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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H1EZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245259**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER HAVEN**
(L4) **1109 EAST HIGHWAY 7**
(L5) **MONTEVIDEO, MN** (L6) **56265**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/26/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Tammy Williams, HFE NEII 10/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/26/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245259

November 8, 2016

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

Dear Mr. Flaherty:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 20, 2016 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 7, 2016

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

RE: Project Number S52590213

Dear Mr. Flaherty:

On August 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 11, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 19, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on August 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 20, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 11, 2016, effective September 20, 2016 and therefore remedies outlined in our letter to you dated August 25, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245259 Y1	A. Building B. Wing Y2	9/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0323	Correction	ID Prefix F0329	Correction	ID Prefix F0431	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.60(b), (d), (e)	Completed
LSC	09/20/2016	LSC	09/20/2016	LSC	09/20/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	09/20/2016	LSC	09/20/2016	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	
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
☒	GA/mm	10/07/2016	32603	09/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/11/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245259 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	9/19/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 09/15/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 09/01/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/15/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	10/07/2016	32603	09/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
8/10/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H1EZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245259**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677040100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER HAVEN**
(L4) **1109 EAST HIGHWAY 7**
(L5) **MONTEVIDEO, MN** (L6) **56265**

4. TYPE OF ACTION: **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 **08/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (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
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 09/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1975
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 25, 2016

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

RE: Project Number S5259023

Dear Mr. Flaherty:

On August 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 20, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 November 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 11, 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

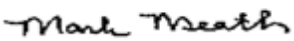
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow manufacturer's guidelines for the proper use of a wheeled walker to prevent accident hazards for 1 of 1 resident (R70) who utilized a walker for ambulation. Findings include: R70's quarterly Minimum Data Set (MDS) dated 6/21/16, identified R70 was cognitively intact and	F 323	Luther Haven failed to assure that all residents are free of accident hazards and receive supervision and assistive devices to prevent accidents. One CNA was observed pushing a resident down the hall sitting on her walker bench which is against manufacturer guidelines and could result in injury. The CNA was immediately educated that this was against current facility policy and that she	9/20/16

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

Electronically Signed | 09/02/2016

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	245259	A. BUILDING _____ B. WING _____	08/11/2016

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F 323	Continued From page 1 had diagnoses which included: dementia, osteoporosis and heart failure. The MDS identified R70 was independent with activities of daily living (ADL's.) The MDS identified R70 ambulated independently and required a walker for mobility. R70's care plan dated 2/18/13, identified R70 had diagnosis of dementia, unable to make daily decisions, was independent with ambulation and required the use of a front wheeled walker (FWW) for mobility. The care plan indicated R70 was independent with transfers and did not use a wheelchair. The care plan identified R70 was at risk for falls related to cognitive deficit and making safe choices, directed staff to assist R70 in making decision regarding safety such as utilizing Rollator walker at all times. On 8/11/16, at 7:17 a.m. R70 was seated on the bench of her wheeled walker in the hallway near the nurses station, while nursing assistant (NA)-D pushed the R70's walker down the hall. NA-D pushed R70, seated on the bench of the walker, around the corner by the nurses station and down the entire length of the hallway. NA-D continued to transport R70, seated on the bench of the walker, down the hallway and stopped at doorway of room #130. R70 stood up, walked into the room and pulled the walker into the room independently without difficulty. During interview on 8/11/16 at 7:20 a.m., NA-D confirmed she had transported R70 utilizing the bench on her wheeled walker. She stated R70 normally walked independently, but reported to her she was tired and had leg pain so she sat on the walker. NA-D confirmed in the past staff had used the wheeled walker for transport of R70	F 323	should allow resident to sit on bench while she leaves to get a wheelchair. All residents with a rollator walker were reviewed for appropriate use and function with rollator walker. All Nursing Department employees were reminded of this policy in report during survey. An all staff in-service is scheduled for 09/15/16 to review Plan of Correction and importance of following policy and manufacturer guidelines. Facility staff will all be aware of the policy and importance of following manufacturer guidelines and will be observing for resident safety and an environment free of hazards. DON or designee will complete visual audits weekly X 4 then biweekly x 4 then monthly thereafter for appropriate use of rollator walkers. QAA made aware of the failure to assure that all residents are free of accident hazards and receive supervision and assistive devices to prevent accidents. QAA will be informed of any resident safety or environmental hazard occurring and results of rollator walker audits.	

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F 323	Continued From page 2	F 323		

when R70 reported being tired. NA-D stated the facility had educated staff in the past on not using walkers for transporting residents.

During interview on 8/11/16 at 12:46 p.m., trained medication aide (TMA)-A stated R70 ambulated independently with Rollator walker, and stated at times R70 did complain of pain and then staff would get a wheelchair to transport R70. TMA-A stated she felt it was acceptable if R70 was in the hallway and could not continue to ambulate, to transport R70 on the Rollator walker. TMA-A indicated it would not be the daily way of transporting someone, but staff had transported R70 with the Rollator walker in the past.

During interview on 8/11/16 at 12:58 p.m., clinical manager (CM)-B confirmed R70 used a wheeled walker to ambulate independently. CM-B stated she was aware staff use R70's walker to transport her to a safe location if she could not walk herself. CM-B stated it would depend on the circumstance, then stated best practice would be to not use the walker for transporting, only for aiding in ambulation, or if R70 had to sit down and take a rest.

During interview on 8/11/16 at 1:03 p.m., the director of nursing (DON) confirmed R70 ambulated independently with the walker, and verified staff were not to use the walker as a transferring device in any circumstance. The DON stated she felt today was an unusual circumstance, and staff were aware they are not to be doing that. The DON confirmed R70's front wheeled walker was a Deluxe Rollator walker and indicated she was aware of the manufacturer's guidelines which directed not to use the walker as a wheelchair, to transport residents.

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F 323	Continued From page 3 Review of undated manufacturer's guidelines, titled Roscoe Medical Deluxe Rollator revealed Rollators are NOT to be used as a wheelchair. Doing so may cause it to tip-over, resulting in injury.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 329	Luther Haven failed to assure all	9/20/16

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F 329	Continued From page 4 review the facility failed to ensure adequate justification for the use of antipsychotic medication for 1 of 5 residents (R38) and failed to ensure adequate indications for the continued use of antibiotics for 1 of 1 resident (R38), reviewed for unnecessary medications. Findings include: R38's quarterly MDS dated 6/23/16, indicated R38's diagnoses included: dementia with behavioral disturbance, major depressive disorder and anxiety. The MDS identified R38 had severely impaired cognition, had no behaviors during the assessment period and did not have any hallucinations, delusions or any physical or verbal behaviors. Further, the MDS identified R38 required extensive assistance for all activities of daily living(ADL's). R38's care plan dated 7/8/16, identified R38 had diagnoses of Parkinson's disease, dementia, and indicated R38 was at risk for side effects from daily use of antidepressants and antiaxiaolytic (sp)(antianxiety agent) medications. R38's care plan identified R38 had history of being demanding, rude and sarcastic comments to staff, was easily angered and dried easily when upset. The care plan listed various interventions to utilize when R38 had expressions of anxiety or depression such as preferred to be in room often, staff to refocus conversation as needed. However, R38's care plan lacked identification of the use of an antipsychotic and antibiotic medications, the target behaviors displayed by the resident, any non pharmacological interventions, or possible side effects of the medications.	F 329	residents' drug regimen is free from unnecessary drugs. 1 resident was found to be on an antibiotic prophylactically without indication for need by the MD. PharmD recommended discontinuation due to lack of need and MD elected to continue the use. The same resident was on an antipsychotic without documented Target Behaviors from the MD and no care plan documentation. All residents in the facility will have their med list reviewed to assure no resident is using antipsychotic medications without an appropriate indication/ diagnosis for use. All residents will have their med list reviewed for inappropriate antibiotic use to assure no resident is receiving inappropriate antibiotics and such use will be discussed with MD. An all staff in-service is scheduled for 09/15/16 to review Plan of Correction and importance of following facility policy for Psychotropic Drug Documentation Policy and the importance of obtaining the target behaviors and medical necessity for the ordered antipsychotic medication as well as importance of care planning medications and non pharmalogical interventions to be used. The appropriate use of antibiotics will be reviewed and monitored as well. All staff in-service on 09/15/2016 will also cover the importance of a drug regimen being free of unnecessary drugs and including an indication for use for all medications administered and clear documentation why the PharmD recommendation will not be followed.	

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F 329	Continued From page 5 On 8/10/16, at 12:37 p.m. R38 was seated in a wheelchair in the dining room, calmly eating her meal independently. R38 proceeded to propel herself out of the dining room, down the hall of the facility. On 8/10/16, at 7:38 p.m. R38 was observed seated in a recliner in her room. R38 was calmly watching television. On 8/11/16, at 7:26 a.m. R38 was observed seated in a wheelchair in her room. R38 was quiet and calm. At 9:06 a.m. R38 was in her recliner chair in her room calmly watching television, no distress noted. At 9:45 a.m. R38 remained in her recliner chair in her room, watching television, R38 was quiet, no yelling out or behaviors observed. Review of R38's current signed medication orders dated 7/12/16, identified R38 received Seroquel (an antipsychotic medication) 25 milligrams (mg) daily, with a start date of 5/20/16, for a diagnosis of unspecified dementia without behavioral disturbance. The signed medications orders also included an order for Amoxicillin (an antibiotic medication) 250 mg daily on Monday, Wednesday and Friday with a start date of 5/25/16, without a diagnosis listed. Review of R38's monthly Medication Administration History forms from 5/1/16 to 8/11/16 revealed R38 had received a daily dose of Seroquel 25 mg since 5/25/16 and had received a dose of Amoxicillin 250 mg every Monday, Wednesday and Friday since 5/25/16.	F 329	DON or designee will complete monthly audit of all psychotropic medications to assure monitoring of target behaviors, side effects, efficacy of medication & interventions and that care plan remains current. DON or designee will review all antibiotics and necessity during completion of monthly Infection Control Report. Any deviations from Current Standards of Practice will be reported to Primary MD and QAA. QAA made aware of the resident's drug regimen was not free from unnecessary drugs. DON or designee will do weekly X 4 then biweekly x 4 then monthly thereafter. Audit results for antibiotic use and antipsychotic use will be reported to QAA	

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The monthly Medications Administration History forms revealed the facility monitored for behaviors of anxiety and depression. However, the forms did not include identification of target behaviors or monitoring of the target behaviors and the non pharmacological interventions used for the target behaviors for the ongoing use of Seroquel.

Review of R38's Behavior documentation dated 5/20/16 to 8/11/16, lacked targeted behaviors for the anti-psychotic medication use and behavior monitoring.

During interview on 8/11/16, at 8:46 a.m. registered nurse (RN)-C reported R38 was an anxious woman and would complain of pain differently to different people. RN-C stated R38 gets worked up, is very impatient, refuses treatments, yells at staff to get out of her room. RN-C denied R38 having any physical or aggressive behaviors or any hallucinations or delusions. RN-C was not aware of any targeted behaviors for R38's use of Seroquel, was not aware of the reason R38 received an antipsychotic medication. RN-C stated R38 did have targeted behaviors for the Ativan use-multiple health concerns, and targeted behaviors for the Celexa, not sociable, does not come out to activities. RN-C was not aware why R38 received an ongoing antibiotic, she stated R38 did have a toe infection, but was on the antibiotic prior to that.

During interview on 8/11/16, at 9:09 a.m., clinical manager (CM)-A confirmed R38 was on the Amoxicillin three times per week as a prophylactic measure to prevent urinary tract infections. CM-A indicated R38 had a history of UTIs, and the last

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urinary infection R38 had was January 2015 and confirmed R38's physician had not documented the clinical rational for the continued use of the antibiotic. CM-A reported R38 has been on the Amoxicillin for at least the past 6 years. CM-A confirmed R38 had no targeted behaviors in place, did not have care plan interventions developed, and did not have monitoring of the medication and its effectiveness or side effects.

During interview on 8/11/16, at 9:27 a.m., nursing assistant (NA)-C reported R38 did have some anxiety but she could "talk her down" a lot of the time. NA-C was not aware of R38 having physical or verbally aggressive behavior, or any hallucinations or delusions.

Review of R38's Resident Progress Notes from 5/1/16 to 8/05/16 revealed the following:
-5/10/16-right toe very red and swollen, painful to touch and had some drainage, appointment made.
-5/11/16-Amoxicillin on hold while on Augmentin
-5/17/16-refused to let nurse do foot soak treatment. Rsdt hollering and upset in her room, bit her hand and pulled her hair. R38 stated to the nurse that she wanted to cut her toe. R38's medical doctor was updated due to increased agitation.
-6/17/16, pleasant with no behaviors noted.
-6/20/16, pleasant with no behaviors noted.
-6/22/16, pleasant with no behaviors noted.
7/10/16, -pleasant, sleeping peacefully.
-7/17/16, agitated, hitting herself on the thighs, given Ativan and has been calm with no further complaints.

Review of the R38's physician notes from 5/12/16 to 7/12/16 revealed the following:

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F 329	Continued From page 8 -5/12/16, indicated R38 had cellulitis on right great toe, was improving. - 5/20/16, indicated R38 had been having more behaviors with aggressiveness at times with assessment of dementia with behaviors and a toe infection. The report identified a change in antidepressant, at least for the short term, a low dose of Seroquel at night. Will reassess on an ongoing basis. -7/12/16, made no mention of the Seroquel or the justification of continued use per the pharmacist recommendation, dated 7/4/16. Review of R38's Pharmacist Recommendation Behavior-Medication Monitoring form dated 7/4/16, identified the consulting pharmacist had identified there were no listed medical problems or described behaviors indicating the use of Seroquel. The consulting pharmacist recommended the Seroquel be held. No further documentation for justification for the continued use of Seroquel was found in R38's record. During interview on 8/11/16, at 11:30 a.m. the consulting pharmacist(CP)-A confirmed he had brought the continued use of the antibiotic to the attention of the physician in January of 2016, but the physician has decided to continue the use, which CP-A felt was not necessary. CP-A confirmed R38 was currently being treated with Celexa and Ativan to manage her current behaviors. He confirmed R38 was also on Seroquel with no identified behaviors, and the physician had not indicated any reason the	F 329		

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F 329	Continued From page 9 resident was on the Seroquel. CP-A confirmed he had recommended the Seroquel be put on hold on his June 2016 visit. During interview on 08/11/16, at 9:48 a.m. the director of nursing (DON) stated she would expect a care plan to be developed to identify the use of an antibiotic and antipsychotic medication, including targeted behaviors for the medication, monitoring for efficacy of the medication, possible side effects, and non-pharmacological interventions. The DON stated she was not aware that R38 was on an antipsychotic medication until 8/8/16. The DON indicated it is not the usual facility protocol to use antibiotics prophylactic, and confirmed the medical record lacked documentation for justification of continued use. The facility's undated Psychotropic Drug Documentation policy indicated the prescriber would specify the medical necessity and specific targeted behavior to be treated in the order for the psychotropic drug. The policy indicated staff would document resident's response to psychotropic drug administration and assessment of side effects in order to assess therapeutic value of therapy, including non-drug approaches and interventions used when possible.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431		9/20/16

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F 431	Continued From page 10 controlled drugs is maintained and periodically reconciled. 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. 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. 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 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 store insulin according to manufacturer's guidelines for 1 of 1 residents (R26) who received insulin in the facility after the documented end of usage date. Findings include: Observations of the 2 Bridge unit medication	F 431	Luther Haven failed to assure that Drug used and stored in the facility were being labeled in accordance with current accepted professional standards by failing to store insulin per manufacturer's guidelines by administering insulin after the 28 day shelf life out of the refrigerator. RN staff immediately checked all insulin's to assure no other insulin was open	

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F 431	Continued From page 11 carts was conducted on 8/11/16, at 8:53 a.m. with registered nurse (RN)-C present. An opened pen of Humalog 75/25 insulin was observed in the medication cart for R26. The open, partially full pen had a handwritten "date vial opened" label, with initials, of 6/21/16 affixed to the pen. RN-C confirmed this was the pen currently being utilized to administer R26's ordered dose of insulin and subsequent doses from 6/21/16 through 8/10/16 would have been administered from the pen. Review of R26's physician order dated 3/18/16, revealed an order for Humalog Mix 75-25 (insulin asp prt-insulin aspart) Solution: 100 unit/milliliter (mL) Nine units to be administered subcutaneous (SQ) daily (QD) in the afternoon (PM) between the times of 16:00 - 18:30. The Humalog Mix 75-25 was to be administered for R26's diagnosis of Type 2 Diabetes mellitus without complications. Review of R26's Diabetic Administration History forms from 6/21/16 to 8/10/16 revealed R26 received a daily dose of Humalog Mix 75-25 insulin during this time. Review of the manufacturer's package insert, Humalog Mix 75/25, revised 2/15, included a table with listed storage of the medication in vial form and in pen form. The table identified for an in use (opened), prefilled pen, the pen was to be stored at room temperature for up to 10 days before it was to be discarded. Further, the product literature identified, " After starting use (open): Prefilled Pens: Keep at room temperature below 86 degrees for up to 10 days. Throw away a prefilled pen 10 days after first use, even if there is insulin left in the pen. Review of the "Insulin Storage	F 431	greater than 28 days. All licensed staff were reminded through report of the importance of checking date opens. Licensed staff will audit med carts weekly and document compliance with dating, storage and expiration of medications. Audit book will be kept at each nursing station and Nurse Managers will check audit compliance to assure they are being completed. All staff in-service on 09/15/2016 will also cover the importance of drugs being used and stored in accordance with a current accepted professional standards and manufacturers guidelines Random audits of Medication carts/storage will be made by DON or designee. QAA made aware of failure to label and store drugs in accordance with current accepted professional standards QAA will be made aware of results of audits.	

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F 431	Continued From page 12 Recommendations" form, dated 8/22/14, identified by facility personnel as provided by pharmacy, identified opened cartridges/pens, prefilled syringes of Humalog Mix 75/25 to be stored up to 10 days. During interview on 8/11/16, at 9:14 a.m. the director of nursing (DON) confirmed the insulin utilized for R26's Humalog Mix 75/25 was outdated according to the package insert and pharmacy Insulin Storage Recommendations. The DON further stated she expected the nurses to check for expiration dates for medications prior to each administration and to follow the product guidelines and pharmacy recommendations regarding the storage and discarding of the opened Humalog insulin. No additional policies were provided related to storage, checking or cleaning of the medication carts.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		9/20/16

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	245259	A. BUILDING _____ B. WING _____	08/11/2016

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F 441	Continued From page 13 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper handwashing techniques were followed during personal cares for 1 of 3 residents (R82) observed during personal cares. In addition, the facility failed to ensure a mechanical lift was properly sanitized after use for 1 of 2 residents (R82) who was observed utilizing the standing mechanical lift. Findings include: R82's significant change Minimum Data Set (MDS) dated 7/4/16, identified R82 had severely	F 441	Luther Haven failed to maintain an environment to prevent the development, transmission and spread of disease and infection by not ensuring proper handwashing technique during observed personal cares on 08/10/2016 by NA-B and not sanitizing common lift. All Nursing staff were immediately reminded through report of the importance of proper handwashing per current standards and the importance of changing gloves between clean and dirty tasks and sanitizing the lift between resident use.	

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F 441	Continued From page 14 impaired cognition and had diagnoses which included dementia, depression and diabetes. Further, the MDS identified R82 was incontinent of urine and bowel and required extensive assistance of two staff for transfers and toileting activities. During observation on 8/10/16 at 7:05 p.m. nursing assistant (NA)- A and NA-B entered R82's room with a mechanical standing lift and proceeded to apply glove to both their hands. NA-A and NA-B assisted R82 to transfer from his wheelchair to the toilet using the standing mechanical lift. NA-B proceeded to pull R82's pants down to his knees and removed R82's brief, which was soiled with urine, discarded the soiled brief in the garbage, while NA-A lowered him onto the toilet. NA-B immediately reached over to wash R82's face, then provided oral cares with the same soiled gloves on during the entire observation. At 7:11 p.m. Wearing the same soiled gloves, NA-B rinsed R82's tooth brush, then gave R82 a drink of water to rinse his mouth with and proceeded to put all of R82's supplies away. NA-A raised R82 off the toilet utilizing the mechanical lift, while NA-B picked up a wash cloth, applied cream to it and began to provide perineal cares for R82. After NA-B dried R82's perineal area, she picked up a clean brief off the back of the toilet and applied the clean brief for R82. NA-B continued to have the same soiled gloves on during the entire observation. At 7:14 p.m. NA-A utilized the standing mechanical lift and transferred R82 from the bathroom to the edge of his bed. NA-B proceeded to hold both the handles of the lift with her soiled	F 441	Nurse Managers or designee will complete audits of personal cares to be sure proper handwashing, glove use and sanitizing of equipment is followed weekly X4 biweekly X4 and random thereafter. Review of the importance of proper handwashing per current standards and the importance of changing gloves between clean and dirty tasks and sanitizing the lift between resident use will occur with Nursing department performance evaluations. An all staff in-service is scheduled for 09/15/16 to review Plan of Correction and importance of following Facility Infection Control Program and maintaining and environment to prevent the development, transmission and spread of disease and infection. QAA made aware of failure to maintain an environment to prevent the development, transmission and spread of disease and infection by failing to follow current standards of handwashing, glove use and sanitizing equipment. Results of audits will be reviewed at QAA.	

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F 441	Continued From page 15	F 441		

gloves, pushed the button on the standing mechanical lift to lower R82 onto his bed, unhooked the strap from his legs, then again took hold of the handles of the standing mechanical lift and pushed it out of the way. NA-B proceeded to remove R82's shoes, pants, and shirt while NA-A removed his compression stockings.

At 7:16 p.m. R82 asked for a drink of water, NA-B picked up his blue water pitcher from the night stand, gave him a drink of water and continued to wear the same soiled gloves during observation. NA-A and NA-B proceeded to lay R82 in his bed, then made him comfortable, put bed in low position, placed call light within reach and NA-A removed his gloves, while NA-B grabbed the bars of the lift with her soiled gloves on and pushed the lift further out of the way by the door.

At 7:18 p.m. NA-A grabbed the lift by the handles and preceded to push the standing mechanical lift out of R82's room and placed the lift across the hallway outside of R82's room while NA-B continued to put supplies away, clean bathroom, gather dirty laundry and garbage out of R82's room with the same soiled gloves on, then at 7:19 p.m. removed her soiled gloves and threw them away. NA-B then took the dirty linen and garbage to the dirty utility room and washed her hands. The standing mechanical lift remained in the hallway un-sanitized for other residents to use until 8:00 p.m.

NA-A and NA-B had not perform hand hygiene or remove their soiled gloves for the entire observation of personal cares from 7:05 p.m. to 7:19 p.m. NA-B did not sanitize the multi use mechanical lift after patient use.

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F 441	Continued From page 16 On 8/10/16 at 7:21 p.m. NA-B confirmed she had not removed her soiled gloves after handling R82's soiled brief and providing assistance with perineal cares for R82. NA-B confirmed the standing mechanical lift had not been sanitized after handling the lift with her soiled gloves and was placed in the hallway for other residents to use as well. NA-B indicated she had never been directed to change her gloves, going from dirty to clean and stated "I should of changed my gloves after I took his dirty brief off." On 8/11/16 at 12:12 p.m. registered nurse (RN)-A confirmed she would expect staff to change their gloves going from dirty to clean areas. RN-A also verified staff should be changing gloves and washing hands after providing perineal cares and they should not be handling the mechanical lifts with soiled gloves. RN-A stated she would expect the lift equipment should of been cleaned and sanitized after use. On 8/11/16 at 12:33 p.m. director of nursing (DON) confirmed she would expect staff to change their gloves going from dirty to clean and stated "they should follow current infection control practices." The DON also indicated she would expect staff to sanitize the lift before being made available for other residents to use, once it has been contaminated. Review of the facility policy titled, Glove Use, dated 5/5/09 indicated the purpose of this procedure is to provide guidelines for the use of gloves to prevent the spread of infection and disease to residents and employees. Gloves should be removed before performing any other personal cares and should be discarded into the designated waist receptacle inside the room.	F 441		

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F 441	Continued From page 17 Review of facility policy titled Multiple Use EZ Stands and Lifts, dated 5/20/13 indicated EZ stands and lifts will be cleaned between residents use. If there is body fluids or blood contaminant during use, the EZ stand or left will be cleaned and disinfected immediately. On 8/11/16 requested hand hygiene policy and one was not provided.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide housekeeping and maintenance services necessary to maintain functional, sanitary conditions for 7 of 7 resident rooms (Rm 115, Rm146, Rm149, Rm 181, Rm185, Rm 188, Rm190) reviewed during the environmental tour. This deficient practice had the potential to affect all residents residing in the facility. Findings include: On 08/10/2016 at 3:40 p.m. an environmental tour of the facility was conducted with the maintenance supervisor (MS) and housekeeping supervisor (HS) present. The MS and HS confirmed the following findings	F 465	Luther Haven failed to provide a safe functional, sanitary and comfortable environment for residents, staff and the public as written in the observations on the environmental tour. Maintenance and Housekeeping staff were verbally educated of environmental tour observations and plans to implement a new policy. Policy written to have housekeeping staff do a thorough audit of resident rooms on their monthly bed wash day assuring each room is audited Monthly. The room audit will be given to the Environmental Services Director and she will provide Maintenance Supervisor with a copy to complete any needed repairs/tasks.	9/20/16

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F 465	Continued From page 18 during the tour: -Room 186, the wooden bathroom door was scraped up, missing varnish, measuring 3 feet across the bottom of the entire door and had a whole measuring approximately 2 inch (in) x 2 in half way up in the middle of the door. -Room 115, the main wall on the right side of the room, behind the recliners, was noted to have an area of wall paper missing with white sheet rock exposed, measuring approximately 6 in x 3 in wide, half way up the wall. -Room 190, the bathroom faucet in the sink had a heavy white/green lime scale buildup on the handles and the base of the faucet hardware and was leaking water. -Room 181, the bathroom, the entire base around the toilet was noted to have dark brown/black matter and was stained. -Room 149, the bathroom, the entire base around the toilet was noted to have dark brown/black matter and was stained and the bathroom faucet in the sink had a heavy white/green lime scale buildup on the handles and the base of the faucet hardware and was leaking water. -Room 146, the bathroom door frames was observed to have paint missing and chipped away from the door frames, approximately 3 foot from the base of the floor. -Room 190, shared bathroom door frames was observed to have paint missing and chipped away from the door frames, approximately 3 foot from the base of the floor.	F 465	Completed audits will be forwarded to Administrator or designee to be filed and maintained. An all staff in-service is scheduled for 09/15/16 to review Plan of Correction and importance of providing a safe functional, sanitary and comfortable environment for residents, staff and the public. QAA was made aware of the failure to provide a safe functional, sanitary and comfortable environment for residents, staff and public as written in the observations on the environmental tour. QAA will be made aware of the monthly audit results.	

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F 465	Continued From page 19 On 8/10/16 at 4:14 p.m. the MS indicated he repaired issues which were written repair slips and verbally reported by either staff and/or housekeeping and stated he was not aware of the above findings in the facility. The MS indicated he did not conduct routine room or facility inspections and stated the environment could be better and room for improvement. The MS indicated he did not keep records of what had been repaired and would prioritize what was repaired first such as what he felt were major issues in the building On 8/11/16 request policy for maintenance and housekeeping, one was not provided.	F 465		

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

F5259024

PRINTED: 09/12/2016
FORM APPROVED
OMB NO. 0938-0391

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 10, 2016. At the time of this survey, Luther Haven 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/01/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Luther Haven is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1974, an addition was added that was determined to be of Type II(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type II(000) construction. Because the original building and the two additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 79 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 61 of the 79 residents, staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 10:00 am to 2:00 pm on 08/10/2016 observations and staff interview revealed: 1) Fire Door by room 56 sticks and will not shut completely. 2) Fire Door by room 40 will not shut completely. 3) Smoke Barrier door sticks at the top not allowing the door to shut properly. This deficient condition was verified by the the Maintenance Supervisor.	K 027	K027: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction in accordance with state and federal regulations: the facility alleges that it will be in substantial compliance with the standards indicated by September 15, 2016. All smoke barrier doors throughout the building will be repaired as needed to assure that the smoke barrier doors shut completely. Luther Haven maintenance along with Ryer Construction will make the necessary modifications to the doors so they shut completely. This will be completed by realigning the doors and hinges and/or shaving of the door to meet compliance with the Life Safety Code Standard. Responsible person: Maintenance engineer and Administrator.	9/15/16

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the corridor and adjacent areas making them untenable, which could negatively affect the exiting capabilities for 18 of the 43 of residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 10:00 am to 2:00 pm on 08/10/2016 observations and staff interview revealed the Soiled Utility Room #50 and Decontamination Room #60 did not positively latch. This deficient condition was verified by the the Maintenance Supervisor.	K 029	K029: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction in accordance with state and federal regulations: the facility alleges that it will be in substantial compliance with the standards indicated by September 1, 2016. Room number 50 and room number 60 doors have been repaired and positively latch. Doors throughout the facility were checked and corrections made as required to assure doors positively latch. The repair on the doors to room number 50 and room number 60 were repaired by tightening the screws on the three hinges which aligned the doors so they positively latch. Responsible person is Maintenance engineer and Administrator	9/1/16
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised	K 144		9/15/16

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 144	Continued From page 4 under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all 79 residents and an undetermined amount of staff and visitors. Findings include: On the facility documentation review between 10:00 am to 2:00 pm on 08/10/2016 observations and staff interview there was no record of the generator cool down cycle and the weekly generator testing was not completed from 6/14/2016 to 07/12/2016. This deficient condition was verified by the the Maintenance Supervisor.	K 144	K144: Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction in accordance with the state and federal regulations: the facility alleges that it will be in substantial compliance with the standards indicated by September 15, 2016. Emergency generator will be tested weekly as required by regulation. The generator cool down cycle will be recorded as part of the monthly exercise of the emergency generator. A weekly Inspection Checklist will be used for weekly testing and an Emergency Generator Monthly Test Log will be used to document the monthly test including the cool down cycle. Responsible persons: Maintenance engineer and Administrator.	