| DEPARTMENT OF HEALTI | | | | | | DICARE & MEDICAID SERVICES |
|--|----------------------|--|---|-------------------------------|---|---|
| | | | | | AND TRANSMITTAL FE SURVEY AGENCY | ID: 60BK Facility ID: 00062 |
| 1. MEDICARE/MEDICAID PROVIDE (L1) 245259 | | 3. NAME AND AI (L3) LUTHER H | DDRESS OF FAC | | TE SURVET AGENCI | 4. TYPE OF ACTION: <u>7</u> (L8) |
| (L2) 677040100 | Ю. | (L4) 1109 EAST (L5) MONTEVII | | | (L6) 56265 | 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint |
| 5. EFFECTIVE DATE CHANGE OF 0 (L9) | OWNERSHIP | 7. PROVIDER/SU 01 Hospital | JPPLIER CATEG 05 HHA | GORY 09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint |
| 6. DATE OF SURVEY 09/08 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other | /2015 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF | 06 PRTF 07 X-Ray 08 OPT/SP | 10 NF 11 ICF/IIE 12 RHC | 14 CORF D 15 ASC 16 HOSPICE | FISCAL YEAR ENDING DATE: (L35) 12/31 |
| 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds | 90 (L18) | Complianc | | AS: | And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code | 7. Medical Director |
| 13.Total Certified Beds | 90 (L17) | B. Not in Con Requirem | npliance with Prog ents and/or Appli | gram ed Waivers: | | (L12) |
| 14. LTC CERTIFIED BED BREAKDO | WN | I | | | 15. FACILITY MEETS | |
| 18 SNF 18/19 SNF 90 | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) |
| (L37) (L38) | (L39) | (L42) | (L43) | | | |
| 16. STATE SURVEY AGENCY REM. | ARKS (IF APPLICA | BLE SHOW LTC CA | ANCELLATION | DATE): | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL Date: |
| Gail Anderson, Unit S | Supervisor | 1 | 0/23/2015 | (L19) | Mark Meath | , Enforcement Specialist 10/23/2015 (L20) |
| PAI | RT II - TO BE | COMPLETED I | BY HCFA RE | EGIONAI | L OFFICE OR SINGLE S | TATE AGENCY |
| DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible | articipate | | IPLIANCE WITH HTS ACT: | H CIVIL | | ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e : |
| 22. ORIGINAL DATE | 23. LTC AGREEN | MENT 24 | 4. LTC AGREEN | //FNT | 26. TERMINATION ACTION | : (L30) |
| OF PARTICIPATION 01/01/1975 | BEGINNINC | | ENDING DA | | VOLUNTARY 00 01-Merger, Closure 00 | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | 8 |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | | | 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal | OTHER |
| (L27) | - | n of Admissions: | (L44) | | 04-Ouler Reason for windrawar | 07-Provider Status Change 00-Active |
| | B. Rescind St | spension Date: | (L45) | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY | | | 30. REMARKS | |
| Dim (1101 (Dimb. | 2) | 03001 | | | | |
| | (L28) | 05001 | | (L31) | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION | I OF APPROVAL | DATE | | |
| | (L32) | 09/16/2015 | | (L33) | DETERMINATION APP | ROVAL |



Protecting, Maintaining and Improving the Health of Minnesotans CMS Certification Number (CCN): 245259

October 23, 2015

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 program.

Effective August 7, 2015 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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 16, 2015

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

RE: Project Number S5259022

Dear Mr. Flaherty:

On July 30, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 16, 2015. 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 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 11, 2015 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 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 7, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 16, 2015, effective August 7, 2015 and therefore remedies outlined in our letter to you dated July 30, 2015, 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, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118 Fax: (651) 215-9697

Form Approved

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) | Provider / Supplier / CLIA / Identification Number 245259 | (Y2) Multiple Construction A. Building B. Wing | | (Y3) Date of Revisit 9/8/2015 | |
|--------------|---|---|---------------------------------------|----------------------------------|--|
| 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) |) Da | ite |
|---------------|-------------------------------|----------------------|---------------|--------------------|----------------------|--------------------|-----------------|-------|------------|
| | | Correction | | | Correction | | | | Correction |
| ID Prefix | F0156 | Completed 08/07/2015 | ID Prefix | F0465 | Completed 08/13/2015 | ID Prefix | | | Completed |
| | | - | | 483.70(h) | | Reg. # | | | |
| LSC | 483.10(b)(5) - (10), 483.10(b |)(1) | LSC | 403.70(11) | | | | | |
| | | | | | | | | | |
| | | Correction | | | Correction | | | | Correction |
| ID Prefix | | Completed | | | Completed | | | | Completed |
| | | | | | | | | | |
| Reg. # LSC | | | Reg. # LSC | | | Reg. # LSC | | | |
| | | | | | | | | | |
| | | Correction | | | Correction | | | | Correction |
| ID Profix | | Completed | ID Drofiv | | Completed | ID Profix | | | Completed |
| ID Prefix | | - | ID Prefix | | | | | | |
| Reg. # LSC | | | Reg. # LSC | | | Reg. # LSC | | | |
| | | | | | | | | | |
| | | Correction | | | Correction | | | | Correction |
| ID Profix | | Completed | ID Profix | | Completed | ID Profix | | | Completed |
| | | | | | | | | | |
| Reg. # LSC | | | Reg. # LSC | | | Reg. # LSC | | | |
| | | | | | | | | | |
| | | Correction | | | Correction | | | | Correction |
| ID Profix | | Completed | ID Drofiv | | Completed | ID Profix | | | Completed |
| | | | | | | | | | |
| Reg. # LSC | | | Reg. # LSC | | | Reg. # LSC | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| Reviewed By | Reviewed E | Зу | Date: | Signature of Surve | yor: | | Da | ate: | |
| State Agency | , GA/mn | n | 09/16/20 | 15 | 28034 | | | 09/08 | /2015 |
| Reviewed By | Reviewed E | Зу | Date: | Signature of Surve | yor: | | Da | ate: | |
| CMS RO | | | | | | | | | |
| Followup to | Survey Completed on: | | | - | | eficiencies. Was a | • | | |
| | 7/16/2015 | | | Uncorrecte | d Deficiencies | (CMS-2567) Sent to | the Facility? Y | (ES | NO |

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) | Provider / Supplier / CLIA / Identification Number 245259 | (Y2) Multiple Construction A. Building B. Wing 01 - MAI | N BUILDING 01 | (Y3) Date of Revisit 8/11/2015 | |
|--------------|---|--|---------------------------------------|-----------------------------------|--|
| 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).

| | (Y5) | Date | (Y4) | Item | | (Y5) | Date | (Y4) | ltem | | (Y5) | Date |
|---------------|-------------------------------|--------------------------------|---|---|---|--|---|---|--|--|--|---|
| | | Correction | | | | | Correction | | | | | Correction |
| | | Completed | | | | | Completed | | | | | Completed |
| | | 08/03/2015 | | ID Prefix | | | 08/03/2015 | | ID Prefix | | | 08/03/2015 |
| NFPA 101 | | | | - | | | | | - | | | |
| K0018 | | | | LSC | K0027 | | | | LSC | K0144 | | |
| | | O | | | | | O | | | | | O a martíne |
| | | | | | | | | | | | | Correction |
| | | 08/05/2015 | | ID Prefix | | | Completed | | ID Prefix | | | Completed |
| NFPA 101 | | - | | | | | - | | | | | |
| K0147 | | | | - | | | | | LSC | | | |
| | | | 1 | | | | | +- | | | | |
| | | Correction | | | | | Correction | | | | | Correction |
| | | Completed | | | | | Completed | | | | | Completed |
| | | - | | ID Prefix | | | | | ID Prefix | | | |
| | | | | Reg. # | | | | | Reg. # | | | |
| | | | | LSC | | | | | LSC | | | |
| | | O | | | | | O | | | | | O a marking |
| | | | | | | | | | | | | Correction Completed |
| | | | | ID Prefix | | | Completed | | ID Prefix | | | |
| | | | | | | | | | | | | |
| | | | | | | | | | LSC | | | |
| | | | | | | | | | | | | |
| | | Correction | | | | | Correction | | | | | Correction |
| | | Completed | | ID Profix | | | Completed | | ID Profiv | | | Completed |
| | | - | | | | | | | | | | |
| | | | | Reg. # | | | | | Reg. # | | | |
| | | | | 200 | | | | | 200 | | | |
| | | | | | | | | | | | | |
| | Reviewed E | Зу | Dat | te: | Signature o | of Surve | yor: | | | | Date: | |
| , | GS/mm | | 09 | 9/16/20 | 15 | | 347 | 64 | | | 08/1 | 1/2015 |
| , | Reviewed E | Зу | Dat | te: | Signature o | of Surve | yor: | | | | Date: | |
| | | | | | | | | | | | | |
| Survey Comple | ted on: | | | | Check | for any | Uncorrected | Defici | encies. Was | a Summary of | 1 | |
| 7/14/2 | 2015 | | | | | • | | | | • | YES | NO |
| | NFPA 101 K0018 NFPA 101 K0147 | NFPA 101 K0018 NFPA 101 K0147 | Correction Completed NFPA 101 Correction K0118 Correction Completed 08/05/2015 NFPA 101 Correction K0147 Correction Completed 08/05/2015 NFPA 101 Correction K0147 Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Completed Main Correction Completed Completed Main Reviewed By Survey Completed on: Survey Completed on: | Correction Completed 08/03/2015 NFPA 101 K0018 Correction Completed 08/05/2015 NFPA 101 K0147 Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Reviewed By Correction Completed Date Of Completed Reviewed By Correction Completed Date Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed | Correction Completed 08/03/2015 ID Prefix NFPA 101 K0018 Reg. # LSC Correction Completed 08/05/2015 ID Prefix NFPA 101 K0147 Reg. # LSC Correction Completed ID Prefix Reg. # LSC Reg. # LSC Correction Completed ID Prefix Reg. # LSC Reg. # LSC Correction Completed ID Prefix Reg. # LSC Sc Correction Completed ID Prefix Reg. # LSC Sc Correction Completed ID Prefix Reg. # LSC Sc Reg. # LSC Sc Reg. # LSC Sc Reg. # LSC Sc Reviewed By Date: O9/16/20 Og/16/20 Survey Completed on: Sc | Correction Completed 08/03/2015 ID Prefix MFPA 101 K0018 Correction Completed 08/05/2015 ID Prefix MFPA 101 NFPA 101 Correction Completed 08/05/2015 ID Prefix | Correction Completed 08/03/2015 ID Prefix ID Prefix NFPA 101 Reg. # NFPA 101 K0018 Correction Completed 08/05/2015 ID Prefix ID Prefix NFPA 101 Correction Completed ID Prefix ID Prefix K0147 LSC ID Prefix ID Prefix Correction Completed Correction Completed ID Prefix ID Prefix Correction Completed Correction Completed ID Prefix ID Prefix Correction Completed ID Prefix ID Prefix ID Prefix Correction Completed ID Prefix ID Prefix ID Prefix ID Prefix Reg. # LSC ID Prefix ID Prefix Reg. # Signature of Surve ID Prefix NFPA 101 ID Prefix ID Prefix ID Prefix ID Prefix ID Prefix ID Prefix ID | Correction Completed 08/03/2015 Correction D Prefix Correction K0018 NFPA 101 LSC K0027 Correction Completed 08/05/2015 Correction Completed 08/05/2015 Correction Completed NFPA 101 Correction Completed Correction Completed MIPA 101 Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed ID Prefix LSC Reg. # LSC Correction Completed Correction Completed Correction Completed Correction Completed ID Prefix Correction Completed Signature of Surveyor: Correction Completed Signature of Surveyor: Correction Signature of Surveyor: Correction Signature of Surveyor: | Correction Completed 08/03/2015 Correction Completed 08/03/2015 Correction Completed 08/05/2015 NFPA 101 K0018 Correction Correction Completed 08/05/2015 Correction Correction Completed Correction Completed NFPA 101 K0147 Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed ID Prefix LSC | Correction Completed 08/03/2015 Correction Completed 08/03/2015 ID Prefix Correction Completed 08/03/2015 ID Prefix K0018 Correction Completed Correction Completed Correction Completed ID Prefix MFPA 101 Correction Completed Correction Completed Correction Completed ID Prefix MFPA 101 Correction Completed Reg.# LSC Correction Correction Correction Correction Correction Completed Correction Completed Correction Correction Correction Correction ID Prefix Correction Completed Correction Completed Correction Correction Correction Completed ID Prefix Correction Completed ID Prefix Reg.# LSC Correction Completed ID Prefix Correction Completed ID Prefix Reg.# LSC Correction Completed ID Prefix Correction Completed ID Prefix Reg.# LSC Signature of Surveyor: 34764 ID Prefix Reviewed By Date: Signature of Surveyor: 34764 Survey Completed on: Survey Completed on: Date: Signature of Surveyor: Survey Completed Deficiencies, Water on Surveyor: | Correction Completed B8/03/2015 Correction ID Prefix Correction B8/03/2015 ID Prefix ID Prefix ID Prefix ID Prefix Reg. # IPPA 101 LSC Reg. # NFPA 101 LSC ID Prefix Reg. # ID Prefix Reg. # <td>Correction Completed 98/03/2015 Correction Completed 98/03/2015 Correction Completed 98/03/2015 ID Prefix Reg. # MFPA 101 LSC Reg. # NFPA 101 LSC LSC Correction Completed Correction Completed Correction LSC Correction Completed ID Prefix LSC ISC ID Prefix LSC ISC ID Prefix ISC ISC ID Prefix ISC ISC ID Prefix ISC ISC ID Prefix ISC ISC</td> | Correction Completed 98/03/2015 Correction Completed 98/03/2015 Correction Completed 98/03/2015 ID Prefix Reg. # MFPA 101 LSC Reg. # NFPA 101 LSC LSC Correction Completed Correction Completed Correction LSC Correction Completed ID Prefix LSC ISC ID Prefix LSC ISC ID Prefix ISC ISC ID Prefix ISC ISC ID Prefix ISC ISC ID Prefix ISC ISC |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | CENTERS FOR MEDICARE & MEDICAID SERVIC | | | |
|---|-------------------------|---------------------------------|---|-----------------|---|--|--|--|
| | | | | | AND TRANSMITTAL | ID: 60BK | | |
| 1. MEDICARE/MEDICAID F | | 3. NAME AND AI (L3) LUTHER H | DDRESS OF FAC | | TE SURVEY AGENCY | Facility ID: 00062 4. TYPE OF ACTION: 2 (L8) | | |
| (L1) 245259 2.STATE VENDOR OR MED | DICAID NO. | (L4) 1109 EAST | | | | 1. Initial2. Recertification3. Termination4. CHOW | | |
| (L2) 677040100 | | (L5) MONTEVII | DEO, MN | | (L6) 56265 | 5. Validation 6. Complaint | | |
| 5. EFFECTIVE DATE CHAN (L9) | NGE OF OWNERSHIP | 7. PROVIDER/SU 01 Hospital | JPPLIER CATEC 05 HHA | GORY 09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 9. Other 8. Full Survey After Complaint | | |
| 6. DATE OF SURVEY | 07/16/2015 (L34) | 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | EISCAL VEAD ENDING DATE: (1.25) | | |
| 8. ACCREDITATION STATU | | 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/III | | FISCAL YEAR ENDING DATE: (L35) | | |
| | 1 TJC 3 Other | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 12/31 | | |
| 11LTC PERIOD OF CERTIF | FICATION | 10.THE FACILITY | IS CERTIFIED | AS: | | | | |
| From (a): | | A. In Complia | nce With | | And/Or Approved Waivers Of | The Following Requirements: | | |
| To (b) : | | | equirements e Based On: | | 2. Technical Personnel 3. 24 Hour RN | 6. Scope of Services Limit | | |
| 12.Total Facility Beds | 90 (L18) | 1 | cceptable POC | | 5. 24 Hour KN 4. 7-Day RN (Rural SN 5. Life Safety Code | 7. Medical Director [F)8. Patient Room Size 9. Beds/Room | | |
| 13.Total Certified Beds | 90 (L17) | X B. Not in Con Requirem | npliance with Prog ents and/or Appli | | * Code: B * | (L12) | | |
| 14. LTC CERTIFIED BED BE | REAKDOWN | | | | 15. FACILITY MEETS | | | |
| 18 SNF 18/ | 19 SNF 19 SNF 90 | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| (L37) (| L38) (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGENO | CY REMARKS (IF APPLICA | ABLE SHOW LTC CA | ANCELLATION | DATE): | | | | |
| | | | | | | | | |
| 17. SURVEYOR SIGNATUR | Æ | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL Date: | | |
| Sherri Softing, H | IPR Dietian | 0 | 08/25/2015 | (L19) | Mark Meath, 1 | Enforcement Specialist 09/14/2015 (L20) | | |
| | PART II - TO BE | COMPLETED I | BY HCFA RI | EGIONA | L OFFICE OR SINGLE S | TATE AGENCY | | |
| 19. DETERMINATION OF E | ELIGIBILITY | | IPLIANCE WITI HTS ACT: | H CIVIL | | ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) | | |
| 1. Facility is Eli | gible to Participate | KIG | 115 AC1. | | 3. Both of the Above | | | |
| 2. Facility is no | t Eligible (L21) | | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION: | (L30) | | |
| OF PARTICIPATION 01/01/1975 | BEGINNING | G DATE | ENDING DA | TE | <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure | <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety | | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburse | | | |
| 25. LTC EXTENSION DATI | | VE SANCTIONS | (120) | | 03-Risk of Involuntary Terminatio | n <u>OTHER</u> | | |
| | A. Suspensio | n of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provider Status Change | | |
| (1 | L27) B Rescind S | uspension Date: | (L44) | | | 00-Active | | |
| | B. Reschiu 5 | uspension Date. | (L45) | | | | | |
| 28. TERMINATION DATE: | 29 | 9. INTERMEDIARY | CARRIER NO. | | 30. REMARKS | | | |
| | | 03001 | | | | | | |
| | (L28) | | | (L31) | | | | |
| 31. RO RECEIPT OF CMS-12 | 539 32 | 2. DETERMINATION | I OF APPROVAL | DATE | | | | |
| | (L32) | | | (L33) | DETERMINATION APPI | ROVAL | | |
| | | | | | | | | |



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 30, 2015

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

RE: Project Number S5259022

Dear Mr. Flaherty:

On July 16, 2015, 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - 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:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 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 July 25, 2015, 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 July 25, 2015 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. Luther Haven July 30, 2015 Page 4

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 16, 2015 (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 Luther Haven July 30, 2015 Page 5

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 16, 2016 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Luther Haven July 30, 2015 Page 6

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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

| | - | AND HUMAN SERVICES | | | · | | APPROVED |
|--------------------------|---|---|---------------------|----|---|---------------|----------------------------|
| | | & MEDICAID SERVICES | | | 0 | <u>MB NO.</u> | . 0938-0391 |
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | | E SURVEY IPLETED |
| | | 245259 | B. WING _ | | | 07/ | /16/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LUTHER | HAVEN | | | | 109 EAST HIGHWAY 7 IONTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENT | ſS | F 0 | 00 | | | |
| F 156 SS=D | as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa regulations has beet your verification. 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governin responsibilities duri facility must also pr notice (if any) of the §1919(e)(6) of the A made prior to or up resident's stay. Re- any amendments to writing. The facility must inf entitled to Medicaid of admission to the resident becomes e- items and services facility services und | of correction (POC) will serve of compliance upon the obtance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the e State developed under Act. Such notification must be on admission and during the ceipt of such information, and o it, must be acknowledged in form each resident who is l benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those | F 1 | 56 | | | 8/7/15 |
| | other items and ser | vices that the facility offers | | | | | |
| | | DER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | TITLE | | (X6) DATE |
| Electron | ically Signed | | | | | | 08/07/2015 |

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.

PRINTED: 08/25/2015

| | | AND HUMAN SERVICES | | | | FORM | 08/25/2015 APPROVED 0938-0391 |
|--------------------------|---|--|--------------------|-----|--|------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245259 | B. WING | | | 07/ [.] | 16/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LUTHER | HAVEN | | | | 109 EAST HIGHWAY 7 IONTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 156 | and for which the re- the amount of charge inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admiss the resident's stay, facility and of charge including any charge under Medicare or M The facility must fur legal rights which in A description of the for establishing elige the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti groups such as the agency, the State life ombudsman progra | esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) is section. Form each resident before, or asion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. Trnish a written description of neludes: manner of protecting personal raph (c) of this section; requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment he institutionalized spouse's or her process of spending | F 1 | 156 | | | |

Facility ID: 00062

If continuation sheet Page 2 of 7

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|-----|--|---|----------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · / | | CONSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245259 | B. WING _ | | | 07 /- | 16/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | STR | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| LUTHER | HAVEN | | | | 99 EAST HIGHWAY 7 DNTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 156 | agency concerning misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsite The facility must pro- written information, applicants for admis- information about h Medicare and Medi | resident abuse, neglect, and resident property in the npliance with the advance | F 15 | 56 | | | |
| | by: Based on interview facility failed to ensi- R89, R106) reviewe the required Notice Centers for Medica (CMS) Form 10123 to an appeal and ex- Medicare coverage discontinuation of s Findings include: R64 was admitted t beginning on 6/1/15 R64 had been discl | | | | F-156 Luther Haven failed to ensu all residents received the required NOMNC form 10123, informing the their rights to appeal and an exped review of their Medicare coverage hours prior to discontinuation of all services. Luther Haven Nurse Man were educated by Director of Nursi the proper timing of Notices of Medica Non Coverage and when to give per instructions on 07/14/15. DON will complete monthly audits of Medica denials and report audit results to 0 quarterly. DON receives CMS email notificati and will be made aware of any upc changes to the NOMNC guidelines | m of ited 48 agers ng on licare er CMS re QAA ons oming | |

Facility ID: 00062

If continuation sheet Page 3 of 7

PRINTED: 08/25/2015

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY IPLETED |
|--------------------------|--|---|---------------------|---|-----------------|---------------------------|
| | | 245259 | B. WING | | 07/ | 16/0015 |
| NAME OF I | PROVIDER OR SUPPLIER | 240200 | | STREET ADDRESS, CITY, STATE, ZIP CODE | 07/ | 16/2015 |
| LUTHER | HAVEN | | | 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIO DATE |
| F 156 | R64 did not receive 10123 48 hour noti skilled services. R89 was admitted beginning on 4/23/ procedures and rec when PT services of met. R89 discharge R89 did not receive 10123 48 hour noti skilled services. R106 was admitted beginning on 5/11/ procedures and rec when R106 was dis goals being met. R facility on 6/5/15. F required CMS Forr discontinuation of s During interview or director of nursing and R106 had not Form 10123. The responsible for issu- time did not unders the resident was di A policy was reque 483.70(h) | ed from the facility on 6/9/15. the required CMS Form ce prior to discontinuation of to the facility on a skilled stay 15, for rehabilitation ceived PT services until 5/4/15 were discontinued due to goals ed from the facility on 5/5/15. the required CMS Form ce prior to discontinuation of d to the facility on a skilled stay 15, for rehabilitation ceived PT services until 6/4/15 scharged from therapy due to 106 discharged from the 106 did not receive the n 10123 48 hour notice prior to skilled services. n 7/14/15, at 3:49 p.m. the (DON) confirmed R64, R89 received the required CMS DON stated the staff member uing the required form at that stand the form was required if | F 156 | educate staff accordingly if chang occur. QAA made aware of the missed N of Medicare Non Coverage and w complete random audits to assure compliance. | lotices 'ill | 8/13/15 |

If continuation sheet Page 4 of 7

| | | AND HUMAN SERVICES | | | FORM | 08/25/2015 APPROVED |
|--------------------------|---|---|---------------------|---|--|---------------------------------|
| STATEMENT | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | E CONSTRUCTION | (X3) DATE | 0938-0391 E SURVEY PLETED |
| | | 245259 | B. WING | | 07/ ⁻ | 16/2015 |
| NAME OF | PROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LUTHER | HAVEN | | | 109 EAST HIGHWAY 7 IONTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 465 | The facility must presentative, and comforesidents, staff and This REQUIREMEN by: Based on observative, the facility for the kitchen in a same potential to affect a the facility. Findings Include: On 7/13/15, at 2:17 conducted with the following was found The cupboard under by a steam table has substance on the b cabinet. The DD in but was not sure in there was approxim had a white colored said it could be lime The DD verified the The microwave loca side of the utility sim- inside right side was covering the fan. It brown colored subs- the covering. The D indicated she was u was. | ovide a safe, functional, ortable environment for the public. NT is not met as evidenced tion, interview and document ailed to maintain equipment in aitary manner. This had the II 82 residents who reside in T p.m. a tour of the kitchen was dietary director (DD) and the dimensional the utility sink located ad greasy brown colored ottom back portion of the dicated it could be lime or rust an addition, under the sink pipe nately 8 inches long area that a substance under it. The DD e built up but was not sure. | F 465 | The week of survey all dietary staf verbally educated by the Dietary Di on the importance of sanitation. Th were instructed on the need to corr with the sanitation schedules and s all tasks after completion. The Sanitation of Dining and Food Services Areas policy was reviewed updated on 07/27/15. An all Dietary staff in-service is sch on 08/13/2015 to review the plan of correction and importance of follow updated policy. Dietary Supervisor or designee will monitor all cleaning tasks weekly b completing and signing weekly san audit. Registered dietician will com random sanitation audit to assure compliance. Audit results will be reported at QA quarterly. Annual Sanitation in-service will be for all dietary staff. | rector ey iply ign out d and eduled f ving the y itation plete | |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | 08/25/2015 APPROVED 0938-0391 |
|--------------------------|--|--|---------------------|-------|---|-----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | NSTRUCTION | (X3) DATE | E SURVEY PLETED |
| | | 245259 | B. WING _ | | | 07/- | 16/2015 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREE | TADDRESS, CITY, STATE, ZIP CODE | - | |
| LUTHER | HAVEN | | | | AST HIGHWAY 7 EVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 465 | steam table, a ledg sticky substance co white colored areas of the steam table, which had two large DD confirmed the fit table had not been needed to be clean The lower cabinet u area, had cleaning dirt on the the botto findings in the cabin In the baking area, side of the sink had it. There was two sh covered with a laye them. During an interview DD verified the abo facility had a cleanin and stated she felt Review of the clean labeled Short Mond microwaves 1 and 2 cleaning schedule t on it indicated to clean the sink and clean a cupboards inside an scheduled labeled I cupboards under the the cleaning schedule | e, could be raised, and had a overing the ledge, and had on the ledge. On the bottom a cabinet with two shelves e plastic glasses stored. The ndings and stated the steam cleaned for two months and ed. Inder the sink in the baking supplies in it and had dust and m of it. The DD verified the | F 46 | 55 | | | |

If continuation sheet Page 6 of 7

| | | AND HUMAN SERVICES | | | | | FORM | 08/25/2015 APPROVED 0938-0391 |
|--------------------------|--|---|-------------------|-----|--|------|--------------|-------------------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | LE CONSTRUCTION | | | E SURVEY PLETED |
| | | 245259 | B. WING | i | | | 07 /- | 16/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | : | | |
| LUTHER | HAVEN | | | | 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD | BE | (X5) COMPLETION DATE |
| F 465 | Continued From pa | ge 6 | F | 465 | i | | | |
| | Service Areas with food service staff w the dining and food cleaning schedule w | anitation of Dining and Food no date on it, indicated the ill maintain the sanitation of service area. In addition, will be posted for all cleaning e accountable for cleaning | | | | | | |

Facility ID: 00062

If continuation sheet Page 7 of 7

| | | AND HUMAN SERVICES | | F5259023 PRINTED: 08/11/2019 FORM APPROVED OMB NO. 0938-039 |
|--------------------------|--|--|--------------|--|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IULTIPLE CONSTRUCTION (X3) DATE SURVEY LDING 01 - MAIN BUILDING 01 COMPLETED |
| | | 245259 | B. WING | NG07/14/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE |
| LUTHER | HAVEN | | | 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 |
| 01015 | STIMMADY STA | TEMENT OF DEFICIENCIES | ID | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION |
| K 000 | INITIAL COMMEN | ГS | кc | < 000 |
| | FIRE SAFETY | | 5 | |
| | ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM | OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR TE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. | | |
| | ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA | F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. | | |
| | Minnesota Departm Fire Marshal Divisio time of this survey, in substantial comp for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA) | Survey was conducted by the nent of Public Safety, State on on July 14, 2015. At the Luther Haven was found not diance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection Standard 101, Life Safety er 19 Existing Health Care | | EPOC |
| | DEFICIENCIES (K- | R THE FIRE SAFETY TAGS) TO: | | |
| | HEALTH CARE FIR STATE FIRE MARS 444 CEDAR STRE ST. PAUL, MN 551 | GHAL DIVISION ET, SUITE 145 | | |
| LABORATORY | DIRECTOR'S OR PROVID | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | |
| Electron | ically Signed | | | 08/07/201 |

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.

古物解析

DEPARTMENT OF HEALTH AND HUMAN SERVICES

00

| Display of consection (n) providensurplus of a submitted of automatic construction (or) participation of a submitted of automatic free department of construction (or) participation (or) parti | CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | | | 0938-0391 |
|---|-----------|--|--|---------|-----|--|--------|------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE LUTHER HAVEN IND RESCRETION Paint HERR SUMMARY STATEMENT OF DEFICIENCIES (Exchored perclosmy was the preceded by the reschored perclosme the perclosme the preceded perclosme the perclosme the reschored perclosme the perclosme the reschored perclosme the perclosme the reschored the perclosme the reschored the perclosme the perclosme the perclosme the reschored the deficiency. 0000 K 000 Continued From page 1 By e-mail to: Marian Whitney@state.mn us K 000 K 000 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: K 000 1. A description of what has been, or will be, done to correct the deficiency. K 100 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 was constructed in 1992 and was determined to be of Type II(000) construction. The most recent addition was added that was determined to be of Type III(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type III(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type III(000) construction. The most recent addition was constructed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a time of the survey. <td>STATEMENT</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>F ' '</td> <td></td> <td></td> <td></td> <td></td> | STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | F ' ' | | | | |
| LUTHER HAVEN 1199 EAST HIGHWAY 7 MONTEVIDEO, MM 56265 CALL SUMMARY STATEMENT OF DEFICIENCIES (BACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISCIDENTIFYING INFORMATION) D PREFIX TAG PREFIX REGULATORY OR ISCIDENTIFYING INFORMATION) D PREFIX TAG CONTINUED FOR MACT ON BOULD BE CROSS REFERENCED TO THE APPORPMATE D D EACH CORRECT VALUES ATON BROULD BE CROSS REFERENCED TO THE APPORPMATE D D D EACH CORRECT VALUES (CROSS REFERENCE) TO THE PREFIX D D EACH CORRECT VALUES (CROSS REFERENCE) TO THE APPORPMATE D D EACH CORRECT VALUES (CROSS REFERENCE) TO THE PREFIX D D EACH CORRECT VALUES (CROSS REFERENCE) TO THE PREFIX TO THE PREVIEW OF THE PREFIX TO THE TARE VALUES (CROSS REFERENCE) TO THE PREFIX TO THE TARE VALUES (CROSS REFERENCE) TO THE PREFIX TO THE TARE VALUES (CROSS REFERENCE) TO THE PREFIX THE PALIN OF CORRECT VALUES (CROSS REFERENCE) TO THE PREFIX TO THE TARE VALUES (CROSS REFERENCE) TO THE PREFIX TO THE TARE VALUES (CROSS REFERENCE) TO THE PREFIX TO THE TARE VALUES (CROSS REFER | | | 245259 | B. WING | ; | | 07/ | 14/2015 |
| MAIL D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED OF FULL TAG D PREFX (EACH DEFICIENCY MUST BE PRECEDED OF FULL PREFX TAG D PREFX (EACH DEFICIENCY MUST BE PRECEDED OF FULL DEFICIENCY) PREFX (EACH DEFICIENCY MUST BE PRECEDED OF FULL DEFICIENCY) PREFX (EACH DEFICIENCY) K 000 Continued From page 1 By e-mail to: Marian Whitney@state.mn.us K 000 K 000 Image: Control of the AmpRopriate DEFICIENCY) Continued From page 1 By e-mail to: Marian Whitney@state.mn.us K 000 Image: Control of the Control of t | | | L | | | 1109 EAST HIGHWAY 7 | | |
| Image: Recollation of white prefiction by Full TAG PREFIX (EACH CORRECTIVA CATION SHOULD BE CROSS-REFERENCE OT INFORMATION) CROSS-REFERENCE OT INFORMATION DEFICIENCY K 000 Continued From page 1 K 000 By e-mail to: Marian.Whitney@state.mn.us K 000 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 to be of Type II(000) construction. The most recent addition was constructed to the original building was determined to be of Type II(000) construction. The facility has a capacity of 91 beds and had a census of 89 at time of the survey. The radium 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: | | | | | | · · · · | | 1 |
| By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A description of what has been, or will be, done to correct the deficiency. The actual, or proposed, completion date. 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 constructed in 1992 and was determined to be of Type II(000) construction. The most recent addition was constructed in 1992 and was determined to be of oper 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 free alarm system that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 99 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | PRÉFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREF | | (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR | ILD BE | COMPLETION |
| K 018 NFPA 101 LIFE SAFETY CODE STANDARD K 018 8/3/15 | К 000 | By e-mail to: Marian.Whitney@s THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre Luther Haven is a 1 basement. The build different times. The constructed in 1963 Type II(000) construc- was added that was II(000) construction was constructed in be of Type II(000) construc- original building and construction type al the facility was surv The building is fully fire alarm system the fire department notic capacity of 91 beds time of the survey. The requirement at | tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. -story building with partial ding was constructed at 3 original building was and was determined to be of uction. In 1974, an addition a determined to be of Type . The most recent addition 1992 and was determined to onstruction. Because the d the two additions met the lowed for existing buildings, reyed as one building. sprinklered. The facility has a nat is monitored for automatic fication. The facility has a and had a census of 89 at 42 CFR, Subpart 483.70(a) is | K | 000 | | | |
| | K 018 | | • | K | 018 | 3 | | 8/3/15 |

Facility ID: 00062

| CENTER | RS FOR MEDICAR | E & MEDICAID SERVICES | | | OMB NO. | OMB NO. 0938-0391 | |
|--------------------------|---|---|--------------------|---|---|----------------------------|--|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | TIPLE CONSTRUCTION ING 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | | |
| | | 245259 | B. WING | | 07/ | 14/2015 | |
| NAME OF F | PROVIDER OR SUPPLIER | | 1 | STREET ADDRESS, CITY, STAT 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 5626 | E, ZIP CODE | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| K 018 SS=F | Doors protecting or required enclosure hazardous areas a those constructed wood, or capable or minutes. Doors in required to resist th no impediment to t are provided with a the door closed. D are permitted. | orridor openings in other than s of vertical openings, exits, or re substantial doors, such as of 1 ³ / ₄ inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only ne passage of smoke. There is he closing of the doors. Doors a means suitable for keeping putch doors meeting 19.3.6.3.6 9.3.6.3 prohibited by CMS regulations | K | 018 | | | |
| | Bsed on observational a corridor door requirements of NF 19.3.6.3.6. This destafety of residents, were allowed to enable findings include: On facility tour betw 07/14/2015, it was | veen 07:30 AM to 11:30 AM on observed that the corridor oom 109, 162, 166, 179 and | | K018: Despite the fact the alleged Notice of following is proposed correction in accordant and federal regulation that it will be in substat with the standards inco 3,2015. Resident room doors and 190 have been fit tightly into the frame a into the frame. All corr checked and changes have doors positively | Violation, the as the plan of nce with the state hs: the facility alleges antial compliance dicated by August 109. 162,166,179 ked so doors fit and positively latch ridor doors were s made as needed to | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00062

If continuation sheet Page 3 of 6

PRINTED: 08/11/2015 FORM APPROVED OMB NO: 0938-0391

| | | | (VO) MULTICS | E CONSTRUCTION | (X3) DATE | 0938-039 SURVEY | |
|--------------------------|---|--|---|---|--|---------------------------|--|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 01 - MAIN BUILDING 01 | | PLETED | |
| | | 245259 | B. WING | | 07/14/2015 | | |
| NAME OF I | PROVIDER OR SUPPLIER | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LUTHER | HAVEN | | 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETIO DATE | |
| K 018 | Continued From pa | age 3 | K 018 | | | | |
| | positively latch into | | | This was completed by Director of Environmental Services(MH). Responsible person: Administrator | , facility | | |
| K 027 | of Environmental S | ice was verified by the Director ervices (MH). FETY CODE STANDARD | K 027 | building engineer. | | 8/3/15 | |
| SS=F | 20-minute fire prote 1 ³ /-inch thick solid protective plates th from the bottom of Horizontal sliding d Doors are self-clos accordance with 19 not required to swin | moke barriers have at least a ection rating or are at least bonded wood core. Non-rated at do not exceed 48 inches the door are permitted. oors comply with 7.2.1.14. ing or automatic closing in 0.2.2.2.6. Swinging doors are ng with egress and positive ired. 19.3.7.5, 19.3.7.6, | | | | | |
| | Based on observa provide proper prot smoke barrier door accordance with NI (2000 edition) secti Fire Doors and Fire deficient practice of patients, staff, and migrate between sr corridor untenable. Findings include: | s not met as evidenced by: tions, the facility has failed to ection for several corridor is throughout the facility in FPA Life Safety Code 101 on 19.3.6.3.1., and NFPA 80 e Windows (99) The following ould negatively affect the visitors as smoke could moke barriers making the | | K027:Despite the facility's objection alleged Notice of violation, the follo proposed as the plan of correction accordance with state and federal regulations: the facility alleges that be in substantial compliance with the standards indicated by August 3, 20 Smoke barrier corridor door by roo has been repaired by Ryer Contract The smoke barrier corridor door clo designed. Facility building engineer checked all smoke barrier corridor for proper door closing as designed meet fire code. Responsible person facility administrator, facility building | wing is in it will ne 015. m 134 cting. oses as f doors d to n: | | |

Facility ID: 00062

If continuation sheet Page 4 of 6

PRINTED: 08/11/2015 FORM APPROVED OMB NO. 0938-0391

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

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | • • | | | DATE SURVEY COMPLETED |
|--------------------------|--|---|--------------------|-----|---|---------------------------|
| | | 245259 | B. WING | | | 07/14/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | <u>.</u> | | | REET ADDRESS, CITY, STATE, ZIP CODE | |
| LUTHER | HAVEN | | | | 09 EAST HIGHWAY 7 ONTEVIDEO, MN 56265 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | 1 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
| K 027 | Continued From pa close as designed v | - | κc |)27 | | |
| K 144 SS=F | These deficient practices were confirmed by the Maintenance Director (MH). NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised | | K 1 | 44 | | 8/3/15 |
| | | inutes per month in | | | r. | |
| | | | | | | |
| | NFPA 101 (2000) L REGULATION - Ge weekly and exercise 30% of the EPS nan per month and shal | s not met as evidenced by: LIFE SAFETY CODE SURVEY enerators must be inspected ed under load at not less than meplate rating, for 30 minutes I be in accordance with NFPA nd NFPA 110 (1999 edition). | | | K144: 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 to it will be in substantial compliance with standards indicated by August 3, 2015. | l hat the |
| | Based upon a staff available records, th weekly inspections 04/16/15- 05/06/20 ⁻ generator. In a fire | not met as evidenced by: interview and review of ne facility did not perform form 02/04/15- 03/10-15 and 15 for the emergency or other emergency, this build adversely affect all visitors | | | Weekly inspections will be performed of the facility emergency generator. An autor for a period of 12 weeks will be conduct by facility administrator to assure compliance with weekly inspections of emergency generator. Responsible person: facility administrator, facility building engineer. | on Idit |
| | · | ce was verified by the | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

いたの

| STATEMENT | OF DEFICIENCIES OF CORRECTION | A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|--|----------------------------|
| | | 245259 | B. WING | ······ | 07/ | 14/2015 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | DULD BE | (X5) COMPLETION DATE |
| K 147 SS=F | Electrical wiring an with NFPA 70, Nat This STANDARD Observations rever installations are no "The National Elect deficiency could ne staff and visitors in Findings include: On facility tour bett and 11:30 PM on 0 revealed that the fe 1) The refrigerator 39 was plugged int This deficient prac | and blanket warmer in Room | К 14 | 7 K147: Despite the facility's obj the alleged Notice of Violation, following is proposed as the pla correction in accordance with s federal regulations: the facility it will be in substantial complian standards indicated by August The refrigerator and blanket wa room 39 will be connected to th outlet directly not using a powe electrical contractor has been I install a two gang outlet close of the blanket warmer and refrige direct connection from these tw appliances is possible. Respor person: facility administrator, fa building engineer. | the an of tate and alleges that nee with the 3, 2015. armer in ne electrical r strip. An nired to enough to rator so /o sible | |
| | | | | | | |

Facility ID: 00062



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 30, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5259022

Dear Mr. Flaherty:

The above facility was surveyed on July 13, 2015 through July 16, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 <u>only a suggestion</u> 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 at (218) 332-5140 or email: 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.

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 Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

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

cc: Original - Facility Licensing and Certification File

| Minneso | ta Department of He | alth | | | | |
|--------------------------|--|---|-------------------------|--|-------------------|--------------------------|
| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00062 | B. WING | | 07/1 | 6/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET ADD | DRESS, CITY, S | STATE, ZIP CODE | | |
| LUTHER | HAVEN | | T HIGHWAY DEO, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | ****ATTEI | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of | nether a violation has been compliance with all rule provided at the tag ile number indicated below. ns several items, failure to the items will be considered | | | | |
| | re-inspection with a result in the assess | Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was | | | | |
| | that may result from orders provided tha the Department with | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance. | | | | |
| | receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.<br="">fobul.htm> The St delineated on the a</http:> | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | TITLE | | (X6) DATE 08/07/15 |

STATE FORM

If continuation sheet 1 of 8

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
|--------------------------|---|---|----------------------------------|--|---------------|------------------------|--|
| | | 00062 | B. WING | | 07/16/2015 | | |
| IAME OF I | PROVIDER OR SUPPLIER | | T ADDRESS, CITY, STATE, ZIP CODE | | | | |
| UTHER | HAVEN | | ST HIGHWAY 7 | | | | |
| | 1 | | VIDEO, MN 56 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE | (X5) COMPLE DATE | |
| 2 000 | Continued From pa | age 1 | 2 000 | | | | |
| | you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm On July 13, 2015 - this Department's s and the following c Please indicate in y correction that you | Although no plan of correction ate Statutes/Rules, please rected" in the box available for n indicate in the electronic cess, under the heading the date your orders will be electronically submitting to the nent of Health. | | | | | |
| | the State Licensing federal software. Ta | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for | | | | | |
| | column entitled "IE statute/rule out of o "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo | number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute t, "This Rule is not met as wing the surveyors findings Method of Correction and rrection. | | | | | |
| | FOURTH COLUM | ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. B ON EACH PAGE. | | | | | |

| Minneso | ta Department of He | alth | | | FORM APPROVEL |
|---------------------------|---|--|-------------------------|--|-------------------------------|
| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| | | 00062 | B. WING | | 07/16/2015 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, | STATE, ZIP CODE | |
| LUTHER | HAVEN | | T HIGHWAY IDEO, MN 5 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRON DEFICIENCY) | D BE COMPLETE |
| 2 000 | Continued From pa | ge 2 | 2 000 | | |
| | PLAN OF CORREC | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES. | | | |
| 2 360 | MN Rule 4658.014 Charges | 5 Agreement as to Rates and | 2 360 | | 8/7/15 |
| | Annually, and when nursing home must services available in charges for those s for services not cow Medicaid or by the A nursing home mu resident's agent or the charges for services | In of rates and charges. Inform the resident of In the nursing home and of ervices, including any charges rered under Medicare or nursing home's per diem rate. Ist inform the resident or the guardian before any change in vices not covered under aid or by the nursing home's | | | |
| | by: Based on interview facility failed to ens R89, R106) reviewe the required Notice Centers for Medica (CMS) Form 10123 | | | Completed | |
| | Findings include: | | | | |
| | R64 was admitted t | o the facility on a skilled stay | | | |
| Minnesota D STATE FORI | epartment of Health M | | 6899 | 60BK11 | If continuation sheet 3 of |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|--|--|--|--|-----------------------------------|-------------------------|--|--|
| | | 00062 | B. WING | | 07/16/0015 | | | |
| | PROVIDER OR SUPPLIER | | B. WING 07/16/2015 ADDRESS, CITY, STATE, ZIP CODE 07/16/2015 | | | | | |
| LUTHER | | 1109 EA | ST HIGHWAY 7 | , | | | | |
| | | | /IDEO, MN 562 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE | | |
| 2 360 | Continued From pa | age 3 | 2 360 | | | | | |
| | R64 had been disc therapy(PT) service met. R64 discharge R64 did not receive | 5, for rehabilitation procedures harged from physical es on 6/8/15, PT goals were ed from the facility on 6/9/15. e the required CMS Form ce prior to discontinuation of | | | | | | |
| | beginning on 4/23/ ⁻ procedures and rec when PT services v met. R89 discharge R89 did not receive | to the facility on a skilled stay 15, for rehabilitation ceived PT services until 5/4/15 were discontinued due to goals ed from the facility on 5/5/15. e the required CMS Form ce prior to discontinuation of | | | | | | |
| | beginning on 5/11/1 procedures and rec when R106 was dis goals being met. R facility on 6/5/15. R | I to the facility on a skilled stay 15, for rehabilitation ceived PT services until 6/4/15 scharged from therapy due to 106 discharged from the 106 did not receive the n 10123 48 hour notice prior to skilled services. | | | | | | |
| | director of nursing and R106 had not r Form 10123. The responsible for issu | 7/14/15, at 3:49 p.m. the (DON) confirmed R64, R89 received the required CMS DON stated the staff member uing the required form at that stand the form was required if scharged home. | | | | | | |
| | A policy was reque | sted, but not provided. | | | | | | |
| | | | | | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------------|---|---------------------------------|-------------------------|
| | | | | | | |
| | | 00062 | B. WING | 07/ | 07/16/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | STATE, ZIP CODE | | |
| UTHER | HAVEN | | 6T HIGHWAY IDEO, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 2 360 | Continued From pa | ige 4 | 2 360 | | | |
| | The Director of Nur could review policy regarding timely no Medicare payment Assessment and As | HOD OF CORRECTION: rsing (DON) and/or designee and provide education for staf tification of change in for residents. The Quality ssurance (QAA) committee udits to ensure compliance. | f | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-one | | | | |
| 21685 | MN Rule 4658.141 Housekeeping, Ope | 5 Subp. 2 Plant eration, & Maintenance | 21685 | | | 8/13/15 |
| | including walls, floc systems, and equip continuous state of with regard to the h well-being of the re | blant. The physical plant, brs, ceilings, all furnishings, brent must be kept in a good repair and operation lealth, comfort, safety, and esidents according to a written e and repair program. | | | | |
| | by: Based on observati review, the facility f the kitchen in a sar | ent is not met as evidenced ion, interview and document ailed to maintain equipment in hitary manner. This had the Il 82 residents who reside in | | Completed | | |
| | Findings Include: | | | | | |
| | | p.m. a tour of the kitchen was dietary director (DD) and the d: | | | | |

STATE FORM

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00062 | | (X2) MULTIPLE A. BUILDING: | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED 07/16/2015 | |
|--|--|--|----------------------------|---|--|------------------|
| | | 00062 | B. WING | | | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | TATE, ZIP CODE | | |
| LUTHER | HAVEN | | T HIGHWAY 7 IDEO, MN 56 | | | |
| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF | CORRECTION | (X5) |
| PRÉFIX TAG | | YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | THE APPROPRIATE | COMPLETE DATE |
| 21685 | Continued From page 5 | | 21685 | | | |
| | The cupboard underneath the utility sink located by a steam table had greasy brown colored substance on the bottom back portion of the cabinet. The DD indicated it could be lime or rust but was not sure In addition, under the sink pipe there was approximately 8 inches long area that had a white colored substance under it. The DD said it could be lime built up but was not sure. The DD verified the area was dirty. The microwave located on a shelf on the right side of the utility sink had a cover attached to the inside right side wall of the microwave that was covering the fan. It had several dried areas of brown colored substance on the lower portion of the covering. The DD verified the finding and indicated she was unsure what the substance was. | | | | | |
| | steam table, a ledge sticky substance co white colored areas of the steam table, which had two large DD confirmed the fi table had not been needed to be clean | | | | | |
| | area, had cleaning | Inder the sink in the baking supplies in it and had dust and m of it. The DD verified the net. | | | | |
| | side of the sink had it. There was two sh | the lower cabinet on the left metal baking pans stored in nelves and both of them where r of dust and dirt particles on | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00062 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---------------------|--|-----------------------------------|-------------------------|
| | | B. WING | | 07/ | 07/16/2015 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| LUTHER | HAVEN | | ST HIGHWAY 7 | | | |
| | | | /IDEO, MN 562 | | | |
| (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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21685 | Continued From page 6 | | 21685 | | | |
| | During an interview on 7/13/15, at 2:17 pm the DD verified the above findings and stated the facility had a cleaning schedule for the kitchen and stated she felt it is not getting done. Review of the cleaning schedules, scheduled labeled Short Monday, indicated to clean microwaves 1 and 2, Monday thru Sunday. The cleaning schedule that has microwave area listed on it indicated to clean microwaves with no day listed to clean them. Scheduled labeled LX Monday indicated to clean the cupboard under the sink and clean and organize storage cupboards inside and out. On Friday the scheduled labeled LC indicated to wipe out the cupboards under the counter inside and out. On the cleaning schedule under Miscellaneous it indicates to wash steam tables on the outside and wipe it down. | | | | | |
| | | | | | | |
| | Service Areas with food service staff w the dining and food cleaning schedule | anitation of Dining and Food no date on it, indicated the vill maintain the sanitation of service area. In addition, will be posted for all cleaning e accountable for cleaning | | | | |
| | Suggested Method | of Correction: | | | | |
| | director of nursing designee, could ed importance of a saf | THOD OF CORRECTION: The (DON), dietary manager or ucate staff regarding the fe, clean, functional and ent. The DON or designee, ith maintenance and |) | | | |

| AND PLAN OF CORRECTION IDENT | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | NTIFICATION NUMBER: A. BUILDING: | | (X3) DATE SURVEY COMPLETED 07/16/2015 | |
|------------------------------|--|---|----------------------------------|--|---|---------------------|
| | | 00062 | | | | |
| | | | | | 07/10/201 | <u>, 2015</u> |
| UTHER | HAVEN | | ST HIGHWAY 7 VIDEO, MN 56 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COM | X5) IPLET ATE |
| 21685 | Continued From pa | ige 7 | 21685 | | | |
| | housekeeping staff to conduct periodic audits to ensure a safe, clean, functional and homelike environment is maintained to the extent possible. | | | | | |
| | TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| nnesota D ATE FORI | epartment of Health M | | ⁶⁸⁹⁹ 60 |)BK11 | If continuation she | et |