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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5TAL

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 **09/18/2017** (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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 11/07/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/29/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/29/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245259 November 7, 2017

Mr. James Flaherty, Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 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 program.

Effective September 30, 2017, the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2017

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

RE: Project Number S5259024

Dear Mr. Flaherty:

On August 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 27, 2017. This survey found the most serious deficiencies to be 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 September 18, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 2, 2017 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 July 27, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 27, 2017, effective September 30, 2017, and therefore remedies outlined in our letter to you dated August 11, 2017, 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.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2017

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

Re: Project Number S5259024

Dear Mr. Flaherty:

On September 18, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility to determine correction of orders found on the survey completed on July 27, 2017, with orders received by you on August 11, 2017. At this time these correction orders were found corrected.

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.

Please feel free to call me with any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5TAL

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**

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 **07/27/2017** (L34)

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 08/24/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/29/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
August 11, 2017

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

RE: Project Number S5259024

Dear Mr. Flaherty:

On July 27, 2017, 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 electronically delivered CMS-2567, whereby corrections are required.

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

Informal Dispute Resolution - 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
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 5, 2017, 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 5, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (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 October 27, 2017 (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 January 27, 2018 (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
Health Regulation Division
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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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 _____	07/27/2017

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 441 SS=F	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441		8/31/17

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

Electronically Signed | 08/18/2017

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.

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 _____	07/27/2017

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 441	Continued From page 1 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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 _____	07/27/2017

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 441	Continued From page 2 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of a Legionella in the facility water systems to prevent cases and outbreaks of Legionnaires' disease. This deficient practice had the potential to affect all 81 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted. The facility utilized Monthly Infection Control Logs from January 2017 through February 2017. The monthly logs only included residents with infections for which antibiotics were prescribed and did not consistently include symptoms and culture results for the infection. The facility's form titled Facility-Level Indicators Worksheet 2017, included data for January through June. The worksheet listed various indicators which included average census for short stay and long stay, number of cultures done, percentage of antibiotics used for urine/respiratory/skin/other infections. The worksheet also included a list of the specific antibiotic used for specific residents. The worksheet did not include symptoms of infection, onset or resolution of infection, specific organisms, and did not include residents with	F 441	F 441 Luther Haven Failed to establish a written infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of Legionella in facility water systems to prevent cases and outbreaks of Legionnaires□ disease. Luther Haven reviewed all Infection control policies and updated to include symptom surveillance and illness prior to the need for antibiotics. In addition to the current Influenza, Gastroenteritis and Respiratory symptom logs for tracking a line listing for abnormal vital signs &/or change in condition we created and put into use on 08/18/2017 at each nursing station. Luther Haven has scheduled a LPN to work with the IP 2-4 days per month to assist in tracking & documenting surveillance , infections, illness trends. She has been scheduled to attend Pathway Health Infection Preventionist Basic Bootcamp for LTC Providers. Luther Haven surveillance Policy was updated to include monthly infection prevention environment rounds to be rotated between departments and staff members to increase the circle of employees completing the rounds, therefore increasing the number of staff	

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 _____	07/27/2017

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 441	Continued From page 3 infections that were not treated with antibiotics. The facility's forms did not identify other infections including viral or gastrointestinal or any other infections that did not require the use of antibiotics. During interview on 7/26/17, at 1:25 p.m. director of nursing (DON), who was responsible for the facility's infection control program, confirmed the monthly infection logs were not completed thoroughly for each resident identified. DON stated the facility only tracked infections which were treated with antibiotics. The DON confirmed she did not update the logs at the time illnesses occurred. The DON indicated she updated the information either weekly, twice a month or monthly. The DON indicated there was no formal system currently in place to track and trend any viral illnesses's such as gastroenteritis or influenza. On 7/27/17, at 9:19 a.m. during follow up interview, DON stated the monthly infection information for July had not yet been completed. DON indicated the facility utilized a new surveillance process which began in March and confirmed the new process lacked such things as identification of specific symptoms that were present, the date the infection resolved and the logs lacked analysis and/or investigation of patterns identified. The DON indicated the facility needed a more formal infection surveillance process.	F 441	with awareness of what to observe for in the environment for possible risk of iillness/infection. Luther Haven Completed the Legionella Environment Assessment form and is working with a water management team that includes but is not limited to: Administrator or designee Infection Preventionist or designee Maintenance Supervisor or Designee City of Montevideo Water works supervisor Housekeeping Supervisor or designee Nursing employee Others as designated Hilllyard Rep To work on the preventing Legionella growth and spread in Luther Haven. Water Management team is utilizing the CDC toolkit. Meetings are now being scheduled to continue implementing and following the water management plan. Team will meet to establish the water management program and will review and revise program if/when event occur and annually at a minimum if no events. All Staff Mandatory Inservices were held on 08/15 and 08/17/17 to inform all staff of survey findings and to update on plan of correction and importance of following facility policy. DON or designee with complete audits of station tracking symptom &/or infection logs at least 5d/week. QAA made aware of failure to establish a	

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F 441	Continued From page 4 LEGIONNELLA POLICY/PROCEDURES During interview on 7/24/17, at 2:15 p.m. the DON stated she was not aware of Legionella requirements, the infection related to the organism or the requirements that the facility should have in place. The DON reported she had not received any education regarding Legionnaires' disease, to prepare her for developing policies, procedures and facility risk assessments. During interview on 7/24/17, at 2:20 p.m. the facility administrator confirmed he was not aware of the CMS requirements regarding Legionnaires' disease. The facility administrator verified the facility had not started a facility risk assessment or policy and procedure development. There was no evidence of water management reports for the facility. A facility policy for the infection control program including comprehensive surveillance of resident symptoms, illnesses and its analysis was requested, but not provided.	F 441	written infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of Legionella in facility water systems to prevent cases and outbreaks of Legionnaires□ disease and Plan of correction including updated policies, Environmental rounds, tracking forms and development of water management team. QAA will be informed of any infection surveillance problems, trends in infections and progress of water management team.	

Electronically delivered
August 11, 2017

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5259024

Dear Mr. Flaherty:

The above facility was surveyed on July 24, 2017 through July 27, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor at (218) 332-5140 or at gail.anderson@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

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
	00062	A. BUILDING: _____ B. WING _____	07/27/2017

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 7/24-7/27/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	2 000		

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2 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable 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.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of a Legionella in the facility water systems to prevent cases and outbreaks of Legionnaires' disease. This deficient practice had the potential to affect all 81 residents who resided in the facility. Findings include: Review of the facility's infection control surveillance program was conducted. The facility utilized Monthly Infection Control Logs from	21375	F 441 Luther Haven Failed to establish a written infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of Legionella in facility water systems to prevent cases and outbreaks of Legionnaires' disease. Luther Haven reviewed all Infection control policies and updated to include symptom surveillance and illness prior to the need for antibiotics. In addition to the current Influenza, Gastroenteritis and Respiratory symptom logs for tracking a line listing for abnormal vital signs &/or change in condition we created and put into use on	8/31/17

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21375	Continued From page 2 January 2017 through February 2017. The monthly logs only included residents with infections for which antibiotics were prescribed and did not consistently include symptoms and culture results for the infection. The facility's form titled Facility-Level Indicators Worksheet 2017, included data for January through June. The worksheet listed various indicators which included average census for short stay and long stay, number of cultures done, percentage of antibiotics used for urine/respiratory/skin/other infections. The worksheet also included a list of the specific antibiotic used for specific residents. The worksheet did not include symptoms of infection, onset or resolution of infection, specific organisms, and did not include residents with infections that were not treated with antibiotics. The facility's forms did not identify other infections including viral or gastrointestinal or any other infections that did not require the use of antibiotics. During interview on 7/26/17, at 1:25 p.m. director of nursing (DON), who was responsible for the facility's infection control program, confirmed the monthly infection logs were not completed thoroughly for each resident identified. DON stated the facility only tracked infections which were treated with antibiotics. The DON confirmed she did not update the logs at the time illnesses occurred. The DON indicated she updated the information either weekly, twice a month or monthly. The DON indicated there was no formal system currently in place to track and trend any viral illnesses's such as gastroenteritis or influenza. On 7/27/17, at 9:19 a.m. during follow up interview, DON stated the monthly infection information for July had not yet been completed.	21375	08/18/2017 at each nursing station. Luther Haven has scheduled a LPN to work with the IP 2-4 days per month to assist in tracking & documenting surveillance , infections, illness trends. She has been scheduled to attend Pathway Health Infection Preventionist Basic Bootcamp for LTC Providers. Luther Haven surveillance Policy was updated to include monthly infection prevention environment rounds to be rotated between departments and staff members to increase the circle of employees completing the rounds, therefore increasing the number of staff with awareness of what to observe for in the environment for possible risk of iillness/infection. Luther Haven Completed the Legionella Environment Assessment form and is working with a water management team that includes but is not limited to: Administrator or designee Infection Preventionist or designee Maintenance Supervisor or Designee City of Montevideo Water works supervisor Housekeeping Supervisor or designee Nursing employee Others as designated Hilllyard Rep To work on the preventing Legionella growth and spread in Luther Haven. Water Management team is utilizing the CDC toolkit. Meetings are now being scheduled to continue implementing and following the water management plan. Team will meet to establish the water management program and will review and	

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21375	Continued From page 3 DON indicated the facility utilized a new surveillance process which began in March and confirmed the new process lacked such things as identification of specific symptoms that were present, the date the infection resolved and the logs lacked analysis and/or investigation of patterns identified. The DON indicated the facility needed a more formal infection surveillance process. LEGIONNELLA POLICY/PROCEDURES During interview on 7/24/17, at 2:15 p.m. the DON stated she was not aware of Legionella requirements, the infection related to the organism or the requirements that the facility should have in place. The DON reported she had not received any education regarding Legionnaires' disease, to prepare her for developing policies, procedures and facility risk assessments. During interview on 7/24/17, at 2:20 p.m. the facility administrator confirmed he was not aware of the CMS requirements regarding Legionnaires' disease. The facility administrator verified the facility had not started a facility risk assessment or policy and procedure development. There was no evidence of water management reports for the facility. A facility policy for the infection control program including comprehensive surveillance of resident symptoms, illnesses and its analysis was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures	21375	revise program if/when event occur and annually at a minimum if no events. All Staff Mandatory Inservices were held on 08/15 and 08/17/17 to inform all staff of survey findings and to update on plan of correction and importance of following facility policy. DON or designee with complete audits of station tracking symptom &/or infection logs at least 5d/week. QAA made aware of failure to establish a written infection control program which included comprehensive surveillance of resident infections to identify and analyze possible patterns of infection in the facility. In addition, the facility failed to implement a program to prevent the risk of Legionella in facility water systems to prevent cases and outbreaks of Legionnaires' disease and Plan of correction including updated policies, Environmental rounds, tracking forms and development of water management team. QAA will be informed of any infection surveillance problems, trends in infections and progress of water management team.	

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21375	Continued From page 4 related to tracking and analyzing all illnesses and symptoms in the facility to minimize the spread of illness. In addition, the DON or designee, could develop and implement policies and procedures related to Legionnaires' disease and ensure the facility risk assessment is completed and reviewed periodically. The DON or designee could educate staff on the policies and the quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2017**

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

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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 July 25, 2017. At the time of this survey, Luther Haven was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 445 Minnesota St., 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 | 08/18/2017

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	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@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 82 at time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 222 SS=F	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS	K 222		9/15/17

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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 222	Continued From page 3 Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to ensure that the egress is accessible at all times in accordance with NFPA Life Safety Code 101 (2012 edition) sections 19.2.1 and 7.2.5. These deficient practice's could affect the safe and rapid evacuation of all residents staff and visitors in the event of an emergency that may require quick evacuation. Findings include: It was observed by MDH that a steam table was set up in front of the emergency exit door that is folded open partially blocking it. 2 different carts set up to form the shape of an "L". staff serve	K 222	K222: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction in accordance with state and federal regulations: the facility alleges that it will be in substantial compliance with standards indicated by 09/15/2017. Luther Haven will ensure that the egress is accessible at all times in accordance with NFPA Life Safety Code 101(2012)sections 19.2.1 and 7.2.5. The steam table will be relocates as not to block the accessibility of egress. By relocating the steam table and other dietary equipment the existing fire	

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	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2017**

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K 222	Continued From page 4 trays here. The fire extinguisher is to the right and behind this area. 07/24/2017 5:57:46 PM -door continues to be blocked. ****let fire marshall know-----continuing to serve. Took picture on 7/26 at lunch time of steam table set up to send to fire marshall. 07/27/2017 8:59:14 AM (station 2 dining room)-confirmed the kitchen always set up the steam table and the plate holder table in front of the open door like that for all meals due to the steam table plug in located on that wall. the dietary manager stated the dietary staff used to set up the stuff further down, but fire marshal cited that because the equipment was in front of the fire extinguisher. This deficient condition was confirmed by the Minnesota Department of Health Survey Team, TW.	K 222	extinguisher will require relocation as to not block access to the fire extinguisher. A new fire extinguisher cabinet has been ordered and will be installed upon arrival. Responsible person: Maintenance and Administrator	
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1	K 901	K901: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of	9/30/17

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K 901	Continued From page 5 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 8:30 AM and 1:30 PM on 07/25/2017, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient condition was confirmed by the Facility Administrator and the Maintenance Supervisor.	K 901	correction in accordance with state and federal regulations: the facility alleges that it will be in substantial compliance with standards indicated by 09/30/2017. Per regulation a risk assessment NFPA 99 will be completed to come into compliance with the rule. Luther Haven has ordered NFPA 99 2012 edition as recommended by the Deputy State Fire Marshall to assist in completion of the risk assessment. Responsible Person: Maintenance engineer and Administrator	
K 920 SS=F	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure.	K 920		9/15/17

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K 920	Continued From page 6 Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a multiple outlet connection was in accordance with the 2012 edition of NFPA 99 section 10.2.3.6 item 2 for total ampacity. This deficient practice could cause an overload of a circuit which could cause a power outage to necessary equipment or cause a fire. This could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:30 AM and 1:30 PM on 07/25/2017, observations and staff interview revealed: 1) Room 125 had 2 extension cords plugged into a powerstrip and in that powerstrip was medical equipment. 2) Room 110 had an extension cord plugged into a light fixture with a powerstrip draped around the toilet plugging in a oxygen concentrator. 3)Room 139 a refrigerator and a nebelizer were plugged into a power strip. 4)Room 141 A multi plug adapter was used to plug into a refrigerator. 5)Room 183 There is an extension cord plugging in a powerstrip and a the refrigerator is plugged into the powerstrip. This deficient condition was confirmed by the	K 920	K920: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction in accordance with state and federal regulations: the facility alleges that it will be in substantial compliance with standards indicated by 09/15/2017. As per the standard extension cords with permanent use will be removed from service. Extension cords will be allowed only for temporary purposes and removed immediately upon completion of the purpose for which it was installed. Medical equipment and refrigerators (appliance) will be plugged into a wall socket directly. Other non-medical and non-appliance equipment will be connected to power strips if a wall socket is not available without the use of extension cords. In order to maintain compliance with this rule monthly checks (environmental rounds audits) will be conducted by staff. Responsible person: Maintenance engineer, social services and administrator.	

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K 920	Continued From page 7 Facility Maintenance Director.	K 920		