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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B1V0
Facility ID: 00329

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245382**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON LUTHERAN HOME**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

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 **06/22/2016** (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 **65** (L18)
13.Total Certified Beds **65** (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
__ 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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 Supervisorf 07/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/26/2016 (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
12/01/1986
(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
06/20/2016
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245382

July 12, 2016

Mr. Justin Hughes, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

Dear Mr. Hughes:

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 June 10, 2016 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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 letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 5, 2016

Mr. Justin Hughes, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382025

Dear Mr. Hughes:

On May 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. 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 June 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 31, 2016 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 May 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 10, 2016 and therefore remedies outlined in our letter to you dated May 20, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245382 (Y1)	A. Building B. Wing (Y2)	6/22/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176 Reg. # 483.10(n) LSC	Correction Completed 06/10/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 06/10/2016	ID Prefix F0242 Reg. # 483.15(b) LSC	Correction Completed 06/10/2016
ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) GA/mm	DATE 07/05/2016	SIGNATURE OF SURVEYOR 28034	DATE 06/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/5/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245382	A. Building 01 - MAIN BUILDING 01 B. Wing	5/31/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0104	Correction Completed 05/26/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 05/26/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/mm	07/5/2016	34764	5/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00329

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(L1) **245382**

2. STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON LUTHERAN HOME**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

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 **05/05/2016** (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 **65** (L18)

13. Total Certified Beds **65** (L17)

10. THE FACILITY IS CERTIFIED AS:
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
	65			
(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
Tammy Williams, HFE NEII
Date : 06/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL
Mark Meath, Enforcement Specialist
Date: 06/15/2016 (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
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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
12/01/1986
(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
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 20, 2016

Mr.. Justin Hughes, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382025

Dear Mr.. Hughes:

On May 5, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<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 June 14, 2016, 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 June 14, 2016 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 August 5, 2016 (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 November 5, 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: 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
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	**900 SECOND AVENUE MADISON, MN 56256**

(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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure 1 of 1 resident R61) was assessed for self-administration of a nebulizer treatment. Findings include: R61's admission record dated 9/11/15, indicated diagnoses included bladder cancer, unspecified disorder of kidney and ureter, atrial fibrillation, and chronic obstructive pulmonary disease (COPD).	F 176	F176 Madison Lutheran Home will ensure safety with self-administration of medications for residents who choose to exercise this resident right. Resident (R65) was admitted to the hospital 5/4/16. Upon his return from hospital, an IDT assessment of resident (R61) safety with self-administration of his nebulizer treatment, as well as other medications he was choosing to self-administrate, was completed 5/10/16. Based on this assessment, a physician order to self-administer his nebulizer	5/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/26/2016

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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	245382	A. BUILDING ______ B. WING ______	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	**900 SECOND AVENUE MADISON, MN 56256**

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F 176	Continued From page 1 A quarterly Minimum Data Set (MDS) dated 1/28/16, indicated R61 was cognitively intact. A medication administration record dated 5/2016 indicated R61 had Pulmacort suspension 0.5 milligram (mg)/2 milliliter (ml) one vial inhale orally via nebulizer two times a day related to chronic obstructive pulmonary disease, must rinse and spit when finished. A review of R61 medical record on 5/4/16 at 12:50 p.m. revealed R61 had two self-administration of medication assessments dated 4/27/16, one for a prescription eye drop and the other for a prescribed thyroid medication. An observation on 5/4/16, at 7:40 a.m. with registered nurse (RN)-A prepared R61's prescribed Pulmacort nebulizer. RN-A put the prescribed Pulmacort solution in the nebulizer cup, placed the mask on R61, and then started the nebulizer machine. RN-A left R61's room. R61 finished the Pulmacort nebulizer, took of the nebulizer mask, and shut off the nebulizer machine. An unidentified nursing assistant (NA) assisted R61 in the wheelchair and brought R61 to the dining room for breakfast. An interview on 5/4/16, at 1:30 p.m. with RN-A stated I do not think R61 can self-administer medication (SAM) nebulizers. RN-A stated the process for nebulizer administration was to put the nebulizer solution in the cup and place the mask on R61, then start the nebulizer machine. RN-A stated when the nebulizer is finished RN-A would check on R61 and take off the nebulizer mask. RN-A stated I did not think I needed to stay in R61's room while the Pulmacort nebulizer was running and verified RN-A left room once the Pulmacort nebulizer was started. RN-A stated I	F 176	treatment was obtained and an individualized plan of care for self-administration of his nebulizer treatment was developed and implemented. This assessment and plan will be reviewed quarterly and revised as needed with changes in resident s condition. The policy and procedure for self-administration of medications was reviewed, revised, and approved at the facility quality assurance/performance improvement meeting on 5/12/16. Education was done with all nursing staff regarding self-administration of medications, including nebulizer treatments, and the policy & procedures were reviewed with staff on 5/16/16. Other residents who wish to exercise their right to self-administer medications are identified as being at risk. These residents will be assessed for safety, a plan developed, and a MD order obtained before initiating medication self-administration. The Director of Nursing, or a designee, will complete a quality assurance audit monthly to ensure all components of the medication self-administration policy and procedure have been followed to ensure safety and ongoing compliance. Based on the results of these audits, any indicated need for further education or process changes will be implemented. Results of these audits will be brought to the Quality Assurance and Performance Improvement Committee at least quarterly for review, discussion, and further planning to ensure ongoing compliance.	

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F 176	Continued From page 2 did not think the Pulmacort nebulizer was SAM after I started the nebulizer machine, I thought it was the actual setting up of the Pulmacort nebulizer into the nebulizer cup on the mask. An interview on 5/4/16, at 10:11 a.m. with the clinical manager (CM)-A stated R61 had SAM's for prescription eye drops and a prescribed thyroid medication. An interview on 5/5/16, at 11:49 a.m. with the CM-A stated I thought as long as the nurse sets up the nebulizer the resident could have the nebulizer on in the resident's room and the nurse would check back on the resident when it was completed. A facility policy Self-Administration of Medication dated 2/2005 indicated a resident may not be permitted to administer or retain any medication in his/her room unless so ordered in writing by the attending physician. The physician's order must be signed and dated prior to self-administration.	F 176	Corrective action completion date of 6/10/16.	
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete and document pre-employment reference checks as directed by the facility policy	F 226	F226 Madison Lutheran Home will maintain appropriate documentation to ensure reference checks are being	5/26/16

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F 226	Continued From page 3 for 5 of 5 newly hired employees (EA, EB, EC, ED, EE) reviewed for abuse prohibition. This deficient practice had the potential to affect all 54 residents currently residing in the facility. Findings include: -Employee A (EA) was hired on 1/15/16, and was currently providing care to residents in the facility. The facility was unable to provide evidence of pre-employment reference checks, as directed by their policy. -Employee B (EB) was hired on 11/30/15, and was currently providing care to residents in the facility. The facility was unable to provide evidence of pre-employment reference checks, as directed by their policy. -Employee C (EC) was hired on 1/11/16, and was currently providing services for residents at the facility. The facility was unable to provide evidence of pre-employment reference checks, as directed by their policy. -Employee D (ED) was hired on 12/7/15, and was currently providing services for residents at the facility. The facility was unable to provide evidence of pre-employment reference checks, as directed by their policy. -Employee E (EE) was hired on 12/10/15, and was currently providing services for residents at the facility. The facility was unable to provide evidence of pre-employment reference checks, as directed by their policy. During interview on 5/4/16, at 3:00 p.m., the administrator confirmed the facility did not have	F 226	completed for all new, potential employees. This deficiency had the potential to affect all 54 residents residing in the facility and all new hires. The screening section in the Madison Lutheran Home Vulnerable Adult Policy has been updated in regards to reference checks and now reads, "References will be attempted on current and/or previous employers" and was updated on 5/23/16. Madison Lutheran Home has created a new reference check form that was completed by our Human Resource Director on 5/23/16 which will be used for all new, potential employees. This form will be kept in the employee s personnel file. The Human Resource Director will complete an audit on new employee files with the Administrator monthly for three months and then the audit will be completed quarterly. The audit form was created on 5/25/16. Based on the results of these audits, any indicated need for further education or process changes will be implemented. Results of these audits will be brought to the Quality Assurance and Performance Improvement Committee at least quarterly for review, discussion, and further planning to ensure ongoing compliance. Corrective action completion date of 6/10/16.	

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F 226	Continued From page 4 any documentation of pre-employment reference checks being attempted or completed on any of the five newly hired employees. The facility's Vulnerable Adult Policy dated 4/14, indicated a reference check would be completed on all prospective employees.	F 226		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed accommodate resident bathing preferences for 1 of 2 residents (R25) who voiced concerns regarding bathing preferences. Findings include: R25's annual Minimum Data Set (MDS) dated 12/16/15, identified R25 had intact cognition, required limited assistance with transfers, and mobility, extensive assistance with toilet use, dressing, and hygiene including bathing, and was occasionally incontinent of urine. On 5/3/2016, at 9:50 a.m. R25 stated he/she received a bath once a week and indicated once a week was not often enough. R25 stated " I	F 242	F242 It is the intent of Madison Lutheran Home to honor all residents rights of self-determination including the right to make choices with activities, schedules, and health care consistent with their interests, assessments, and plans of care. Resident (R25) has been accommodated with his choice of two baths weekly as of 5/6/16. Root cause analysis of this incident showed a breakdown in communication between quality assurance audits done by Social Services and the IDT. Resident s choosing to bathe more frequently than the standard weekly bath would be at risk of not having their choice honored. All current residents will be	5/26/16

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F 242	Continued From page 5 have told them before " regarding the request for more baths per week and continued to receive only one bath per week. On 5/4/2016, at 7:30 a.m. ward clerk (WC)-C provided the bath schedule and verified it to be the current bath schedule for all residents on unit one. Review of the unit one weekly bath schedule, identified R25 received one bath each week, at 1:00 p.m. on Friday. On 5/4/2016, at 12:44 p.m. the clinical manager (CM)-A indicated the ward clerk was responsible for scheduling the bathing for residents, and the schedule was reviewed at the time of each resident's care conference. CM-A also indicated a quality questionnaire was completed by each resident regarding choices in the facility. Review of R25's undated quality questionnaire provided by CM-A, identified The facility utilized a form titled Resident Interview & Resident Observation, Centers for Medicare and Medicaid Services (CMS) form, dated 3/20/13, and section B Choices, number 3, documented R25 did not choose how many times a week he/she took a bath or shower, and "I'd like 2x week" was handwritten on the form. On 5/4/2016, at 12:54 p.m. CM-A verified the current bath schedule provided R25 one bath per week, and R25 had identified with the questionnaire two baths per week were preferred. CM-A indicated R25 should have been provided with two baths per his/her request.	F 242	interviewed regarding bathing choices and will be accommodated with their choices. All staff education regarding residents right to make choices regarding type of bath, frequency of bath, and time of day for bath was done 5-16-2016. Staff has been instructed to listen and report any resident preferences or choices regarding care, including bathing, to the clinical care coordinator. Resident bathing choices will be discussed at the time of admission and with every care conference. Choices will be documented in the resident s medical record and communicated to the bath scheduler. All efforts will be made to accommodate these choices. Social Services will conduct monthly quality audits to assure bathing preferences have been discussed, care planned, and scheduled for new admissions and resident s having a care conference during the previous month. If no problems are noted in the first three months, audits will be done quarterly, to ensure ongoing compliance. Based on the results of these audits, any indicated need for further education or process changes will be implemented. Results of these audits will be brought to the Quality Assurance and Performance Improvement Committee at least quarterly for review, discussion, and further planning to ensure ongoing compliance. Corrective action completion date of 6/10/16.	

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F 242	Continued From page 6 On 5/4/2016, at 2:26 p.m. Social Services (SS)-A identified she completed the Resident Interview and Observation form with each resident prior to the resident's care conference. The information from these questionnaires were then reviewed by the interdisciplinary team and changes made if needed. SS-A indicated she did not know why the bathing schedule had not been changed to accommodate R25's wishes for two baths per week. The facility policy titled Bathing dated 2/16, directed the following: Residents will be provided hygiene of their wishes from 1 to 3 times per week for hygiene and comfort.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to identify and monitor bruising for 1 of 3 residents (R61) who had a history of bruising. Findings include: R61's admission record dated 9/11/15, indicated	F 309	F309 Madison Lutheran Home will provide necessary care and services to residents, so they may attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. These services include monitoring of bruising	5/26/16

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F 309	Continued From page 7 diagnoses included bladder cancer, unspecified disorder of kidney and ureter, atrial fibrillation, and chronic obstructive pulmonary disease (COPD). A quarterly Minimum Data Set (MDS) dated 1/28/16, indicated R61 was cognitively intact and required staff assistance with all activities of daily living (ADL). R61's care plan dated 4/27/16 identified R61 needed assistance with transfers and used a walker with assistance of one staff for ambulation. The care plan identified R61 was on anticoagulant therapy, history of chemotherapy, and had potential for skin breakdown. However, the care plan did not address potential for bruising or monitoring of bruises. R61's medication administration record (MAR) dated May 2016 indicated R61 routinely received Coumadin 5 milligrams (mg) one time a day four days a week and 7.5 mg one time a day for the other three days of the week. During observation on 5/3/16, at 3:01 p.m. R61 was at an activity, seated in a wheelchair. R61 had bruises on the left elbow area, on the top of the left hand, and the right forearm area had three bruises. The bruises were faded red brown color. During an interview on 5/4/16, at 7:48 a.m. with R61 stated "I get bruises all over me all the time." R61 stated he routinely took the medication Coumadin (a blood thinner). R61 also indicated he was not aware of how the multiple bruises had occurred. An interview on 5/3/16, at 3:27 p.m. with nursing assistant (NA)-A stated the usual practice was to notify the nurse if there were any abnormal issues with a residents skin. NA-A stated the skin abnormality would then be charted in the residents chart. NA-A stated shift report would also inform on coming staff if a resident had	F 309	and other non-pressure and pressure skin conditions. Resident (R65) was admitted to the hospital 5/4/16, on this day there was documentation of bruising in the progress notes of Point Click Care. Upon his return from hospital, a comprehensive skin assessment, Braden scale, turning and repositioning form, and non-pressure wound tracking were completed 5/9/16. The comprehensive care plan was reviewed and revised also at that time. There has been ongoing weekly tracking of the non-pressure bruising. All residents are identified as at risk for non-pressure skin conditions like bruising. Staff education was done regarding skin conditions and new processes for assessment and tracking with licensed staff 4-18-2016 and nursing assistants 4-27-16. These new processes had been initiated 5-1-16. Following our survey, on 5-16-16, all nursing staff was educated regarding skin assessment, reporting, tracking, and care planning. New policies and procedures that were reviewed, revised, and approved during our quality assurance/performance improvement meeting on 5/12/16. This was communicated to staff at this meeting. The Director of Nursing or her designee will do monthly audits of new processes with skin assessment, tracking, reporting, and care planning to ensure ongoing compliance. Based on the results of these audits, any indicated need for further education or process changes will be implemented. Results of these audits will be brought to the Quality Assurance and	

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F 309	Continued From page 8 bruising or skin tears. An interview on 5/4/16, at 9:31 a.m. with NA-C indicated if a resident had a skin issue, a nurse would be informed and a body assessment form filled out and given to the nurse. Review of R61's progress notes from 4/4/16 to 4/29/16 lacked documentation of any bruises for R61. An interview on 5/4/15, at 12:44 p.m. with licensed practical nurse (LPN)-C, she stated she was not aware R61 had bruising on the arms and hand. LPN-C indicated staff should report to nurses if the residents have bruising. LPN-C verified there was no documentation in the progress notes and no skin assessment or body assessment form had been completed related to R61's bruising. An interview on 5/4/16, at 1:49 p.m. with the clinical nurse manager (CM)-A stated staff should tell the nurses when a bruise is noted and then document where the bruises are. CM-A stated any skin issue that is not normal should be reported to the nurses. CM-A stated the bruising and skin issues should be monitored and a note in the chart should be documented as to where R61 said the bruising or skin issue came from. A facility policy/procedure Non-Pressure Ulcer Skin Conditions Form dated 2007 directed staff to fill out form on any skin concern that is not a pressure ulcer, arterial wound, venous wound, or neuropathy/diabetic wound. To be filled out upon discovery of skin condition and then at least weekly thereafter.	F 309	Performance Improvement Committee at least quarterly for review, discussion, and further planning to ensure ongoing compliance. Corrective action completion date of 6/10/16.	

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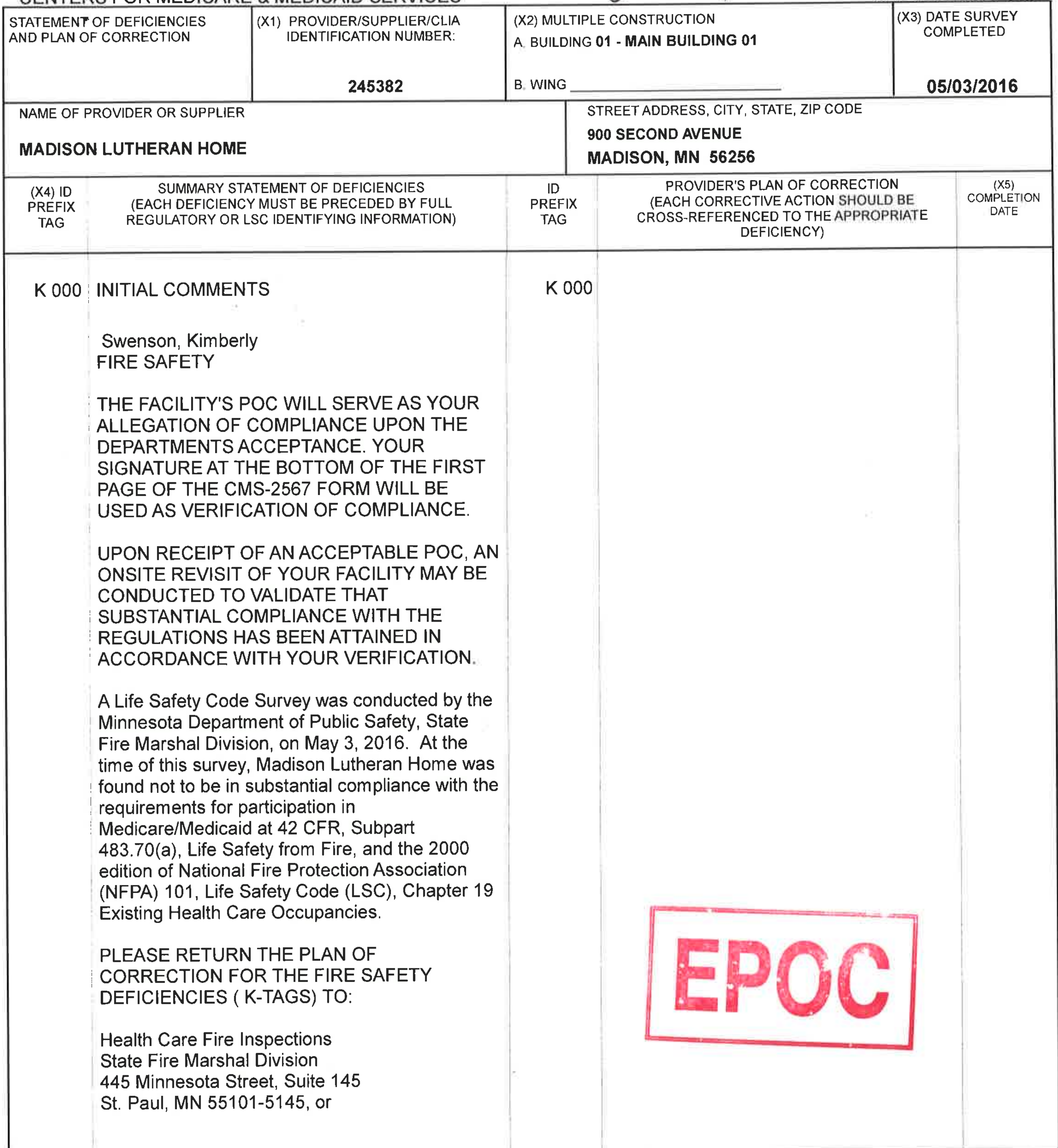

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/03/2016**

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K 000	INITIAL COMMENTS Swenson, Kimberly FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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 May 3, 2016. At the time of this survey, Madison Lutheran Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/26/2016

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.

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

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MADISON LUTHERAN HOME	**900 SECOND AVENUE** **MADISON, MN 56256**

(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 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto: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. Madison Lutheran Home is a 3-story building with partial basement, and is fully fire sprinkler protected. The original building was constructed in 1914 and was determined to be of Type I(322) construction. The 1952 addition was determined to be of Type I(332) construction. The 1968 addition was determined to be of Type II(111) construction. The 1977 addition was determined to be of Type II(111) construction. The 1991 addition was determined to be of Type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The 1914 and 1952 buildings are now a "B" Occupancy. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 capacity of 65 beds and had a census of 54 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 This STANDARD is not met as evidenced by: Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5 FINDINGS INCLUDE: On 05/03/2016 at 10:00AM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no documentation could be provided verifying the fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3,	K 104	K104 Madison Lutheran Home will ensure the fire/smoke dampers will be checked every four years to maintain compliance. Chappell Central from Willmar, MN is scheduled for June 9, 2016 at 8:00 A.M. to complete the four year inspection of the fire/smoke dampers for the entire campus, which includes the Madison Lutheran Home. The Facility Manager will be responsible for ensuring this work is complete. The Facility Manager will be putting reminders on his calendar to ensure the four year inspection is not missed for the facility in the future. Corrective action completion date 6/10/16.	5/26/16

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K 104	Continued From page 3 Section 3-4.7. Last documented damper test was June 2010. This deficient practice was verified by the Assistant Maintenance.	K 104		
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: On facility tour between 10:00 AM to 2:00 PM on 05/03/2016, during the review of all available documentation for the emergency generator, revealed the facility did not document the required cool down for the emergency generator. This deficient practice was verified by the Assistant Maintenance.	K 144	K144 Madison Lutheran Home will initiate the documentation of the five minute cool down to maintain compliance. The emergency generator documentation now has an area for documenting the five minute cool down times for the emergency generator. The Facility Manager will be responsible for ensuring this is documented each month. The new area to document the five minute cool down time was completed on 5/04/2016. Corrective action completion date of 6/10/16.	5/26/16