legs which allowed both heels to float over the bed and offered R114 an oral pain medication. R114 expressed relief from pain with pressure relief from floating the right heel and declined the medication at that time. LPN-A confirmed R114's heels had been resting on the mattress upon entry to R114's room. LPN-A indicated R114 should have had a pillow under his legs so both heels could be floated over the bed.

Review of R114's current orders revealed a physician order dated 8/18/14 to "keep heels elevated at all times when in bed."

Review of R114's Comprehensive risk data collection form dated 8/18/14, identified R114 had multiple areas of bruising, a skin tear and had rough, dry skin on both hands and feet with areas cracked and peeling.

Review of R114's Skin-Luther Haven Skin Risk Assessment with Braden Scale(a tool used to identify risk for developing pressure ulcers) form dated 8/18/14, identified R114 had very limited mobility, was chairfast, skin was often moist, and required moderate to maximum assist with moving. The form identified R114 was at "moderate risk" for the development of pressure ulcers.

Review of R114's Skin-Luther Haven Skin Risk Assessment with Braden Scale (Acuity)form dated 8/20/14, identified R114 required extensive assist for bed mobility, utilized a mechanical lift for transfers, utilized a alternating air mattress on bed. The form identified R114 was "at risk" for development of pressure ulcers and had two

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F 314	Continued From page 10 open areas on right heel which had developed on 8/18/14. Review of R114's weekly wound documentation progress forms from 8/18/14 to 9/3/14, revealed the following -8/18/14, identified measurements of two right heel wounds. The first wound identified as #1 included measurements of 1 centimeters (cm) x 0.5 cm. The second wound identified as #2 included measurements of 1.4 cm x 0.9 cm. The form further identified R114's right heel had a purple area on the medial side 0.9 cm away from #2, pink base, no drainage. The form lacked identification on type or stage of wounds. The form further revealed R114 experienced pain to the right heel when the area was touched. -8/20/14, non-pressure ulcer of the right heel with two open areas. The two areas were identified as areas A and B. The form identified the following measurements for area A; 1 cm by 0.5 cm and for area B; 1.4 cm by 0.8 cm. The form further identified area A as having new skin and area B had 100% granulation tissue (pink tissue with a granular appearance), area B had a scant amount of clear drainage, wound edges were calloused with scaly build up and the area was tender when touched. -8/27/14, non-pressure ulcers of the right heels with two areas identified as areas A and B. Area A was identified as having been closed over by a callous. The form revealed measurements for area B as 1.5 cm by 1.5 cm with a darkened area to the side, calloused wound edges. -9/3/14, revealed a stage 2 pressure ulcer (partial	F 314		

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F 314	Continued From page 11 thickness loss of dermis presenting as a shallow open ulcer with red or pink wound bed, without slough, may also present as an intact or open blister), measurements of 1.5 cm by 1.2 cm, pink base, darkened area to the side, open and unmeasured, surrounding skin calloused, stable progress of healing. Review of R114's nursing progress notes from 8/18/14 to 9/4/14 revealed the following: - 8/18/14, R114 had been seen in the clinic for purple toes and right heel pain with 2 small open areas. A physician order had been obtained which directed staff to keep heel elevated with a pillow under legs when in bed. -8/28/14, right heel remained open in one area, and measurements had been documented on the wound form. - 9/3/14, was seen by physician and physician had determined open area on heel was a pressure ulcer. On 9/10/4, at 8:09 a.m. registered nurse (RN)-A confirmed R114's heels were to be floated at all times when in bed due to the presence of the pressure ulcer. RN-A confirmed R114's care sheet directed staff to float R114's heels and confirmed she would expect staff to follow care plan and care sheet interventions at all times. On 9/10/14, 8:30 a.m. the director of nursing (DON) verified R114's physician orders directed staff to float heels when in bed. The DON indicated she expected staff to follow R114's interventions listed on the care plan and care	F 314		

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F 314	Continued From page 12 sheets. On 9/10/14, at 10:18 a.m. observation of dressing change to R114's right heel completed by RN-B and LPN-A revealed an area which measured 2 cm by 1.8 cm with an inner open area which measured 0.8 cm by 0.6 cm. The wound bed was covered approximately 75% with slough (stringy, yellowing tissue which adheres to the wound bed, thus impairing healing). The surrounding skin was moderately red with no swelling or odor present. RN-B confirmed R114 had a stage 2 pressure ulcer on the heel. R114 stated the heel was sore when touched or on something, but otherwise did not hurt. On 9/10/14, 12:18 p.m., the assistant director of nursing (ADON) confirmed R114 had a current pressure ulcer to the right heel. The ADON verified R114's heels were to be floated when in bed to aid in healing the pressure ulcer. The ADON further confirmed the that pressure on the heel could impair healing of the pressure ulcer. On 9/11/14, at 12:18 p.m. R114 stated "sometimes" staff put pillows under legs to keep his heels off of the bed. R114 stated he experienced pain briefly at the pressure ulcer site when the area was touched. Review of the policy provided by the facility titled Pressure Ulcer Prevention and Treatment Interventions and Guidelines, dated 2007, directed staff to avoid positioning resident on a pressure ulcer and to elevate heels off bed and directed to place pillows under calf to raise heels off the bed or utilize foam heel lift boots. Review of the policy provided by the facility titled	F 314		

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F 314	Continued From page 13 Policy and Procedure for Prevention and Treatment of Skin Breakdown, dated 2007, revealed residents would be routinely assessed to identify those at increased risk for pressure ulcers, preventative measures implemented and appropriate interventions implemented for treatment of pressure ulcers.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure 1 of 4 residents received adequate supervision while bathing in the facility provide a safe environment during bathing for 1 of 4 residents (R4) reviewed for accidents. Findings include: The quarterly Minimum Data Set (MDS) dated 6/18/14, identified R4 had diagnoses which included anxiety and manic depression. The MDS identified R4 had intact cognition, had upper extremity impairment on one side, and required staff assistance with bathing. During an interview on 9/8/14, at 5:30 p.m. R4	F 323	F 323: Luther Haven must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident R4 was observed, by surveyor, to be left alone (for 7 min) in the whirl pool tub without chair seat belt on. CNA (NA E) was immediately counseled, coached, and educated regarding Bath policy and procedure which states Residents are not to be left alone in the Tub. Memo regarding this policy and procedure was distributed to all stations for review during daily/shift report. Audits to assure that residents are not left in the tub unattended	10/7/14

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F 323	Continued From page 14 stated nursing assistant (NA)-E's usual practice was to leave R4 with out a call light and unsupervised in the whirlpool tub. R4 stated a safety belt was never used for her in the whirlpool tub and R4 was fearful of future possible complications when she was left alone in the whirlpool tub. R4 stated NA-E had told her to "sit and relax" while NA-E left the room to complete her work, and to "holler" if NA-E was needed. R4 stated "sometimes I hollered 3 times" before NA-E returned. R4 stated the other nursing assistants who assisted her in the tub routinely did not leave her alone in the tub room. During an observation on 9/10/14, at 10:47 a.m. NA-E walked from the tub room into the hallway of the facility and made entries on the kiosk (computer monitor) mounted on a wall in the hallway. The hallway curtain was closed, and the door to the whirlpool tub room was open approximately 3 to 4 inches. NA-E returned to the tub room at 10:54 a.m. R4 was left alone in the tub room, while seated in the whirlpool tub During an interview on 9/10/14, at 12:20 p.m. registered nurse (RN)-C confirmed the practice of staff leaving some residents alone in the tub room while in the whirlpool. RN-C stated placing the call light near the tub was not the procedure at this time, however; "everyone is belted in." During an interview on 9/10/14, at 12:40 p.m. NA-E confirmed she had left R4 alone in the whirlpool tub room, with the water level to the top of R4's chest. NA-E stated a safety belt was not utilized for R4, nor was a call light with in reach. NA-E further stated she routinely used the safety belt only for residents who were not able to hold on to the bars on each side of the bath chair, and	F 323	will be completed weekly for 4 wks and randomly thereafter. Results of audits will be discussed/reviewed at the next QI/QA meeting (Oct. 7th, 2014) and until necessary. This will also be reviewed, discussed, and results summarized at an All Staff In-service Oct. 23rd, 2014. Responsible Person: Director of Nursing and/or Designee	

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F 323	Continued From page 15	F 323		

had not thought of placing the call light within reach for R4. NA-E indicated she routinely left R4 and R71 alone in the tub room, and stated she routinely stayed in the tub room with all of the remaining residents she assisted with bathing.

During an interview on 9/10/14, at 1:55 p.m. the assistant director of nursing (ADON) stated it would be unusual for a resident to be alone in the whirlpool tub room, however; an exception may be made for an alert resident with the approval of the nurse manager. The ADON stated a safety belt "should be used" for residents when in the whirlpool tub. The ADON consulted with the director of nursing (DON), who confirmed the expectation had been that the safety belt be on the resident when unattended, and the charge nurse consulted prior to leaving the resident alone.

During an interview on 9/10/14, at 2:05 p.m. R4 confirmed NA-E had left the tub room while she was in the whirlpool tub, a safety belt had not been applied and a call light had not in reach for her to utilize to call for assistance if she needed to call. R4 stated she had a fear of being alone in the whirlpool tub room "in case of sliding and going down" in to the tub water, and also a fear for other residents that may be left alone.

R71's quarterly MDS dated 7/28/14, identified R71 had moderate cognitive impairment, and required supervision with hygiene.

During an interview on 9/11/14, at 9:18 a.m. R71 confirmed he routinely utilized the whirlpool bath, however; stated he was not left alone in the tub room. R71 indicated staff may "step out just for a minute to grab a towel" but that is it. R71 further

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F 323	Continued From page 16 stated a safety "belt was always" used when bathing, so he did not slip. R71 confirmed he felt safe when in the whirlpool tub. Review of the undated facility policy and procedure titled Bath (TUB) identified for staff, in all capital letters under #4 "NEVER LEAVE A RESIDENT IN THE TUB ALONE."	F 323		

Luther Haven

This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employee, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.

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	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/17/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 17, 2014 At the time of this survey, Luther Haven was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/30/2014

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.

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Luther Haven is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1974, an addition was added that was determined to be of Type II(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type II(000) construction. Because the original building and the two additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 89 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		10/12/14

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LUTHER HAVEN	**1109 EAST HIGHWAY 7** **MONTEVIDEO, MN 56265**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144 SS=F	Continued From page 2 Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, the generator area does not have battery-powered emergency lighting. This deficient practice could affect all occupants including residents, staff and visitors in the event the emergency generator fails to start as required in a power outage and repairs are needed to the unit. Findings include: On facility tour between 8:00 AM and 11:00 AM on 9/17/2014, it was observed that the structure housing the emergency generator, did not have battery-powered back-up lighting as required by NFPA 110(99), Sec. 5-3.1. This deficient practice was verified by the Maintenance Supervisor at the time of discovery.	K 144	Despite the facility's objection to the alleged Notice of Violation, the following is proposed plan of correction in accordance with state and federal regulations:the facility alleges that it will be in substantial compliance with the standards indicated by October 12, 2014. The facility has contracted with Heartland Electric to order and install a weather proof battery - powered emergency light for the structure housing the emergency generator. This is a special order due to the fact that it is weather proof. The battery - powered emergency light was ordered the week of September 22, 2014. Responsible Person: Administrator, facility building engineer.	