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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: F92R

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 11/25/2013 (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 **71** (L18)

13.Total Certified Beds **71** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	71			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 12/02/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:
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
Posted 12/31/2013 CO.
F92R

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/26/2013
(L33)

DETERMINATION APPROVAL

CNN: 24-5522

On September 30, 2013, a health PCR was completed by review of the facility's plan of correction and verified correction of health deficiencies. However, lack of verification of the LSC deficiencies by the 70th day, resulted in this Department recommending to the CMS RO, the following remedy for imposition:

Mandatory DOPNA, effective November 22, 2013

The facility was subject to the loss of NATCEP for a two year period beginning November 22, 2013.

On November 25, 2013, a LSC PCR was completed and all LSC deficiencies were found corrected. As a result of the LSC PCR, this Department recommended the following to the CMS RO:

Mandatory DOPNA, effective November 22, 2013 be rescinded.

Since DOPNA did not go into effect, the facility was no longer subject to a loss of NATCEP.

Please refer to the CMS 2567B. Effective September 30, 2013, the facility is certified for 71 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5199

November 21, 2013

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

RE: Project Number S5522023 and H5522014

Dear Ms. Campbell:

On September 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 22, 2013 that included an investigation of complaint number H5522014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 30, 2013, the Minnesota Department of Health completed a revisit by review of the plan of correction. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2013. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey, completed on August 22, 2013.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the August 22, 2013 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective November 22, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective November 22, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 22, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Luther Memorial Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 22, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the September 30, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 February 22, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

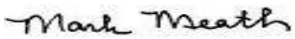
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5522r1_70dayNotice.rtf

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

December 9, 2013

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

RE: Project Number F5522021

Dear Ms. Campbell:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 22, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years fromNovemberf 22, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on August 22, 2013, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our November 21, 2013 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 November 25, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 22, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 30, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 22, 2013, as of September 30, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of November 21, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective November 22, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective November 22, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective November 22, 2013, is to be rescinded.

In our letter of November 21, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 22, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 30, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5522r2_70DayAllCorr.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245522	A. Building B. Wing	9/30/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/30/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/30/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/30/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/30/2013**
ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **09/30/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/KS	11/21/2013	28651	09/30/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	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
8/22/2013			

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245522	A. Building B. Wing 01 - MAIN BUILDING 01	11/25/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 09/06/2013	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/16/2013	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	12/02/2013	22373	11/25/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/23/2013		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: F92R

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 **08/22/2013** (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 **71** (L18)

13.Total Certified Beds **71** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	71			
(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):
At the time of the Standard survey completed on August 22, 2013, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NEII 10/01/2013
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 11/26/2013
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
11/26/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2791

September 9, 2013

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

RE: Project Number S5522023, Complaint Number H5522014

Dear Ms. Campbell:

On August 22, 2013, 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. In addition, at the time of the August 22, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5522014, which was found to be unsubstantiated.

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;

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
Division of Compliance Monitoring
Licensing and Certification Section
1400 E. Lyon St.
Marshall, MN 56258
Telephone: (507) 537-7158 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 October 19, 2013, 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 October 19, 2013, the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 22, 2013 (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 February 22, 2013, (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure
cc: Licensing and Certification File

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

PRINTED: 09/06/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	08/22/2013

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. A standard recertification survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint H5522014 was not substantiated during this survey.	F 000	RECEIVED SEP 20 2013 Minnesota Department of Health Marshall	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the modified call system was accessible for 1 of 30 residents (R12) reviewed in the admission sample. Findings include:	F 246	approved 9/23/13 F246 The survey team determined that the modified call system for R12 was not accessible twice. 1) R12 has severe cognitive impairment and rarely utilizes a call system as a means to summon assistance. The care plan was revised to include instructions to "Anticipate needs" in addition to providing the modified system of placing the call bell within reach.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Allison Campbell | TITLE: LNHA | (X6) DATE: 9/20/2013

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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F 246	Continued From page 1 R12's diagnoses included Alzheimer's disease, congestive heart failure (CHF), and hypertension. R12 also had a left leg prosthesis. The annual,quarterly/sig change? Minimum Data Set (MDS) dated 5/15/1203 indicated R12 had poor memory recall ability, impaired decision-making skills, and was a high risk for falls. The care plan dated 6/24/13 indicated R12 needed extensive assistance for transferring and mobility, and did not walk. The care plan directed staff to use a hand-held call bell for R12. A call light with a cord was not used for R12 as a safety measure. The nursing assistant "nursing care instructions" sheet also directed staff to use "no call light, use call bell, related to safety." On 8/21/2013 at 9:52 a.m., R12 was in her room, sleeping in bed, and was lying atop a perimeter mattress (a mattress with lipped edges) and there was a mat on the floor next to the bed. R12's bed was not equipped with any side rails. R12 was lying on her back, and covered with a light blanket. Next to the bed was a night stand, and a call bell was on top of the night stand. The call bell was 1 ½ inches in diameter, and had a 6" handle. The night stand, where the bell was placed, stood one and one-half feet from the bed. The call bell was out of the reach of R12. During an interview on 8/21/13 at 9:55 a.m., nursing assistant (NA)-E verified that R12's call bell was on top of the night stand, and stated that when in bed, the bell was to be placed "next to R12 in the bed." NA-E immediately took R12's call bell from the night stand and placed it in the bed, next to R12's hands. On 8/21/13 at 2:10 p.m., R12 was again observed sleeping in bed. R12's head was facing the wall,	F 246	2) The RN-Managers and Director of Nursing (DON) reviewed the resident roster and identified other residents whose profile resembles R12. Those care plans were also revised to include "anticipate needs" in addition to ensuring that a call light (system) is available to them at all times. 3) LMH cannot guarantee that human error will not occur (e.g. the resident causes the call light to be inaccessible), but in the spirit of cooperation to address this regulation, audits will be conducted routinely of each resident hallway to measure the frequency of discovering that call lights are accurately placed within reach for each resident. Also, re-education was provided to all staff on 9/18/13 at the Mandatory All Staff Meeting. 4) The DON and RN Managers will review the completed call light audit sheets and implement new strategies as needed to ensure compliance. They will report their findings at the Quality Assurance meeting for at least two quarters. Correction Date: September 30, 2013	

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F 246	Continued From page 2 with the right leg was flexed, and R12 was covered with a blanket. R12's call bell was again observed atop the night stand, which stood one and one-half feet from R12's bed. The call bell was out of R12's reach. An interview on 8/21/2013 at 2:15 p.m. with NA-D confirmed that R12's call light was on top the night stand. NA-C stated that "whoever checked R12 on rounds forgot to give her the bell." NA-C then removed the call bell from the night stand, and placed the call bell next to R12 in bed. During an interview on 8/21/2013 at 2:34 p.m., NA-G stated that when leaving a resident in his/her room, after toileting or repositioning, and the resident was going to be alone, the nursing assistant would make sure the call light was given to the resident. NA-G stated that since no call light was used, for R12, but rather the call bell, the bell was placed next to R12 on the bed within R12's reach. On 8/21/2013 at 2:40 p.m., licensed practical nurse (LPN)-A stated in an interview, that when any resident was left alone in their room, it was usual procedure to make sure the call light "was in reach of a resident." LPN-A also stated that although R12 does not use a call light, the call bell needs to be within reach, whether when in bed or when R12 is out in the wheel chair. On 8/22/2013 at 11:33 a.m., during an interview, the director of nursing (DON), said the expectation was that when in their rooms, residents always have call lights within reach. The DON stated that although R12 had impaired cognition, it was still the facility practice to have the call bell within reach at all times.	F 246		

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F 246	Continued From page 3 A facility policy, "Answering the Call Light," undated, directed that "when the resident is in bed or confined to a chair, be sure the call light is within easy reach of the resident."	F 246	F279 1) The care plan for R13 was updated on 8/22/13 to state "Fragile skin, at risk for bruising". The care plan was updated on 8/28/13 to include approaches that address minimizing risk for injury (i.e. "must wear long sleeves or geri-sleeves at all times to protect skin from bruising and skin tears"). 2) A review of all residents' care plans related to Skin and bruising risk will be reviewed and updated to ensure that identification of risk has been documented as well as effective approaches to minimize risk for injury. 3) LMH cannot prevent accidents due to human error from happening (e.g. resident takes action that results in injury). But, in the spirit of cooperation to address this regulation, staff will continue to be responsible for monitoring residents' skin daily and reporting their observations, including injuries, to the Nurse per care plan. The care team will continue to explore interventions to minimize residents' risk for	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive care plan related to bruising for 1 of 3 residents (R13) reviewed for non-pressure related skin conditions.	F 279		

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F 279	Continued From page 4 Findings include: R13's plan of care dated 4/3/13 did not identify a risk for bruising, nor indicate the need for monitoring for bruising due to fragile skin and other risks. R13 was admitted to the facility with diagnosis including anemia, cardiovascular disease and peripheral vascular disease. On 08/19/2013 05:11 p.m. R13 was observed to have dark purple bruising to the top of both hands between her thumb and forefinger. At this time resident had on a long sleeve sweatshirt. On 8/22/13 at 8:37 a.m. R13 was observed in her bed asleep. It was noted that her lower right arm had bruising as well as a gauze bandage wrapped around the forearm. F13's left arm had dark purple bruising to the elbow with two big Band-Aids located below the elbow. A bruise was also noted on the resident's left thumb tip. The care plan dated 4/3/13 did not identify R13 at risk for bruising. The care plan identified R13 as being at low risk for skin breakdown and included interventions such as: monitor skin daily with care and report changes to charge nurse. During an interview on 8/22/13 at 10:01 a.m., with registered nurse (RN) A, she stated that R13 bruises easily and has very fragile skin. She verified that interventions related to R13's risk of	F 279	injury. Re-education was provided to licensed nurses and NARs on 9/18/2013. 4) The Director of Nursing (DON) and RN Managers will review incident reports and they will be responsible for ensuring that interventions are implemented with "reducing risk of injury" as goal. Completion Date: 9/30/13	

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F 279	Continued From page 5 bruising had not been identified on the care plan. During interview with the director of nursing on 8/22/13 at 10:49 a.m., it was also verified that this should have been on the care plan for R13.	F 279	F280 The survey team determined that the care plan had not been updated for R31 to reflect the use of a 1/2 side rail and trapeze for bed mobility.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care to indicate current side rail and trapeze usage for assistance with bed mobility for 1 of 2 residents (R31) reviewed for restraint use. Findings include:	F 280	1) R31's care plan was revised on 8/22/13 under the category of "bed mobility" to include "left half side rail used to aid with bed mobility and he uses the trapeze to aid with bed mobility". 2) The RN-Managers will continue to rely on the nurses and NARs charted information as well as personal observation to gather the necessary information needed to revise residents' care plans on at least a quarterly basis. 3) LMH cannot guarantee that human error will not occur, but in the spirit of cooperation to address this regulation, LMH will continue to employ the services of the Health Information Consultant who does record review on a monthly basis. LMH will continue to implement her recommendations as its able. 4) The DON and RN Managers will continue to report the consultant's	

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F 280	Continued From page 6 R31's plan of care was reviewed. The care plan had not been revised to identify any need for the use of an outer half side rail or trapeze for assistance with bed mobility. The care plan indicated R31 was independent with bed mobility and transferred with the extensive assist of one person. During an observation on 8/22/13 at 7:05 a.m., R31 was observed to be transferring from the bed, using the side rail and extensive assistance of one staff to assist himself into the wheelchair. Record review indicated R31 had been admitted to this facility with diagnoses including spinal stenosis and peripheral vascular disease. The record included a BIMS (brief interview for mental status) worksheet dated 8/19/13, with a score dated of 15/15, which indicated that R31 had no problems with long or short term memory. A Side Rail Assessment dated 12/21/12, had been completed by a physical therapy assistant (PTA). The Side Rail Assessment identified the following: "recommend left (L) half rail, trapeze and raised bed to assist (A) with bed mobility and functional mobility." During interview with registered nurse (RN)-A on 8/22/13 at 9:13 a.m., RN-A verified that the care plan should have been revised to address the use of the outer half side rail and trapeze to assist R31 with transfers and bed mobility.	F 280	findings at each Quality Assurance meeting. Correction Date: September 30, 2013	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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F 309	Continued From page 7 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide necessary care and services related to monitoring/preventing bruising for 1 of 3 residents (R13) reviewed for non pressure related skin conditions. Findings include: The facility failed to monitor R13's skin for bruising, related to her behavioral incidents and/or the presence of fragile skin. R13 was admitted to the facility with diagnosis including anemia, cardiovascular disease and peripheral vascular disease. On 08/19/2013 05:11 p.m., R13 was observed to have dark purple bruising to the top of both hands between her thumb and forefinger. At this time R13 was seated in the wheelchair, wheeling down the hallway by pulling on the handrails to propel forward. R13 had on a long sleeve sweatshirt. On 8/22/13 at 8:37 a.m. R13 was observed in bed with her eyes closed. It was noted that her lower right arm had bruising as well as a gauze	F 309	F309 1) The care plan for R13 was updated on 8/22/13 to state "Fragile skin, at risk for bruising". The care plan was updated on 8/28/13 to include approaches that address minimizing risk for injury (i.e. "must wear long sleeves or geri-sleeves at all times to protect skin from bruising and skin tears"). 2) A review of all residents' care plans related to Skin and bruising risk will be reviewed and updated to ensure that identification of risk has been documented as well as effective approaches to minimize risk for injury. 3) LMH cannot guarantee that human error will not occur, but in the spirit of cooperation, it will continue to expect nurses to document information about discovered skin conditions, including bruises, in the e-chart (ECS), including setting up the "To Do List" function which assists in capturing ongoing documentation about the skin, including progress (or lack of progress) towards healing. Re-	

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	245522	A. BUILDING _____ B. WING _____	08/22/2013

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 309	Continued From page 8 bandage wrapped around forearm. R13's left arm had dark purple bruising to the elbow with two big Band-Aids located below the elbow. A bruise was also noted on the resident's left thumb tip. The surveyor stated "it looks like you have some bruises." R13 smiled and said yes. When asked what happened, R13 said "I bumped them." During review of the facility incident reports for the last 6 months the following was noted: (1) on 3/24/13 a scrape to R13's right lower leg and a skin tear to residents right lower arm; Other factors related to the incident were identified as "behaviors". The interdisciplinary team review identified that nursing will monitor skin tear/abrasion for healing and will remind staff if resident is combative with cares to leave alone and re-approach; (2) on 5/28/13 a bruise was noted to left elbow with a related behavioral incident during the evening shift on 5/27/13; (3) on 7/10/13 a skin tear was noted to left upper outer arm with related behavior identified as, "Resident was seen scratching self/arm, has fragile skin"; and (4) on 7/19/13 a skin tear was noted on the right lateral forearm and related behavior during this time indicated, "Attempting to hit out with transfers and calling staff names; not following directions, transferring with one assist and EZ stand, wears long sleeves and bruises easily." During review of the care plan dated 4/3/13, it was noted that any mention related to R13's bruising risk and/or fragile skin was lacking. No	F 309	education was provided to the licensed nurses on 9/18/2013. 4) The RN Managers will continue to be responsible for reviewing the charting provided by the floor nurses. The DON will continue to be responsible for providing corrective action to reinforce the importance of monitoring skin conditions, including bruises. Completion Date: 9/30/13	

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F 309	Continued From page 9 interventions were identified related to monitoring the skin condition of R13. After the surveyor questioned the bruises noted, registered nurse (RN)-B documented an incident report as follows; "Bruise to left upper arm, 10 cm x 8.0 cm; light purple/pink; Area #2 lateral to upper aspect of noted bruise; (sic) is a purple bruise irregular shape 3.6 cm x 3.8 cm, has pin coloring around edges. Two Band-Aid removed from left elbow. Intact steri strips found, scant light tan drainage." Also noted was, "An abrasion (sic) like line (7 cm) noted on right forearm, tiny scattered bruising along this line. Two very small areas open with scant drainage adhering to gauze. (0.6 cm x 0.4 cm and 0.8 cm x 0.4 cm)" Nurses note from 8/21/13 at 9:30 p.m. noted "Res [resident] very combative and verbally abusive, scratching NAR's [nursing assistant registered] arm, kicking, hitting, swearing all during HS (hour of sleep) cares." During an interview with NA- J on 8/22/13 at 8:37 a.m., it was indicated that R13 was very combative this morning and when this behavior is exhibited, staff leave her alone and return later for cares. NA-J further stated that R13 was, "Kicking and hitting staff this morning." She also stated, "The bruising and skin tears come from her abusive behavior!", hitting and kicking etc. and she wheels herself down the halls and sometimes we find her pushed up against the handrails; and R13 flails her arms and hits out. During an interview with RN-B on 8/22/13 at 9:39	F 309		

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F 309	Continued From page 10 a.m., she stated that R13 is, "A little resistive, she bumps into the handrails a lot when she is wheeling. She bruises easily. We measure and monitor any new bruises if they are new on her there is slight swelling and they are purple and red around. The bruises seem to spread. When we find a bruise we measure them and chart and put on the to do list to monitor until resolved." "She has very fragile skin. We use long sleeve sweatshirts during the day when she is up and about and they have helped a lot." RN-B verified that there was no monitoring of the bruising in the medical record. During an interview with licensed practical nurse B (LPN-B) on 8/22/13 at 9:56 a.m., she stated that R13 bumps into things and is combative at times. She also indicated that R13 bruises easily. During an interview with RN-A on 8/22/13 at 10:01 a.m., she stated that R13 has fragile skin and is combative. She stated that R13 was 'at risk' for bruising and was unaware if anything had been tried to prevent R13 from bumping into the handrails or if anything other than sweatshirts had been attempted to prevent further bruising. Interview with the director of nursing on 8/22/13 at 10:49 a.m. verified that R13 has very fragile skin and bruises quite easily. She indicated that bruises were to be charted daily until resolved and ongoing weekly skin checks should be completed.	F 309		
F 356	483.30(e) POSTED NURSE STAFFING	F 356		

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F 356 SS=C	Continued From page 11 INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to appropriatly post the required nurse staffing information. This had the potential to affect all 54 resident currently residing in the	F 356	F356 The survey team noted that the posted staffing hours as required by regulation did not include the total number of hours each discipline worked. 1) The "Report of Nursing Staff Directly Responsible for Resident Care" was modified to include the total number of hours each discipline worked. 2) The problem identified in this deficiency is not applicable to any other situation. 3) LMH cannot guarantee that human error will not occur, but in the spirit of cooperation to address this regulation, LMH will continue to post the report on a daily basis, keeping it updated to the best of its ability in the ever-changing staffing environment of a nursing facility. 4) The DON will continue to be responsible for ensuring that this report is posted properly. Correction Date: September 30, 2013	

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F 356	Continued From page 12 facility and any interested public visitors. Findings include: A review of the facility's Report of Nursing Staff Directly Responsible for Resident Care postings from 8/19/13 to 8/22/13, revealed the following: the facility listed the number of full time equivalents working on each shift, for each category of staff, including registered nures, licensed practical nurses and certified nursing assitants. The posting also included specific hours each category of nursing staff worked, but did not include the total number of hours each discipline worked. Interview with the director of nurses at 12:00 p.m. on 8/22/13, it was verified the posting did not have the required elements.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure foods were handled in a sanitary manner during the lunch	F 371		

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F 371	Continued From page 13 meal observation in 1 of 1 dining room, for 2 of 27 residents (R24 and R60) in the facility who required assistance to cut up food, and/or to add condiments to food, while in the dining room. Findings include: On 8/21/13 at 12:15 p.m., nursing assistant (NA)-A was observed to be wearing gloves in the dining room while waiting for the plates to be served at the tables. NA-A was observed to place her hands on her hips and to pull up on her pants with her gloved hands. When resident meal plates were served, NA-A was observed to handle R24's wheelchair to move the resident closer to the table. Without changing her gloves, or using hand sanitizer, NA-A assisted R24 to put ketchup and mustard on the hamburger the resident was served. NA-A handled the top of the bun during this assistance. NA-A then assisted R60 by placing her gloved hand on to the top of R60's hamburger, to cut the hamburger in half. She continued to assist the rest of the residents at the table. The lack of hand hygiene was observed throughout the meal during observations from 11:45-12:46 p.m. During interview with the dietary manager (DM) on 8/21/13 at 12:45 p.m., the DM revealed that she would expect NA-A who was the condiment aide, to change her gloves after touching environmental surfaces such as the wheelchair, or her uniform, before touching a resident's food items.	F 371	F371 1) Re-education on hand hygiene was presented to NA-A and all staff on 9/18/13. 2) Education on hand hygiene will continue to be offered at the time of orientation, annual education, and as needed for all employees. 3) LMH cannot guarantee that human error will not occur, but in the spirit of cooperation, it will continue to enforce the Handwashing Policy (i.e. Standard Precautions) with all staff. In addition, the Dietary Manager will conduct audits of hand hygiene during dining service and report findings at no less than two Quality Assurance meetings. 4) The DON and Dietary Manager will continue to be responsible for ensuring that sanitary conditions exist during meal preparation and service by all staff involved. Completion Date: 9/30/13	

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F 371	Continued From page 14 The facility's Hand washing Policy and Procedure undated, was reviewed. The policy indicated staff were to, "Observe Standard Precautions throughout the facility" and indicated the, "Use of gloves does not replace handwashing."	F 371		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an appropriate emergency water plan to ensure the residents would have enough potable and non-potable water in the event of a loss of normal water supply. This deficient practice had the potential to affect all 54 residents who currently reside in the facility. The findings include: During an interview on 8/22/13 at 8:47 a.m., the maintenance supervisor (MS) verified the facility had a contract with specified bottled water company to provide bottled water to the facility in case of an emergency. The MS was unsure as to what the policy specifically required and what the contract spelled out.	F 466	F466 1) The Emergency Water Agreement was revised to include the formula for estimating the volume of potable water needed for each resident and employees. 2) The revised agreements were mailed to the water supply companies for their signature of approval. 3) The water agreements will continue to be the responsibility of the Administrator and Director of Environmental Services to review and update every three years. Completion Date: 9/30/13	

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F 466	Continued From page 16 The facility's Emergency Water Agreement dated 2/15/12, was reviewed. The policy indicated the supplier of water, when water would be supplied, and in what quantities and types of containers water was supplied. The agreement did not provide a method for distributing water, nor a method for estimating the volume of water required. In an interview on 8/22/13 at 1:07 p.m., the administrator acknowledged that the current agreement with the water supplier listed the facility's normal consumption of water, and stated that figure was based on the current water usage from their city utility, which was their normal supplier. The administrator acknowledged the agreement did not specifically calculate water use needs for each resident.	F 466		

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2013**

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K 000	INITIAL COMMENTS	K 000		

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, on August 23, 2013. At the time of this survey, Luther Memorial Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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

POC ok
FS 11-21-13

RECEIVED
SEP 20 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Campbell	LNHA	9/20/2013

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

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K 000	Continued From page 1	K 000		

By eMail to:
Barbara.Lundberg@state.mn.us, and
Marian.Whitney@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Luther 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 71 beds and had a census of 55 at time of survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based upon a review of available records, it was determined the facility had failed to conduct one or more quarterly fire drills during the previous year, in accordance with NFPA 101 (2000) Chapter 19, Section 19.7.1.2. In a fire emergency, this deficient practice could adversely affect 71 of 71 residents, staff and visitors throughout the facility. FINDINGS INCLUDE: On 08/23/2013 at 9:45 AM, while reviewing the facility's fire drill reports, no documentation could be provided verifying that fire drills were conducted on the Night-Shift during 4th Quarter of 2012 nor the AM-Shift during 2nd Quarter of 2013. This finding was confirmed with the facility administrator.	K 050	K050 1) It was discovered post-survey that the two fire drills noted in this summary (i.e. NOC 4th Quarter 2012 and Days 2nd Quarter 2013) were, in fact, completed and documented. The Environmental Services Director had not placed a copy of those drills in the book that was reviewed by the Fire Marshal on 8/23/13. The Environmental Services Director has remedied this clerical error. 2) The Environmental Services Director will continue to be responsible for maintaining the documentation of fire drills. Completion Date: 09/06/2013	

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the fire sprinkler system in accordance with the provisions at NFPA 101 (2000) Chapter 19 and NFPA 13 (1999). In a fire emergency, this deficient practice could adversely affect all personnel in the Dietary Department. FINDINGS INCLUDE: On 08/23/2013 at 1:50 PM, while surveying in the Dry Storage Cooler room within the main kitchen area, observation revealed a cardboard box was stored closer that 18-inches from a fire sprinkler. This arrangement was not in conformance with NFPA 13 (99), Chapter 5, Sections 5-5.5.2.1 and 5-5.6. Continuous or noncontinuous obstructions less than or equal to 18-inches below a sprinkler deflector can prevent the spray pattern from fully developing. This finding was verified with the facility administrator.	K 062	K062 1) The cardboard box was moved and the sprinkler head is now clear of objects more than 18" from itself. 2) The Environmental Services Director will work with the Dietary Services Director to ensure that this Dry Storage Cooler is kept in compliance. Completion Date: 09/16/2013	