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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CRHO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00695

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245522**

2. STATE VENDOR OR MEDICAID NO. (L2) **443343200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER MEMORIAL HOME**
(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

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 **02/09/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (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
	61			
(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 :
Susan Kalis, HFE NE II 03/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/272017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/01/1987
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245522

April 17, 2017

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

Dear Ms. Campbell:

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 March 22, 2017 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 17, 2017

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Number S5522027

Dear Ms. Campbell:

On February 23, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 30, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 27, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 22, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2017, effective March 22, 2017 and therefore remedies outlined in our letter to you dated February 23, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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
245522 Y1	A. Building B. Wing Y2	3/30/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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 F0253	Correction	ID Prefix F0278	Correction	ID Prefix F0282	Correction
Reg. # 483.10(i)(2)	Completed	Reg. # 483.20(g)-(j)	Completed	Reg. # 483.21(b)(3)(ii)	Completed
LSC	02/10/2017	LSC	03/22/2017	LSC	03/22/2017
ID Prefix F0309	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.45(d)(e)(1)-(2)	Completed	Reg. # 483.60(i)(1)-(3)	Completed
LSC	03/22/2017	LSC	03/22/2017	LSC	03/22/2017
ID Prefix F0428	Correction	ID Prefix F0431	Correction	ID Prefix F0465	Correction
Reg. # 483.45(c)(1)(3)-(5)	Completed	Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.90(i)(5)	Completed
LSC	03/22/2017	LSC	02/10/2017	LSC	03/22/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	04/17/2017	03048	3/30/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
2/9/2017	

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
245522 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	3/27/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0300	03/22/2017	LSC K0324	03/22/2017	LSC K0346	02/13/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0354	03/22/2017	LSC K0521	03/22/2017	LSC K0712	02/23/2017
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0781	03/22/2017	LSC K0918	02/13/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	04/17/2017	35482	3/27/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/10/2017

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CRHO

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Facility ID: 00695

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(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

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5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
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5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/09/2017** (L34)

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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
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18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Susan Kalis, HFE NE II 03/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/272017 (L20)

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

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3. Both of the Above :
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11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 23, 2017

Ms. Dawn Campbell, Administrator
Luther Memorial Home
221 6th Street Southwest
Madelia, MN 56062

RE: Project Number S5522027

Dear Ms. Campbell:

On February 9, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 March 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 21, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

(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 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain resident living areas and furnishings in a sanitary and comfortable manner for 1 of 30 resident's (R45) whose toilet was set too high for the resident. The findings include: During observation on 2/5/17, at 3:45 p.m. the bathroom toilet room #123 was elevated with wooden blocks approximately 2 inches x 10 inches. The placement of the wooden blocks underneath the toilet resulted in a gap of approximately 1/2 inch between the tile flooring and the porcelain base of the stool. At this time, R45 indicated this had been added as a result of	F 253	F253 1. The necessary repair to R45□s toilet was completed. 2. There are no other bathrooms with conditions that match R45. 3. We will continue to address complaints made by residents to the best of our ability and within reason to provide a comfortable and sanitary living space. ¿A log was started by the Assistant Maintenance Director to keep track of the maintenance requests and complaints, recording when the work is completed. 4. The Environmental Services Director along with the Housekeeping Supervisor	2/20/17

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

Electronically Signed | 03/07/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	02/09/2017

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F 253	Continued From page 1 the toilet leaking water. R45 further explained that after the toilet repair, she was unable to touch the floor with her feet while using the toilet, making it uncomfortable. R45 also stated the toilet seat was loose and would move about when R45 was seated on it. R45 expressed frustration over the condition of the toilet and her inability to touch the floor. R45 stated she had complained about the condition of the toilet but stated nothing had been done yet. During a tour with the maintenance staff in charge (M)-A on 2/9/17, at 11:34 a.m. it was confirmed that R45's toilet was in poor repair and the toilet stool had been elevated on wood blocks causing a separation space between the floor and the stool. M-A confirmed that a plumber would need to be summoned to repair the stool properly.	F 253	will continue to be responsible for addressing these types of concerns. The Environmental Services Director or the Administrator will report on the results of the log at QA. Completion Feb 20, 2017	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		3/22/17

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F 278	Continued From page 2 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) assessment for 2 of 2 residents (R21, R33) reviewed for oral needs. Findings include: The current quarterly Minimum Data Set (MDS) assessment dated 12/1/16, identified that R21 had no problems with her teeth/oral cavity; (no missing or chipped teeth) . Review of R21's most current oral assessment dated 8/30/16, identified the resident as having all natural teeth with no concerns/problems with her teeth. The assessment identified that R21 had no chipped and/or missing teeth. During observation of R21's oral cavity on 2/6/17 at 3:27 p.m., with nursing assistant (NA)-F, it was noted that R21 had a missing tooth on each side	F 278	F278 1. The assessments for R21 and R33 that were reviewed at the time of the survey are quarterly assessments. ¿According to the RAI Manual, this type of assessment limits the facility's ability to accurately reflect a person's oral health because only two questions are presented in Section L. ¿Those questions are: "Broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose)" and "Mouth or facial pain, discomfort or difficulty with chewing". ¿Neither of those conditions were true at the time of assessment for either R21 or R33. ¿According to the RAI Manual, at the time of an annual assessment, a comprehensive assessment is completed and issues such as broken and missing teeth are answers that can be provided.	

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F 278	Continued From page 3 of her upper oral cavity as well as a chipped front tooth. During interview with NA-F at that time, it was confirmed that R21 had missing teeth as well as a chipped front tooth for at least a year. Interview and observation of R21 with the MDS coordinator on 2/9/17, at 9:05 a.m. confirmed the resident had a chipped front tooth as well as missing teeth on each side of the upper oral cavity. The MDS coordinator verified the MDS as well as the oral assessment had been inaccurate at the time of completion. R33's most current quarterly MDS dated 12/16/16, identified the resident as cognitively intact with no obvious or likely cavity, or broken natural teeth. During observation on 2/6/17, at 4:24 p.m. R33 was observed to have broken and missing teeth on both top and bottom gum lines. During interview on 2/7/17, at 3:07 p.m. R33 stated another tooth had broken off the night before. R33 also stated her teeth have been in poor condition with many being broken and/or missing for at least a year, and stated she would probably need dentures soon. When interviewed on 2/8/17 at 11:40 a.m., registered nurse (RN)-A verified R33 had broken and lost teeth in the past and routinely has dental appointments due to the poor condition of teeth. When interviewed on 2/9/17 at 9:55 a.m., RN-B confirmed R33's mouth had many broken and missing teeth. RN-B further verified the MDS dated 12/16/16 was inaccurate. A policy on accuracy of MDS's was requested but	F 278	¿The comprehensive assessment for R21 is due this month (March 2017) and R33's comprehensive assessment is due in June 2017. ¿We expect that their oral status will be accurately coded on the MDS at the time of their comprehensive assessments. 2. All residents are affected by the RAI process and have the potential to not have their oral health status reflected accurately on the quarterly MDS. 3. ¿We will continue to provide oral healthcare to all our residents which includes ensuring they are offered the opportunity to be seen regularly by dental professionals and per their request. 4. ¿The Director of Nursing will continue to be responsible for the overall accuracy of the MDS and she will continue to delegate authority to the MDS Coordinator to manage this process. The DON will review MDS's submitted for one quarter to ensure that the condition of resident's teeth are accurately being recorded. She will report her findings at the QA meeting in June 2017. Completion Date: March 22, 2017	

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F 278	Continued From page 4 not provided by facility.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and monitor bruising as identified in the written plan of care for 2 of 4 resident (R35, R43) reviewed for non-pressure related skin issues. Findings include: R35 had diagnosis of long term (current) use of anticoagulants (blood thinners). R35's quarterly Minimum Data Set (MDS) assessment dated 1/13/17, included a Brief Interview for Mental Status (BIMS) score of 10 indicating moderately impaired cognition. It also identified R35 as receiving anticoagulants. Review of R35's physician orders updated 2/8/17, included an order for Coumadin (blood thinner) 5 milligrams (MG) daily. Review of R35's care plan last revised 8/3/16, identified a potential for uncontrolled bleeding related to anticoagulant therapy. Interventions included: inspect skin frequently, report any signs	F 282	F282 1. The identified bruises at the time of the survey for R35 and R43 are healed. 2. Five residents currently fit the profile of having "report signs of bruising" in their care plan due to a potential for uncontrolled bleeding related to anticoagulant therapy. 3. We will continue to follow our system of having signs of bruising reported to the charge nurse. When a bruise is reported to the nurse, the nurse will investigate. If the bruise has already been reported and is currently being monitored, no further action will be taken. If it's a newly reported bruise, the nurse will assess the bruise, take measurements, complete an incident report and set up a "To Do" List for bruises that measured greater than 1 inch which triggers continuous charting on the bruise until the bruise is resolved (healed). The DON will verify that this system is being followed with each newly	3/22/17

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F 282	Continued From page 5 of bleeding (pink or red-tinged urine, darker stools, bruising, bleeding gums), and report signs of bruising. During observation on 2/6/17, at 6:08 p.m. R35 was noted to have a dime sized dark purple bruise on the left hand. R35 did not know the origin for the bruise. During observation and interview on 2/9/17, at 8:25 a.m. R35 was observed seated in wheelchair of lobby with the same dime sized dark purple bruise on the left hand and a quarter sized dark purple bruise to the left wrist area as well. When interviewed on 2/9/17, at 8:33 a.m. nursing assistant (NA)-C verified she had assisted R35 with bathing and had completed a skin observation. NA-C stated no skin concerns nor bruises were noted on R35. NA-C observed R35's left hand and wrist area with the surveyor at this time and verified that bruising was present. NA-C confirmed the bruising should have been noted during R35's bath and reported to the licensed nurse. During interview on 2/9/17, at 10:20 a.m. the director of nursing (DON) stated her expectation was that staff identify a bruise and notify the nurse per R35's plan of care. R43's diagnoses list noted in the electronic medical record included: Major depressive disorder, hypertension (high blood pressure) and hypothyroidism. Review of the most recent quarterly MDS assessment dated 12/20/16, included a BIMS score of 15 indicating intact cognition. The MDS identified that R43 required extensive assistance with dressing and personal	F 282	reported bruise for the next quarter with corrective actions provided as needed. She will report her findings at the QA meeting in June. 4. The Director of Nursing will continue to be responsible for the overall skin monitoring system and she will continue to delegate authority to the charge nurses to manage the process. Completion Date: March 22, 2017	

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F 282	Continued From page 6	F 282		

hygiene.

The plan of care for R43 with a goal date of 11/30/16 included: Potential for bruising easily. Interventions included: Monitoring for bruising. Review of R43's "To Do" List located in the electronic record related to monitoring of skin issues lacked any documentation of bruising

On 2/7/17, at 1:20 p.m. R43 was observed walking independently in room and a purple quarter sized area was noted on the back of his left hand extending onto wrist area. R43 did not respond when questioned whether he knew how he had obtained the bruise on his hand.

During observation on 2/8/17, at 10:00 a.m. R43 was ambulating independently in the hall using his walker and walking in a shuffling manner. The bruised area located on the back/wrist area of his left hand was visible as he ambulated with his walker. R43 made no response when questioned again whether he knew the how he had obtained the bruise on his left hand.

When interviewed on 2/8/17, at 9:19 a.m. RN-A indicated R43 has a history of bruising easily and is often reluctant to allow staff to assess areas. RN-A indicated she was aware of the bruise on R43's left hand and indicated skin is monitored with the weekly bath. RN-A confirmed R43's bruise located on his left hand should have been documented and setup on the "to do" list for ongoing monitoring.

When interviewed on 2/9/17, at 8:34 a.m. licensed practical nurse (LPN)-A indicated she was not aware of a bruise on R43's left wrist and then observed the bruised area. LPN-A

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F 282	Continued From page 7 confirmed this should have been reported and monitored. After the area was measured, the following measurements were documented: 2 centimeter (cm) x 1.2 cm; description-pale, purple/red bruised area located on the left wrist . The DON was interviewed on 2/9/17, at 10:00 a.m. and indicated her expectation was that staff report, document and monitor bruising as stated in the plan of care.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced	F 309		3/22/17

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F 309	Continued From page 8 by: Based on observation, interview and document review, the facility failed to identify and monitor bruising for 2 of 4 residents (R35, R43) reviewed for non-pressure related skin issues. Findings include: R35 had diagnosis of long term (current) use of anticoagulants (blood thinners). R35's quarterly Minimum Data Set (MDS) assessment dated 1/13/17, included a Brief Interview for Mental Status (BIMS) score of 10 indicating moderately impaired cognition. It further identified R35 as receiving anticoagulants. Review of R35's physician orders updated 2/8/17, included an order for Coumadin (blood thinner) 5 milligrams (mg) daily. Review of R35's care plan last revised 8/3/16, identified a potential for uncontrolled bleeding related to anticoagulant therapy. Interventions were to inspect skin frequently, report any signs of bleeding (pink or red-tinged urine, darker stools, bruising, bleeding gums), and report signs of bruising. During observation on 2/6/17, at 6:08 p.m. R35 was noted to have a dime sized dark purple bruise to left hand. R35 did not know the origin for the bruise. During observation on 2/9/17, at 8:25 a.m. R35 was observed seated in wheelchair of lobby with same dime sized dark purple bruise to left hand and a quarter sized dark purple bruise to left wrist area as well.	F 309	F309 5. The identified bruises at the time of the survey for R35 and R43 are healed. The quality of life for R35 and R43 had no negative impact as a result of the small bruises. 6. Five residents currently fit the profile of having "report signs of bruising" in their care plan due to a potential for uncontrolled bleeding related to anticoagulant therapy. 7. We will continue to follow our system of having signs of bruising reported to the charge nurse. ¿When a bruise is reported to the nurse, the nurse will investigate. ¿If the bruise has already been reported and is currently being monitored, no further action will be taken. ¿If it□s a newly reported bruise, the nurse will assess the bruise, take measurements, complete an incident report and set up a To Do List for bruises that measured greater than 1 inch which triggers continuous charting on the bruise until the bruise is resolved (healed). ¿The DON will verify that this system is being followed with each newly reported bruise for the next quarter with corrective actions provided as needed. ¿She will report her findings at the QA meeting in June. 8. The Director of Nursing will continue to be responsible for the overall skin monitoring system and she will continue to delegate authority to the charge nurses to manage the process. Completion Date: March 22, 2017	

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F 309	Continued From page 9	F 309		

Review of the weekly skin observation form dated 2/9/17 for R35, indicated a morning bath was given with no bruising or skin concerns identified.

During interview on 2/9/17, at 8:33 a.m. NA-C verified she assisted R35 with his morning bath and had completed the current weekly skin observation form. NA-C confirmed R35 was observed to have no skin concerns that included bruising.

During observation at 9:00 a.m. with NA-C, R35 was observed to have a bruise on the left hand and wrist. NA-C indicated she should have identified the bruises during R35's bath that morning and reported to the charge nurse.

During interview on 2/9/17, at 10:20 a.m. the director of nursing (DON) stated her expectation is that staff would identify a bruise and notify the nurse to assess the area for monitoring per their policy.

Measurement and description of left hand bruise per RN-B was dark purple 2 centimeters (cm) x 1 cm and left wrist dark purple bruise 1 cm x 1.5 cm.

R43's diagnoses list noted in the electronic medical record included: Major depressive disorder, hypertension (high blood pressure) and hypothyroidism.

Review of the most recent quarterly MDS assessment dated 12/20/16, included a BIMS score of 15 indicating intact cognition. The MDS identified that R43 was independent with activities of daily living (ADL) related to bed mobility, transferring, locomotion on/off unit, and eating but

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F 309	Continued From page 10 required extensive assistance with dressing and personal hygiene. R43's plan of care with a goal date of 11/30/16, included: Potential for bruising easily. Interventions included: long sleeves and monitoring for bruising. Problem: potential for impaired skin integrity. Interventions included: weekly skin assessment. Monitor skin daily with cares and report changes to nurse. Review of R43's "To Do" List located in the electronic record related to monitoring of skin issues lacked any documentation of bruising. On 2/7/17, at 1:20 p.m. R43 was observed walking independently in room and a purple quarter sized area was noted on the back of his left hand extending onto wrist area. R43 did not respond when questioned whether he knew how he had obtained the bruise on his hand. During observation on 2/8/17, at 10:00 a.m. R43 was ambulating independently in the hall using his walker and walking in a shuffling manner. The bruised area located on the back/wrist area of his left hand was visible as he ambulated with his walker. R43 made no response when questioned again whether he knew the how he had obtained the bruise on his left hand. When interviewed on 2/8/17, at 9:19 a.m. RN-A indicated R43 has a history of bruising easily and is often reluctant to allow staff to assess areas. RN-A indicated she was aware of the bruise on R43's left hand and indicated skin is monitored with the weekly bath. RN-A further indicated R43 frequently obtained various sized bruising (small/large) on his arms. RN-A explained that monitoring of skin issues is set up on a	F 309		

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F 309	Continued From page 11 computerized program; "to do" list. RN-A then commented R43 frequently has a note on the "to DO" list for bruising but when reviewed, confirmed there was no documentation evident in the electronic record related to the current bruise noted on the left hand. RN-A confirmed R43's bruise located on his left hand should have been documented and setup on the "to do" list for ongoing monitoring. When interviewed on 2/9/17, at 8:34 a.m. licensed practical nurse (LPN)-A indicated she was not aware of a bruise on R43's left wrist and then observed the bruised area. LPN-A confirmed this should have been reported and monitored. LPN-A indicated this bruise was not present when she had last worked on Sunday. LPN-A confirmed it was not listed on the staff "to do" list nor documented in the record. After the area was measured, the following measurements were documented: 2 centimeter (cm) x 1.2 cm; description-pale, purple/red bruised area located on the left wrist . The director of nursing (DON) was interviewed on 2/9/17, at 10:00 a.m. and indicated her expectation was staff report, documents and monitor bruising. The DON confirmed the "To Do " portion of the electronic record should have been set up for staff notification. Although a policy was requested related to non-pressure related skin issues, the only policy recieved was in reference to pressure areas, open areas or skin tears.	F 309		
F 329 SS=D	483.45(d) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		3/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	02/09/2017

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F 329	Continued From page 12 (d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility to evaluate the continued use the antidepressant medication for 1 of 5 residents (R9) reviewed for unnecessary medication. Findings include: R9's Diagnosis report obtained in the medical record included: major depressive disorder, single episode, unspecified and anxiety disorder. R9 was prescribed Prozac HCL 40 milligrams (mg) daily (antidepressant) for the past year. Observation on 2/6/17, at 3:03 p.m. R9 was observed participating in bingo. The resident was calm and focused.	F 329	F329 1. The next pharmacy consultant review is scheduled for March 8, 2017. R9□s Prozac will be addressed at that time. The Drug Regimen review will be sent to R9's physician with a recommendation to evaluate the Prozac dose. 2. Four other residents fit the same profile as R9 as ¿having discharged to the hospital and then re-admitted between Sept 1 and February 28th. Nine other residents fit the profile of being prescribed psychoactive medications. Their medication records will also be reviewed by the pharmacy consultant on March 8th. The drug regimen review reports with	

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F 329	Continued From page 13 Observation on 2/7/17 at 7:30 a.m. R9 was observed to be eating breakfast at the dining room table. The resident was calm and dozing off at intervals. Interview with the resident at this time, indicated he was sleepy but slept well during the night. Interview on 2/8/17, at 8:02 a.m. with nursing assistant (NA)-E, indicated R9 has been calm and cooperative and has not yelled out for several months. Observation and interview with R9 on 2/8/17 at 1:56 p.m. the resident was observed to be watching TV in his room. R9 denied feeling depressed and indicated he felt fine. The resident was observed to be calm mannered and smiling through out the interview. Review of the most current quarterly Minimum Data Set (MDS) dated 12/21/16, identified R9 as having no concerns with mood in the assessment period. The resident was identified as having behaviors of yelling out 4-6 days during the assessment period, but not daily. Review of R9's daily mood and behavior monitoring log, identified R9 as having no mood or behaviors over the past 4 months. Review of R9's physician notes over the past year, did not include an evaluation of R9's prescribed psychoactive medication related to the continued need and use of the Prozac. Review of the pharmacy recommendations over the past year for R9, did not include a review of the residents Prozac for continued need and	F 329	recommendations will be sent to the residents' attending physicians for review and action (e.g. continue orders as written, write new orders, dictate comments, etc.) 3. Re-education of the pharmacy consultant on how to read the Medication Administration Record (MAR) will take place on March 8, 2017. We will continue our process of having residents' medication records reviewed on a monthly basis, sending recommendations and reports to the physicians for their final decisions on continuing orders, changing orders, etc. 4. The DON will continue to be responsible for the overall monitoring of the Drug Regimen Review process and will work in consultation with the pharmacy consultant and medical director. We will continue to report the findings of the Drug Regimen Review at QA meetings. The next QA is scheduled for March 8, 2017. Completion Date: March 22, 2017	

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F 329	Continued From page 14 current dose/reduction. During interview with the MDS coordinator on 2/9/17, at 10:00 a.m. confirmed the use of R9's Prozac had not been evaluated by the physician for continud need and/or current dose/reduction.	F 329		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a clean ice machine and ensure that staff properly handle	F 371	F371 1. Plate covers were ordered to have	3/22/17

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F 371	Continued From page 15 plate cover lids during meal service and failed to maintain the cleanliness of storage carts. This had the potential to affect all 43 residents in the facility who were served food from the kitchen, and recieved ice water from the ice machine. Findings include: During observation of the evening meal on 2/6/17, at 5:45 p.m. dietary aide (DA)-A was noted to retrieve covered plates with lids from the kitchen serving window and deliver the plated food to residents seated in the dining room. With gloved hands, DA-A removed the resident tray cover lid, placed it onto the dining table, rearranged resident's personal clothing protector, assisted with setting up and/or cutting food items and proceeded to touch the plate cover lid by handling the sides/edges of the lid. The plate cover lid was returned to the kitchen window for reuse on another resident's plate. DA-A also was noted to use the perimeter of the plate cover lid to rearrange french fries and/or sandwich condiments on the resident's plate. After the used plate covers lids were delivered back to the kitchen window, dietary staff located in the kitchen would grip/handle the outside surface of the lid covers and place them over newly dished plates of food. Although DA-A was observed to change her gloves between residents, the plate lids were reused on resident trays after they had been handled by DA-A after resident contact. These individual plate cover lids were also stacked with the inside of the lid facing up and then placed on top of the steam table. The inner surface of one plate cover lid came in direct contact with the area handled by DA-A while serving/assisting residents with their meal. The plate cover lids were repeatedly handled and then	F 371	enough on hand so that we do not need to re-use a cover when serving meals. Hand-hygiene re-education with the dietary staff was provided by the Dietary Supervisor on 2/10/17. The dirty carts and lowerator were cleaned. The cleaning schedules for the cart and equipment was revised to reflect the need to clean all equipment that was used as close to the time of soiling as possible and to leave it ready for the next shift in ready-working order. We are working with our vendor that sells cleaning chemicals to help us identify what is needed to remove the calcification on the ice machine. 2. The Dietary Manager will continue to be responsible for managing the sanitation and cleaning practices in the Nutrition Services Department. She will conduct audits for one quarter and report findings at the next QA meeting in June 2017. She plans to utilize the Dietician consultant to assist with the audits, using the QIS survey form as their standard guide. Completion date: March 22, 2017	

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F 371	Continued From page 16	F 371		

reused to cover a subsequent plated meal. The food was covered with the lid in preparation for staff delivery to resident tables. This process occurred repeatedly during the entire process of the meal service.

The breakfast meal was observed on 2/7/17, at 8:15 a.m. and again DA-A delivered resident meal trays, removed the plate cover lids, placed them onto the table, assisted with plate set up of the food, rearranged resident clothing protectors as needed and handled the lid covers with the same gloves hands which touched food and/or the resident. The lids were returned to the kitchen serving window for reuse on another resident's plated food. No handwashing and/or hand sanitizer was observed between each tray delivery. This process occurred repeatedly during the breakfast meal as it had been implemented the prior evening during the supper meal on 2/6/17.

During breakfast meal observation on 2/8/17, at 7:40 a.m. DA-A again served breakfast trays with same routine which included the reuse of plate cover lids which had been handled after intermittent resident/food contact. DA-A did not utilize either hand sanitizer and/or handwashing throughout the process of assisting with food set up and/or the use of personal clothing protectors between resident assistance. At 7:48 a.m. DA-A placed the plate cover lid onto the table, applied condiments to the resident's food and arranged the resident clothing protector. After touching the resident, DA-A picked up the plate cover lid and delivered it to the kitchen serving window for reuse for another resident tray. After DA-A delivered the lid to the window, DA-A removed the soiled gloves. It was observed that after the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 17	F 371		

gloves were removed, the dietary aide located in the kitchen picked up the soiled gloves and plate cover lid. The aide then disposed of the soiled gloves into the trash container and stacked the reusable plate cover lids on the surface of the steam table.

On 2/8/17, at 7:56 a.m. DA-A served resident breakfast trays, returned the plate cover lids to the kitchen window counter and proceeded to walk from the dining room into the hall area. With the same gloved hands, DA-A returned to the dining room transporting a resident seated in a wheelchair (w/c) to the dining room table. Without a change in gloves and/or handwashing, DA-A rearranged the resident's clothing protector. It was noted on 2/6/17, 2/7/17, and 2/8/17 DA-A did not properly wash her hands and/or utilize hand sanitizer after removal of soiled gloves and prior to the application of clean gloves during tray distribution in the main dining room.

When interviewed on 2/8/17, at 8:04 a.m. DA-A confirmed the expectation was that staff frequently change gloves and implement hand washing and/or utilize hand sanitizer between assistance with residents. DA-A confirmed "most of the time" she would utilize hand sanitizer or wash her hands between glove changes, but this morning she had not used hand sanitizer nor washed her hands between residents.

During observation of the food preparation and service on 2/8/17, at 12:58 p.m. the following was noted:
(1) The cart which stored clean trays was located adjacent to the steam table. It contained dried food debris and white splattering on the inside of the cart and on the usable surface of the trays.

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F 371	Continued From page 18 When the day cook (DC) was questioned about the splattering, she explained it could have occurred as a result of another soiled cart being washed and splattering [food] onto the clean cart which stored the clean trays. The area where soiled carts were routinely cleaned was in close proximity to the clean cart. The DC indicated she was unaware of last scheduled cleaning of the tray cart ; and (2) Located on the opposite end of the steam table from the tray storage cart, was another cart which contained clean plates on a lowerater. A buildup of grime/residue was noted around the base of the three rubber plate holders and dried food particles were also noted on the surface of the metal unit on which the plates were stored. When a cleaning schedule was requested for this unit, there was none available for review. When interviewed on 2/8/17, at 12:28 p.m. the dietary manager (DM) indicated the soiled tray cart had been cleaned most recently a month ago and confirmed the cart was soiled with food and white splatter. The DM also indicated the plate and tray carts were on a monthly cleaning schedule but added, they may have to be cleaned more frequent. The DM confirmed the plate and tray lowerator was visibly soiled. The DM stated that DA-A was expected to only deliver food trays and plates to residents and that nursing staff were expected to set up resident food items after delivery and provide assistance as needed. The DM confirmed there should be time to wash hands/use hand sanitizer between serving trays and assisting residents, stating the expectation was for handwashing between changing gloves. The DM indicated the practice had been to reuse plate cover lids for an extended period of time and was not aware of how many lids were	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 19 available to use during meals. Review of the facility policy Hand Washing (not dated): Staff will wash hands as frequently as needed throughout the day following proper hand washing procedures. If chemical sanitizing gels are used, staff must first wash hands. When to wash hands: (1) during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and (2) Before donning gloves for working with food. During the initial tour of the facility on 2/6/17, at 11:34 a.m. an ice machine was noted in the kitchenette located on the Birch hall. There was a large bed sheet on the floor under the ice machine absorbing leaking water. The sheet appeared wet with brown colored stains. The outside of the ice machine was coated with a thick scale of white, debris/deposits on all four sides of the unit. The door to the ice machine also had a thick build-up of white, scaley debris on the inside of the door and on the seal around the door. The scaley material would flake off and fall from the seal when touched. When the inside of the machine was inspected, it was noted that ice chunks were piled up and stuck to the back of the machine, extending up the entire back of the unit. On the inside of the door instructions were posted related to disinfection and cleaning, but was difficult to read. The kitchenette with the ice machine was again observed on 2/6/17, at 7:22 p.m. a dietary aide confirmed this ice machine was used three times daily for ice water delivery to each resident room. There is a wet soiled sheet on the floor under the ice machine.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 20 On 2/8/17, at 9:24 a.m. a nursing assistant (NA) was observed standing in front of the ice machine filling insulated mugs with ice for resident room delivery. There was a sheet noted underneath the machine, damp and stained with water dripping from the ice machine. The outside of the machine had scale deposits on all outside surfaces, inside and outside of the door and around the seal of the door. On 2/9/17, at 8:54 a.m. the ice machine door was opened and nursing assistant (NA)-B filled insulated mugs with ice for delivery to resident rooms. When interviewed at this time, NA-B confirmed the build-up of white thick scale deposits/debris evident on the outside of the machine, the door and on the seal of the ice machine door. NA-B verified the ice build-up noted along the inside (back) wall of the unit had been present for quite a long time. NA-B acknowledged the stained wet sheet located on the floor underneath the machine, stating the unit has been in this condition "for a long time." NA-B confirmed that maintenance staff were responsible for cleaning, disinfecting and maintenance of the ice machine. It was noted that located on top of the ice machine was a large plastic container which stored two 2 large ice scoops. The plastic container appeared soiled around the edges and the bottom had loose dirt, dust, debris and scales floating in the water on the bottom of the container. The scoop handles which staff used to fill the thermal glasses with ice were touching the inside of the soiled appearing container. During a tour with maintenance staff (M)-A on 2/9/17, at 11:45 a.m. it was indicated the ice	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 21 machine was cleaned and disinfected on a rotating schedule, which is documented on a card located in the maintenance office. M-A stated, "I just cleaned it last month, that stuff does not come off." M-A also confirmed the sheet located underneath the machine was used to catch the water dripping from the machine. When the documentation was reviewed related to the disinfection of the ice machine, it revealed it had been cleaned on 5/11/16 and 11/15/16 (6 months apart). Documentation was lacking to indicate it had been cleaned since 11/15/16. A policy or manual was requested from M-A and the administrator related to the cleaning and disinfection of the ice machine but none was submitted for review.	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the	F 428		3/22/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 22 facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility consulting pharmacist failed to identify irregularities related to ongoing monitoring for effectiveness of psychoactive medications for 1 of 5 residents (R9) reviewed for unnecessary medication.	F 428	F428 1. The next pharmacy consultant review is scheduled for March 8, 2017. R9's Prozac will be addressed at that time. 2. Four other residents fit the same profile as R9 as having discharged to the	

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F 428	Continued From page 23 Findings include: R9's Diagnosis report obtained in the medical record included: Major depressive disorder, single episode, unspecified and anxiety disorder. R9 was prescribed Prozac HCL (an antidepressant) 40 milligrams (mg) daily for the past year. On 2/6/17, at 3:03 p.m. R9 was observed participating in BINGO, was calm and focused. On 2/7/17, at 7:30 a.m. R9 was observed to be eating breakfast at the dining room table. R9 was calm and dozing off at intervals. When interviewed at this time, R9 indicated he was sleepy but slept well during the night. Interview on 2/8/17, at 8:02 a.m. with nursing assistant (NA)-E, indicated R9 has been calm and cooperative and has not yelled out for several months. Observation and interview with R9 on 2/8/17 at 1:56 p.m. the resident was observed to be watching TV in his room. R9 denied feeling depressed and indicated he felt fine. The resident was observed to be calm mannered and smiling during the interview. Review of the most current quarterly Minimum Data Set (MDS) dated 12/21/16, identified R9 as having no concerns with mood in the assessment period. In addition, the resident was identified as having experienced behaviors of yelling out 4-6 days during the assessment period. Review of R9's daily mood and behavior monitoring log, identified R9 as having no mood	F 428	hospital and then re-admitted between Sept 1 and February 28th. Their medication records will also be reviewed by the pharmacy consultant on March 8th. 3. Re-education of the pharmacy consultant on how to read the Medication Administration Record (MAR) will take place on March 8, 2017. 4. The DON will continue to be responsible for the overall monitoring of the Drug Regimen Review and will work in consultation with the pharmacy consultant. We will continue to report the findings of the Drug Regimen Review at QA meetings. The next QA is scheduled for March 8, 2017. Completion Date: March 22, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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F 428	Continued From page 24 or behaviors over the past 4 months. Review of R9's physician notes over the past year, did not include an evaluation of R9's prescribed psychoactive medication related to the continued need and use of the Prozac. Review of the pharmacy recommendations over the past year for R9, did not include a review of the resident's Prozac for continued need and/or current dose/reduction. During interview with the MDS coordinator on 2/9/17, at 10:00 a.m. confirmed the use of R9's Prozac had not been evaluated by the physician for continud need and/or current dose/reduction. Interview with the facility's consulting pharmacist on 2/9/17, at 11:19 a.m. verified he had not recommended a review for the continued use of R9's Prozac because he thought it had been discontinued while the resident was in the hospital in September 2016, which it had not. The pharmacist confirmed if R9 had not been exhibiting behaviors/moods over the past 4 months and had no no physician justification for continued use, the Prozac should be evaluated for continued need and dose/reduction.	F 428		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 431		2/10/17

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F 431	Continued From page 25 (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 431		

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F 431	Continued From page 26 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a secure system was implemented which limited access to disposed Fentanyl patches stored in the medication room to identify loss and prevent diversion of controlled medication. Findings include: During interview on 2/7/17, at 11:19 a.m. registered nurse (RN)-A confirmed that once Fentanyl patches (opiod analgesic similar to morphine but more potent) were removed from a resident, the used Fentanyl patch was placed into a Sharps box (container used to safely dispose of sharps/needles) located in the medication room. According to facility policy, RN-A explained that two nurses are required to witness and document the disposal of the Fentanyl patch (controlled drug) at the time it is placed into the container. This Sharps container is kept locked in the medication cabinet with a padlock, in the locked medication room. The contents are kept stored in the container until the destruction by the pharmacist and the director of nursing (DON). The medication cabinet padlock is accessed by each licensed nurse. On 2/8/17, at 1:25 p.m. a tour of the medication room was conducted with licensed practical nurse (LPN)-B who confirmed the process related to the disposition of the Fentanyl patches identified by	F 431	F431 1. The containers of used Fentanyl patches that were identified during the survey process were handed off to the Watonwan County Sheriff's department for proper destruction on 2/9/17. 2. At this writing, there are no residents currently prescribed Fentanyl patches. 3. The procedure for destroying used Fentanyl patches was revised by the Director of Nursing. Used patches are now removed by the nurse in the presence of a witness and immediately flushed in the hopper. The destruction date/time is recorded on a medication destruction flow sheet. 4. The DON will continue to be responsible for the overall system for medication destruction and documentation system. She has re-educated the licensed nurses to the new procedure and will audit this process for one quarter to ensure that the proper procedure is being followed. She will report her findings at the next QA meeting in June 2017. Completion date: 2/10/17	

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F 431	Continued From page 27	F 431		

RN-A. During the tour of the medication room on 2/8/17, at 1:56 p.m. the medication room was locked and there was a secondary cabinet, padlocked, which stored the used Fentanyl patches until destroyed. LPN-B opened the padlocked cabinet and the following was noted: a large one gallon sharps container full of used Fentanyl patches and gloves and one medium sized Sharps container which was approximately 2/3's full of used patches/gloves. LPN-B revealed that each licensed nurse has access to this medication cabinet storage unit with the key attached to the medication cart key ring. It was noted that inside the cabinet was a narcotic log which documented the signatures of two (2) licensed nurses reconciling every Fentanyl patch. Although the Sharps container remained full of used patches, documentation on the narcotic log identified the most recent entry indicating a patch had been placed into the Sharps container was dated November 2016.

A policy and procedure related to Fentanyl patch disposal was requested on 2/8/16 at 2:30 p.m. from the DON. The DON revealed the used Fentanyl patches are routinely stored in the locked medication room cupboard (padlock) until destroyed by the pharmacist and the DON during the pharmacist's monthly visits. The DON confirmed that all of the licensed nurses have access to this cupboard containing the used Fentanyl patches during times when they are not reconciling the disposal of the patches.

When further interviewed on the following day on 2/9/17, at 9:37 a.m. the DON verified the Sharps container boxes had been removed from the two medication room cupboards and placed in a locked file cabinet and locked in the DON's office.

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F 431	Continued From page 28	F 431		

The DON verified it was difficult to determine the number of used Fentanyl patches in each container after review of the documentation log located in the medication room. The DON verified the used patches are not reconciled daily by nursing staff. A system had not been developed to identify the loss or diversion of controlled medication (Fentanyl) so as to minimize the time between actual loss or diversion and the determination of the extent of loss or diversion. The DON confirmed that a stricter Fentanyl disposal process could be implemented related to the disposal of Fentanyl patches.

During a phone interview on 2/9/17, at 11:10 a.m. the process for Fentanyl patch disposal was reviewed with the registered pharmacist (RPh) consultant and the RPh concurred a stricter disposal policy could be implemented related to Fentanyl patches.

Review of the policy titled, Fentanyl Patch disposal, dated March 2013, identified the purpose as: Safe secure disposal of Fentanyl patches. The procedure indicated: (1.) Licensed nurse to remove Fentanyl patch's from residents using gloves with a witness observing; (2.) Nurse to dispose of patch and gloves in biohazard non-retrievable sharps container. (3.) Licensed nurse then needs to sign on the Fentanyl patch disposal record sheet, and licensed nurse and the witness that observes the Fentanyl patch removal. Then fill out and sign the Fentanyl patch disposal record sheet. The sheet for signing are kept in the lock box in the medication room. (4.) The sharps container is placed in a locked cabinet in the medication room. (5.) Keep full sharps container locked in the cabinet in the medication room until biohazard company picks

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F 431	Continued From page 29 up the biohazard waste.	F 431		
F 465 SS=F	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident bathrooms were clean and maintained in good repair for 5 of 30 residents (R31, R11, R17, R34, R62) whose room environments were reviewed, and failed to maintain the cleanliness of the ovens/range located in the dietary kitchen. Findings include: The following observations were noted during a tour of the environment: On 2/6/17, at 1:16 p.m. R31's bathroom floor tile around the toilet stool was observed to be cracked and covered with thick grime and brown debris extending 1.5 inches out from the edge of the back of the toilet. In addition, the metal frame of a commode located in R31's room was noted to have a rough and rusty surface making it	F 465	F465 1. Bathrooms for R31, R11, R17, R34, and R62 were examined and cleaned by the Assistant Maintenance Director on 2/20/17. He consulted with our vendor who sells housekeeping chemicals to best select the product to address the stains, build-up and future cleaning schedule. It was discovered that the newer housekeepers were not aware of several of the different types of cleansers available. The back of the convection ovens were cleaned on 2/10/2017. 2. All bathrooms are being thoroughly cleaned by Maintenance and then handed off to Housekeeping for routine cleaning. 3. The Housekeeping Supervisor will meet with the chemicals representative for re-education on the product line and will	3/22/17

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F 465	Continued From page 30 difficult to clean/disinfect. On 2/6/17, at 4:38 p.m. R11's bathroom stool revealed a 6 inch piece of loose caulk stringing away from the base of the toilet stool; it appeared soiled with grime and thick brown debris which extended 1.5 inches from the back of the stool. The brown thick debris covered the tile around the entire base of the toilet stool. On 2/6/17, at 3:59 p.m. R17's bathroom floor tile surrounding the stool revealed thick brown debris extending out 1.5 inches in the back of the stool. The brown soil covered the surface of the tile and caulk around the base of the stool. On 2/6/17, at 7:48 p.m. R34's faucet on the bathroom sink was leaking, and the base of the faucet was stained green, and revealed a crusty build-up extending down to the drain. The base of the toilet was surrounded by tiles soiled with a thick brown crusty debris. Between the tiles on the bathroom floor the grout was stained and easily released dirt and debris. Behind the head board of R34's bed the wall had black marks and a 4 by 4 ft. area where paint was missing exposing the wall board beneath. On 2/7/17, at 9:37 a.m. R62 bathroom sink faucet was leaking, revealing a green stain and debris at the base, covering a 4 inch surface. Between the tiles on the bathroom floor the grout was stained and easily released grimy dirt and debris. The vent cover in the bathroom revealed thick gray dust. The toilet was stained brown inside the bowl, covering a 4 inch surface. During the tour on 2/9/17, at 11:45 a.m. the maintenance staff (M)-A verified that	F 465	be expected to re-train her staff on which products best address things like lime, grime, rust, etc. The Dietary Manager re-educated her staff on when and how to clean the convection oven. 4. The Housekeeping Supervisor will be responsible for the overall cleanliness of resident bathrooms and commons areas. The Dietary Manager will maintain responsibility for the overall cleanliness of the Kitchen and its equipment. The Administrator and Housekeeper will conduct audits for one quarter and report their findings at the QA meeting in June 2017.	

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F 465	Continued From page 31	F 465		

housekeeping staff clean each room daily including the bathroom. M-A stated the housekeeping and nursing staff were responsible to report repairs as needed. M-A presented a bulletin board utilized for communication related to environmental issues in need of repair. This board lacked any notes related to the noted findings. M-A verified the finding of the rusting commode and stated they would need to replace the commodes that were rusted.

A policy for building maintenance was requested on 2/9/17, at 11:00 a.m. A policy titled, Maintaining and Repairing equipment indicated the equipment that is owned by Luther Memorial Home (not on a maintenance contract with a vendor) will be maintained and repaired by the facility.

During observation of the food preparation and service on 2/8/17, at 12:58 p.m. the following was noted:

The double convection ovens and the range located in the center of the kitchen were positioned so that staff were able to move around the entire units. Located on the back surface of both ovens was a motor unit and ventilation system with fan. The motor housing extending out from the ovens, the vents and the fan were heavily soiled with dust. The range unit also had a large ventilation opening which was heavily laden with soil and dust. When questioned about the cleaning schedule for these units on 2/8/17, at 1:00 p.m. the day cook (DC) indicated she never inspected this part of the ovens/ range and had no idea whether these units were cleaned; stating, "this will have to be put on the list".

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE FORM CMS-2567 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. At the time of this survey, Luther Memorial Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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 By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 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 Luther Memorial Home was constructed as follows: The original building was constructed in 1958, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st addition was constructed in 1973, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 2nd addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The 3rd addition was constructed in 2001, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has a fire alarm system with smoke detection throughout the corridor system. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 61 beds and had a census of 42 at	K 000		

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K 000	Continued From page 2 time of survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to maintain complete documentation on the Annual Fire/Smoke Door Inspection per NFPA 80. The deficient practice could affect 42 out of 42 residents. Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation reviewed revealed that not all the required information is being documented during the Annual Fire and Smoke	K 300	K300 1. The fire door assemblies will be identified and inspected in accordance with NFPA 80 Chapter 5.2. The inspection will include overall condition of the doors and overall performance of the doors. 2. Seeing as this inspection is scheduled annually, it will be completed before 12/31/2017. It will be started no later than March 22, 2017. 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	3/22/17

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K 300	Continued From page 3 Door Inspection per the NFPA 80. This deficient practice was verified by the Facility Maintenance Director.	K 300		
K 324 SS=F	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking	K 324	K324 1. A request was made with the vendor that inspects the Kitchen Fire Suppression System to send a copy of the report,	3/22/17

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST** **MADELIA, MN 56062**

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K 324	Continued From page 4 Operations.This deficient practice could affect 42 of the 42 residents. Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation reviewed could not show that the Kitchen Fire Suppression System was inspected on a semi-annual schedule during the past 12 months. This deficient practice was verified by the Facility Maintenance Director.	K 324	demonstrating that the inspection was completed in 2016. An invoice showing that the work had been paid for was found. 2. Seeing as this inspection is scheduled annually, it will be either demonstrated as completed or actually completed before 12-months pass since the inspection in 2016. 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	
K 346 SS=E	NFPA 101 Fire Alarm System - Out of Service	K 346		2/13/17

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

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K 346	Continued From page 5 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Alarm Out of Service Policy. Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation review revealed that the Out of Service Policy for the Fire Alarm System does not have current Staff/Fire Marshal contact information. This deficient practice was verified by the Facility Maintenance Director.	K 346	K346 1. The policy titled "Out of Service Fire Sprinkler System Impairments" was revised to include the updated contact information for the current fire marshal. 2. Completion Date was February 13, 2017. 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	
K 354 SS=E	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the	K 354		3/22/17

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

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K 354	Continued From page 6 extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a current and accurate Fire Sprinkler Out of Service Policy. Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Findings include: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation review revealed that the Out of Service Policy for the Fire	K 354	K354 1. The policy titled "Out of Service Fire Sprinkler System Impairments" was revised to include the updated contact information for the current fire marshal and the out of service time will be updated to 10-hours. 2. Completion Date will be March 22, 2017. 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

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K 354	Continued From page 7 Sprinkler System does not have current Staff/ Fire Marshal contact information and the 10 hour out of service time needs to be updated. This deficient practice was verified by the Facility Maintenance Director.	K 354		
K 521 SS=F	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to ensure that the fire/smoke dampers were maintained according to 9.2 and in accordance with the manufacturer's specifications. The deficient practice could affect 42 out of 42 residents. HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation could not be provided that indicated the fire/smoke damper	K 521	K521 1. A request was made to our local vendor to send a copy of the most recent smoke/damper test. We will schedule a test, if needed, in order to resume compliance with the requirement to have this test every four years. 2. Completion date March 22, 2017 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	3/22/17

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K 521	Continued From page 8 test had occurred within the past 4 years. This deficient practice was verified by the Facility Maintenance Director.	K 521		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to conduct Fire Drills in accordnance with 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. This deficient practice could affect 42 of 42 residents. Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 712	K712 1. The schedule for fire drills resumed on January 16, 2017. Drills will be conducted in accordance with the regulation. The most recent drill on record occurred on February 23, 2017. 2. Completion date was February 23, 2017. (There cannot really be a correction for missing a drill in quarter 4 of the previous year.) 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for	2/23/17

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2017**

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K 712	Continued From page 9 Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7. Findings include: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation review revealed that a evening shift fire drill was not conducted during the 4th quarter (Oct-Dec), 2016. This deficient practice was verified by the Facility Maintenance Director.	K 712	preventing recurrence of this deficiency.	
K 781 SS=F	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide a written and current Space Heater Policy.This deficient practice could affect 42 of 42 residents. Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8	K 781	K781 1. A policy prohibiting the use of portable space heaters by residents, family, and employees was created. Residents, Families, and Employees will be educated on its provisions. The Resident Handbook and Employee Handbook were updated to reflect this new change. 2. Completion Date was March 22, 2017. 3. Dawn Campbell, Nursing Home	3/22/17

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K 781	Continued From page 10 FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation reviewed revealed that the Facility does not have a written Space Heater Policy that is specific to Luther Memorial Home. This deficient practice was verified by the Facility Maintenance Director.	K 781	Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	
K 918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of	K 918		2/13/17

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K 918	Continued From page 11 maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of Generator maintenance and testing are maintained and readily available. This deficient practice could affect 42 of 42 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to	K 918	K918 1. The Monthly Emergency Generator Load Test log was updated to include a place to record the cool down time after the 30-minute load test. Annual inspection of the main and feeder circuit breakers will also be added to a schedule. 2. Completion Date was February 13, 2017. 3. Dawn Campbell, Nursing Home Administrator, and the Director of Maintenance will be responsible for preventing recurrence of this deficiency.	

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K 918	Continued From page 12 manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 10:00 AM and 2:00 PM on 02/10/2017, documentation reviewed revealed that not all the required information is being documented during the Month Emergency Generator Load Test.The transfer time of how long it takes the emergency generator to assume power and the cool down time after the 30 minute monthly load test is not being recorded. Also, documentation review revealed that the Main and feeder circuit breakers are not being inspected annually. This deficient practice was verified by the Facility Maintenance Director.	K 918		