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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: ITU7

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 **08/12/2018** (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 :
Gail Anderson, Unit Supevisor 08/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/15/2018 (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
08/07/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245259

August 15, 2018

Ms. Tamara Borstad, Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Dear Ms. Borstad:

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 July 23, 2018 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 15, 2018

Ms. Tamara Borstad, Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Project Number S5259025

Dear Ms. Borstad:

On July 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2018. 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 August 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 30, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective July 23, 2018 and therefore remedies outlined in our letter to you dated July 13, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: ITU7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00062

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2.STATE VENDOR OR MEDICAID NO.
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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 **06/28/2018** (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
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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:
Susan Bachleitner, HFE NE II 07/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 08/03/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

Electronically delivered
July 13, 2018

Ms. Tamara Borstad, Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Project Number S5259025

Dear Ms. Borstad:

On June 28, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” 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
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
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 August 7, 2018, 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 August 7, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 2018 (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 December 28, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure

cc: Licensing and Certification File

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 _____	06/28/2018

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 25 through June 28, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 25 through June 28, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		7/23/18

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

Electronically Signed | 07/23/2018

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.

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 _____	06/28/2018

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 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 8 of 8 residents(R69, R226, R47, R61, R20, R40, R1 and R72) who received	F 550	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and	

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 _____	06/28/2018

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 550	Continued From page 2 assistance with eating in the East dining room. Findings include: R69's admission Minimum Data Set (MDS) dated 6/1/18, identified R69 had diagnoses which included Alzheimer's disease, arthritis and weakness and had severe cognitive impairment. R69's MDS further identified she did not walk and required extensive assistance with all activities of daily living (ADL). R69's Care Area Assessment (CAA) dated 6/5/18, identified R69 had rheumatoid arthritis that affected her ability to use hands and fingers, weakness in lower extremities and difficulty with comprehension and communication. The CAA indicated R69 required extensive to total assistance of 1-2 staff with all ADLs, and diet per order and no referral necessary as RD (registered dietician) and MD (medical physician) were monitoring. R69's comprehensive care plan, revised 6/21/18, instructed staff to provide extensive assistance of 1 and encourage R69 to feed self with adaptive equipment and to provide assistance with intake at meals. On 6/25/18, at 6:00 p.m. R69 was seated at one of the two tables near the kitchenette, in the East dining room with her supper meal on the table in front of her. At 6:13 p.m. nursing assistant (NA)-D sat to the left of R69, assisting a tablemate to eat her meal. NA-D stood up, walked to another table and stood by a resident at the table, and assisted her bites of her meal. At 6:17 p.m. NA-D walked back to R69's table and sat down next to her. She applied R69's clothing protector and began to	F 550	federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to provide a dignified dining experience for residents who received assistance with eating in the East dining room. Luther Haven assignments were reviewed and specific assignments were made for assisting in the dining room with feeding to assure staff are able to feed all residents in a dignified manner. Staff were educated that they need to feed residents until meal is completed without interruption. Charge Nurses have been educated they need to direct CNAs to follow assignments. Charge nurses or designee need to be in the dining room every meal during resident assisted times to assure CNAs are completing their assigned duties with appropriate interventions. DON or designee will observe meals at least 3x per week for x 4 weeks and then weekly thereafter to assure dining room assignments are being followed. After 6 months of achieved dignified dining DON or designee will train charge nurses on audits and they will audit all meals for dignified dining and turn in weekly audits for review by QAPI team monthly. DON or designee will observe dining room assistance to assure charge nurses and	

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	245259	A. BUILDING _____ B. WING _____	06/28/2018

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F 550	Continued From page 3 feed her some chipped beef with toast. At 6:21 p.m. NA-D stood up, left the table to assist another resident out of the dining room. At 6:22 p.m. NA-D returned to the dining room, sat down next to R69 and assisted her to eat a bite of mashed potatoes. At 6:27 p.m. NA-D again stood up, walked around the table, stood next to a resident to cut up her food. At 6:28 p.m. NA-D walked to the next table, picked up a clothing protector from the table and carried it to the kitchen. NA-D returned to the dining room, stood next to a resident at another table and assisted that resident to eat a bite of potatoes and then walked to R69's table, sat down, picked up a spoon and continued to assist her with bites of her food. At 6:31 p.m. NA-D stood up, walked out the dining room to wheel another resident out of the dining room. At 6:32 p.m. NA-D returned to the dining room, sat down next to R69 and began to feed R69 her soup. At 6:34 p.m. NA-D continued to assist R69 to eat her watermelon. At 6:43 p.m. NA-D stood up, walked over to R69's tablemate, stood at her side to assist her to eat a few spoonfuls of her food. NA-D then walked back to R69's side of the table, sat down next to R69 and assisted her to eat more watermelon. The director of nursing (DON) entered the dining room at that time and sat down at a nearby table to assist a resident to eat their meal. On 6/25/18 , at 7:29 p.m. NA-D indicated staffing determined how many residents she needed to assist to eat their meals. NA-D confirmed during the supper meal she had fed the 4 residents at R69's table and fed one resident at the other table. NA-D also indicated she had gotten up a "few times" while feeding R69, took one resident to the bathroom and assisted another resident out of the dining room. NA-D indicated her usual	F 550	CNAs are completing meal assistance in a dignified manner.	

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F 550	Continued From page 4 practice was to assist several residents to eat at the same time, and would stand and walk around the residents routinely during meals. NA-D indicated she would give a resident a "quick bite" then return to feeding her resident until she saw the other residents needed help again. On 6/28/18, DON stated staff should not interrupt dining for residents and indicated it was not dignified to stand up repeatedly and stand next to a resident while they assisted residents with their meal. DON indicated all staff should pass trays for the meals, and 3 nursing assistants should remain in the dining room to assist residents. DON provided a list of residents who sat at the two tables near the kitchenette and routinely required assistance/supervision for meals on Station 2/East Wing, which listed R69, R226, R47, R61, R20, R40, R1 and R72. A facility policy for dignified dining was requested, but not provided.	F 550		
F 575 SS=C	Required Postings CFR(s): 483.10(g)(5)(i)(ii) §483.10(g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and	F 575		7/23/18

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F 575	Continued From page 5 (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to post current complete contact information of all pertinent State agencies and advocacy groups for residents and/or resident representatives to view. This had the potential to affect all 77 residents currently residing in the facility. Findings include: 06/27/18, at 7:36 a.m. the Bill or Rights (BOR) postings were observed in an approximate 18 inch by 24 inch black frame, which was approximate 3.5 feet off the ground across from the Station 2 nursing desk. There was a second identical BOR posting next to the business office door at Station 1. The BOR postings were dated 2016, which was not the most current version. On the bottom of the BOR postings was contact information for three State agencies, which was not the most current contact information and email addresses. No other current contact information for advocacy groups or the State agency were noted in the facility. On 6/27/18, at 10:58 a.m. director of nursing (DON) reviewed the BOR posting next to the	F 575	Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. The facility failed to post email addresses for the state agencies and advocacy groups as required. Facility posted a laminated listing of all state agency and advocacy groups with email, mail and phone numbers next to the current posted bill of rights on the east and west end of the building. Current postings are listed. If changes to required postings occur in the future DON and Administrator are signed up to receive S&C memos. Additionally DON and administrator are signed up to receive notification for MN statewide phone calls and will listen when occur to remain current with requirements.	

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F 575	Continued From page 6 business office at Station 1 and confirmed the BOR posting did not have current complete contact information for the State agencies or advocacy groups and contact information was not posted in the building elsewhere. DON also confirmed the BOR posting at Station 2 was identical.	F 575	DON will monthly check CMS website and MDH website for updated information regarding changes to required postings and document results of monthly check of websites DON and Administrator receive the weekly newsletter from Leading Age which also alerts to any upcoming changes. If upcoming changes recommendations occur they will be brought to the QAPI team for recommendations to assure compliance with upcoming changes. QAPI team will be updated monthly of any proposed new posing requirements.	
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop an abuse policy to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of	F 607	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and	7/23/18

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F 607	Continued From page 7 unknown source and misappropriation of resident property are reported to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within the required time frames. This deficient practice had the potential to affect all 77 residents residing in the facility. Findings include: Review of the facility's abuse policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 5/10/17, stated the nursing home administrator would report "abuse" to the state agency per State and Federal requirements. The policy also included the following; -If the injury is unexplainable (i.e., fracture), and if the findings of abuse are substantiated (physical, verbal, sexual, financial exploitation), and if there is caregiver neglect (i.e., care plan not followed resulting in resident injury), or if therapeutic error resulted in injury a report must be made to the facility to OHFC IMMEDIATELY (or per State guidelines) of the initial findings. (Call to Administrator and Designee is made immediately) -Initial reporting of allegations: if an incident or allegation is considered reportable, the Administrator or designee will make an initial (immediate or within 24 hours) report to the State Agency. -all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, in accordance	F 607	federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven policy failed to include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency .The policy failed to include all alleged violations involving abuse, not only substantiated alleged violations, are reported immediately, but not later than 2 hours after the allegation is made. Luther Haven policy is that all allegations of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident proper are reported immediately. Luther Haven Policy now includes that when the alleged violations involve abuse, neglect, or mistreatment including injuries of unknown source and misappropriation of property are reported immediately but not later than 2 hours after the allegation is made. If the allegations do not involve abuse and do not resident in serious bodily injury the facility must report immediately but not later than 24 hours after the allegation is made.	

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F 607	Continued From page 8 with State law through established procedures. In addition, local law enforcement will be notified of any responsible suspicion of a crime against a resident in the facility. -Under Centers for Medicaid and Medicare Services (CMS) - Definitions; immediately; means as soon as possible, immediately for the purposes of reporting a crime resulting in serious bodily injury means covered individual shall report immediately, but not more than 2 hours after forming the suspicion. -Serious Bodily Injury reporting- if the events that cause the reasonable suspicion result in serious bodily injury to a resident, the covered individual shall report the suspicion immediately. -"abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The policy failed to include all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the the State Survey Agency . The policy failed to include all alleged violations involving abuse, not only substantiated alleged violations, are reported immediately, but not later than 2 hours after the allegation is made.	F 607	Luther Haven policy is updated to include all allegations of abuse and the definitions of immediate with specific time requirements. All staff have been updated on the definitions and time requirements. DON will monthly check CMS website and MDH website for updated information regarding changes to Abuse & Neglect policies and document results of monthly check of websites DON and Administrator receive the weekly newsletter from Leading Age which also alerts to any upcoming changes. If upcoming changes recommendations occur they will be brought to the QAPI team for recommendations to assure compliance with upcoming changes. QAPI team will be updated monthly of any proposed new posing requirements.	

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F 607	Continued From page 9 On 6/27/18, at 10:54 a.m. director of nursing (DON) confirmed the facility's abuse policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property, dated 5/10/17, was the most current policy.	F 607		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		7/23/18

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be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental

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F 623	Continued From page 11 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Long Term Care Ombudsman received timely written notification of discharge to the hospital for 2 of 2 residents (R71, R19) reviewed for hospitalization. Findings include: R71's annual Minimum Data Set (MDS) dated 6/13/18, identified R71 had moderate cognitive impairment and diagnoses included hypertension, diabetes, hemiplegia, and depression.	F 623	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to failed to ensure the Long Term Care Ombudsman received timely written notification of discharge to the hospital or ER.	

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F 623	Continued From page 12 Review of R71's progress notes from 2/2/18 to 2/15/18 revealed: -2/2/18, R71 had been transferred to the hospital with complaints of pain in the pelvic region. - 2/8/18, R71 had been readmitted to the facility. On 6/28/18, at 11:22 a.m. the licensed social worker (LSW) verified being responsible to notify the ombudsman of resident discharges. The LSW indicated the most recent report to the Ombudsman was sent on May 7, 2018, and included resident discharges from 1/1/2018 through 4/30/2018. R71's hospitalization in February was reported to the ombudsman May 7, 2018, three months after the hospitalization. She indicated she was unaware of how often a report was to be sent to the ombudsman ; however, identified her practice was to send a report three times a year. On 6/28/18, at 12:31 p.m. the director of nursing verified the licensed social worker was responsible to notify the ombudsman of resident discharges in writing and did so quarterly. R19's quarterly Minimum Data Set (MDS), dated 4/17/18, indicated R19 was severely cognitively impaired. Diagnoses included hypertension and schizophrenia. R19's Resident Progress Notes identified on 5/2/18 R19 oxygen saturation level was low at	F 623	The LSW or designee is now making weekly notification to the area Long Term Care Ombudsman. All Staff were educated on the Notice of Requirements before Transfer & Discharge. Transfer and Discharge policy was written to include requirements of Notice for both planned and unplanned transfers and discharges. DON or designee will audit timely notification of Long Term Care Ombudsman weekly x 4 and then randomly thereafter, DON will monthly check CMS website and MDH website for updated information regarding changes to Notification of Transfers/Discharges and document results of monthly check of websites DON and Administrator receive the weekly newsletter from Leading Age which also alerts to any upcoming changes. If upcoming changes recommendations occur they will be brought to the QAPI team for recommendations to assure compliance with upcoming changes. QAPI team was notified of this deficient practice. QAPI team will be updated monthly of any proposed new notification requirements results of monthly audit of websites and audit of notifications to the Ombudsman. QAPI team will observe for trends, problems and make recommendations as	

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F 623	Continued From page 13 68%. Heart rate elevated at 126. Appeared weak and pale in color. R19 was sent to the hospital. R19's medical record lacked documentation of notification of the ombudsman. R19's Resident Census record identified on 5/2/18, R19 was on hospital leave, returning on 5/8/18. During an interview on 6/27/18 at 2:04 p.m. the licensed social worker (LSW) stated the ombudsman was notified of hospitalizations every 4 months via fax. LSW stated R19 was hospitalized 5/2/18 and the ombudsman would be notified of the hospitalization in August 2018. The requested facility policy was not provided.	F 623	necessary.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in	F 676		7/23/18

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F 676	Continued From page 14 accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide necessary services for activities daily living (ADL) for 1 of 2 residents (R69) who required the use of adaptive equipment to promote independent eating. Findings include: R69's admission Minimum Data Set (MDS) dated 6/1/18, identified R69 had diagnoses which included Alzheimer's disease, arthritis and weakness. The MDS identified R69 had both short term and long term memory problem, and had severely impaired cognitive skills for daily decision making skills. R69's MDS further identified she required extensive assistance with all ADLs and did not walk. R69's admission Care Area Assessment (CAA)	F 676	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to provide necessary services for activities daily living (ADL) for 1 of 2 residents who required the use of adaptive equipment to promote independent eating. Charge Nurses have been educated they need to direct CNAs to follow assignments. Charge nurses or designee need to be in the dining room every meal during resident assisted times to assure	

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F 676	Continued From page 15 dated 6/5/18, identified R69 had rheumatoid arthritis that affected her ability to use hands and fingers, weakness in lower extremities and difficulty with comprehension and communication. The CAA further indicated R69 required extensive to total assistance of 1-2 staff with all ADLs. R69's CAA listed diet per order and no referral necessary as RD (registered dietician) and MD (medical physician) were monitoring. R69's comprehensive care plan (CP) last revised 6/21/18, instructed staff to provide assistance with intake at meals. R69's CP also instructed staff to provide extensive assistance of 1 and encourage R69 to feed self with adaptive equipment. R69's group one Station II Care Sheet, undated, directed to use large handled silverware, and to use a coffee cup with handles for liquids. Review of untitled dining card for R69, dated 6/28/18 had a picture of R69 and a picture of a coffee cup with handle and white cover. The card instructed staff to use black built-up utensils. The card also indicated beverages: offer juice, offer milk, offer water and regular diet. On 6/25/18, at 6:00 p.m. R69 was served her supper meal in the East dining room, which was chipped beef on toast with soup. R69 was not provided larger handled black utensils or a coffee cup with handle for her liquids. At 6:14 p.m. nursing assistant (NA)-D began to feed R69 her supper meal using regular silverware. At 6:22 p.m. NA-D continued to feed R69 her chipped beef with toast and mashed potatoes using regular silverware. At 6:28 p.m. NA-D continued to feed her bites of her food. At 6:32 p.m. NA-D	F 676	CNAs are completing their assigned duties with appropriate interventions. All Nursing staff educated to follow interventions on care sheets. Dietary has reviewed diet slips to make sure they are clear and easy to follow. When therapy recommends dietary equipment for a resident direct care nursing staff and dietary manager receive a therapy education on what adaptive equipment is needed when & why needed. This is then entered on the diet slip as well as on the care sheet for the resident to assure all staff are aware of adaptive equipment needs. DON or designee will observe meals at least 3x per week for x 4 weeks and then weekly thereafter to assure dining room assignments are being followed. Dietary and Nursing reviewed all residents for adaptive equipment needs to assure they are being followed. DON or designee will observe meals at least 3x per week for x 4 weeks and then weekly thereafter to assure dining room assignments are being followed and adaptive equipment is being utilized per care plan. After 6 months of achieved dignified dining DON or designee will train charge nurses on audits and they will audit all meals for dignified dining and turn in weekly audits for review by QAPI team monthly.	

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F 676	Continued From page 16	F 676		

fed R69 her soup with a regular spoon. At 6:34 p.m. NA-D assisted R69 to eat her watermelon with a regular fork. NA-D did not encourage R69 to drink or feed herself throughout the entire meal. R69 did not have larger handled utensils or a cup with handles for her liquids throughout the entire meal.

On 6/25/18, at 7:29 p.m. NA-D indicated R69 did not feed herself, and that R69 would rather have them feed her.

During interview on 6/26/18, at 12:28 p.m. family member (FM)-A and FM-B indicated they were concerned staff fed R69, and did not allow her to try to feed herself. FM-A indicated R69 had been in therapy in the past and therapy had given R69 silverware with bigger handles to use.

On 6/27/18, at 8:54 a.m. R69 was seated near a table in the West main dining room. At 9:04 a.m. NA-E sat down next to her and began feeding her the breakfast meal. NA-E continued to feed R69 the entire breakfast meal. NA-E did not encourage R69 to feed or drink her self. R69 did not have larger handled black utensils or a cup with handle for her liquids.

On 6/27/18, at 12:22 p.m. R69 was seated in the East dining room with a plate in front of her which held a hamburger, soup, and a regular glass of milk and a regular glass of water. A black larger handled silverware was observed across the table from R69, unused. Trained medication aide (TMA)-C was seated next to R69 and asked her if she could pick up her hamburger. R69 touched her hamburger, then TMA-C asked her if she wanted her fork, which was a regular silver fork, and placed it on R69's plate. R69 did not pick up

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the fork. TMA-C then cut up R69's hamburger in half, then half again and cued her to eat and drink. At 12:37 p.m. TMA-C questioned R69 "not going to eat anything?" TMA-C then handed R69 her glass of water. R69 held the glass between both of her hands, and R69 finished the glass of water independently. At 12:38 p.m. TMA-C exited the dining room.

At 12:45 p.m. R69's family member (FM)-A and FM-B entered the dining room and sat next to R69, one on each side of her. FM-A asked R69 if she wanted to try a piece of her hamburger. R69 took a piece of the hamburger and began eating it. FM-A reached across the table, picked up the black larger handled silverware and handed it to R69. R69 began feeding herself, with the large handled silverware, and ate soup, potatoes and beets independently with encouragement and cuing from FM-A and FM-B.

On 6/28/18, at 8:52 a.m. R69 was seated in the West main dining room with a plate of cut up french toast and syrup in front of her. R69 had regular silverware, a regular glass of orange juice and a maroon colored coffee cup with coffee in it. R69 made no attempts to feed herself. At 8:54 a.m. NA-E sat down next to R69 and began to feed her. R69 did not have larger handled black utensils or a cup with handle for her juice. NA-E indicated she had fed R69 yesterday also. NA-E indicated R69 occasionally would drink independently, but would not eat independently. NA-E was observed to feed R69, and made no cues for R69 to feed herself. At 8:58 a.m. NA-E put the glass of orange juice in R69's hands, and she began to drink, holding it with both hands.

R69's admission nutrition assessment dated

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6/11/18, identified R69 requires supervision and/or cueing. It also identified R69 required partial assistance limited to extensive.

R69's occupational therapy (OT) note dated 6/18/18, identified was discharged from OT and was at the highest level of function with ADLs. The noted identified R69 was able to feed self with supervision due to decreased attention span to task and benefits from appropriate utensils and cups related to her rheumatoid arthritis diagnosis.

Review of R69's Therapy Caregiver Education form, dated 6/6/18, instructed staff to provide regular but larger handled black utensils for all meals. The form also instructed staff to use coffee cup with handle for all beverages for use with right u/e (upper extremity) at all meals.

On 6/27/18, at 1:19 p.m. TMA-B indicated R69 had to be fed, and could drink liquids if handed the glass. She indicated R69 did not utilize adaptive equipment to eat. TMA-B and surveyor reviewed Station II care sheet and she confirmed it did contain instructions for large handled silverware, but indicated she had never observed R69 feed herself, only staff feeding her.

On 6/28/18, at 8:32 a.m. nurse manager (NM)-A indicated occupational therapy had worked on dining with R69 in the past and she had required the use of adaptive silverware. NM-A indicated R69 required cuing and extensive assistance to eat. NM-A indicated she felt R69 was doing better at eating with cuing since therapy. NM-A indicated R69 was able to hold onto items. NM-A indicated staff would know R69 was to use adaptive equipment for meals from her dietary card and care plan.

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F 676	Continued From page 19 On 6/28/18, at 10:35 a.m. occupational therapist (OT)-A confirmed she had worked with R69 in the past. OT-A indicated staff were feeding R69 prior to therapy, so therapy had worked on her eating using larger handled silverware and a cup with a handle she could use with her right hand and arm. OT-A indicated the cup used by R69 with her right hand was best, since she had limitation in her left arm. She indicated it was easier for R69 to hold than a glass with both hands. OT-A indicated it was easier for her to use the handled cup because of her arthritis in her fingers also. OT-A indicated she would expect staff to follow her recommendations. On 6/28/18, at 11:33 a.m. director of nursing (DON) indicated she would expect R69 to be provided with the recommended adaptive equipment at every meal and for staff to encourage her to feed herself for as long as she was able. A facility policy regarding adaptive equipment use for dining was requested, but not provided.	F 676		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced	F 695		7/23/18

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F 695	Continued From page 20 by: Based on observation, interview, and document review, the facility failed to ensure oxygen therapy was administered according to physician orders for 1 of 2 residents (R50) reviewed who received routine oxygen therapy. Findings include: R50's Face Sheet, printed on 6/28/18, identified a diagnoses of chronic obstructive pulmonary disease. R50's quarterly Minimum Data Set (MDS), dated 5/24/18, indicated R50 was moderately cognitively impaired. R50 required extensive assistance with bed mobility, personal hygiene, and dressing. R50 received oxygen therapy. R50's Physician Order Report identified an active order, with a a start date of 2/15/18, for 2 liters (L) of oxygen via nasal cannula at night and as needed (PRN) for oxygen saturations less than 88%. R50's Care Plan, dated 5/30/18, lacked identification of respiratory concerns or oxygen use. R50's Group sheet document (identified as the nursing assistants care guide), dated 6/25/18, directed: "O2 [oxygen] @ 2L @ NOC [night] PRN if 80% or under." The group sheet incorrectly listed 80%, and not the 88% directed by the physician. During observations on 6/25/18, at 6:06 p.m. R50 was seated in a wheelchair, self propelled himself out of the dining room. A nasal cannula and tubing was observed on R50's face and attached	F 695	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to ensure oxygen therapy was administered according to physician orders for who received routine oxygen therapy. Licensed staff were notified that if residents have an order for Oxygen PRN to keep sats > a specified % they need to document sats on room air. They should be entering in the documentation fields for the orders to document sats on room air. Licensed staff were educated to use the lowest amount of oxygen required to achieve desired saturation levels. All oxygen orders were reviewed for proper documentation. Licensed staff were also informed that if they need to administer oxygen continuous for an extended period of time for Oxygen PRN to keep sats > a specified % they need to update the MD to see if there need to be changes made to oxygen order or residents medication/treatment orders . DON or Designee will audit O2 orders weekly x 4 then monthly thereafter to assure residents are utilizing the least amount of oxygen needed to reach	

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F 695	Continued From page 21 to an oxygen tank on the back of R50's chair, set at 2 liters and turned on During observations on 6/26/18, at 9:34 a.m. R50 was sleeping in bed. An oxygen concentrator was on and set at 2 liters. R50 was receiving oxygen via a nasal cannula on his face. R50's June 2018 Treatment Administration record (TAR) indicated "O2 via NC [nasal cannula] at NOC 2L and PRN ONLY for O2 sats less than 88%." Between 6/1/18 and 6/25/18 R50's oxygen saturation levels ranged between 89% and 95% during the day, 88% to 94% during the evening, and 88% to 93% during the night. The TAR did not identify whether R50 received oxygen during the day or evening shift. R50's Vials Report log between 6/20/18 and 6/26/18 and between the hours of 8 a.m. and 8 p.m. revealed the following: A total of 10 documented oxygen saturations. All above 88%, ranging between 89-94%. All 10 times, documentation identified R50 was receiving 2 Liters of oxygen, although R50's oxygen levels were above 88%. R50's record lacked documentation of the reasons for the continued use of oxygen therapy during the day and evening hours. During an interview on 6/26/18, at 10:12 a.m. family member (FM)-C stated R50 always had oxygen on. During an interview on 6/27/18, at 11:24 a.m. nursing assistant (NA)-B stated R50 was on continuous oxygen at 2 liters. When R50 was in his room, the concentrator was used. When R50 was in his wheelchair an oxygen tank on the back	F 695	oxygen saturation goals. DON or designee will 3x/week observation of all resident receiving oxygen for 2 weeks. If no problems identified with these audits DON or designee will complete weekly audits thereafter. QAPI team had been informed of these audits and will review audits monthly for any problems identified &/or trends and make recommendations as needed.	

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F 695	Continued From page 22	F 695		

of his wheelchair was used. NA-B stated her usual practice was to ensure the oxygen tank in on, full, and R50 was wearing the nasal cannula.

During an interview on 6/27/18, at 1:08 p.m., registered nurse (RN)-B reviewed R50's physician oxygen orders and stated " I will have to ask the nurses on how they interpret that." RN-B stated "I thought he was on it [oxygen] continuously." RN-B went to the nursing station and asked licensed practical nurse (LPN)-B when R50 received oxygen.

LPN-B stated R50 was on continuous oxygen. LPN-B reviewed R50's physician orders upon RN-B's request. LPN-B stated "It does say PRN." LPN-B stated R50's oxygen levels drop when he was off oxygen. LPN-B reviewed R50's documented oxygen saturations and stated there would be no way of knowing if the oxygen was adjusted when R50's saturations were above 88. LPN-B stated she was not aware if the physician had been contacted regarding R50's continuous oxygen use. LPN-B stated the physician should be notified and an order for continuous oxygen obtained. RN-B stated she felt the oxygen order was unclear and should have been clarified with the physician if R50 was requiring oxygen continuously.

During an interview on 6/27/18, at 1:08 p.m. the director of nursing (DON) stated nurses need to follow the physician orders for oxygen. She indicated if an order for continuous oxygen was needed for falling oxygen levels, staff were to notify the physician for direction.

A facility policy related to oxygen administration was requested and not provided.

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F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		7/23/18

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F 758	Continued From page 24 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the duration of use of an as needed (PRN) psychotropic medication was obtained for 1 of 1 residents (R72) reviewed for PRN psychotropic medication use. Findings include: R72's significant change Minimum Data Set (MDS), dated 12/11/17, indicated R72 received antianxiety (psychotropic) medication. R72 required extensive staff assistance for eating, dressing, and personal hygiene. R72's care plan, dated 6/12/18, indicated R72 had a history of becoming weepy and crying. Interventions included to administer medication as ordered, monitor behavior and document, and during periods of weepiness and at bedtime to assist resident with putting on her "Danny O'Donnell CD." R72's current Physician Order Report, dated 5/1/18, identified a 12/4/17 order for Lorazepam (antianxiety/psychotropic) 0.5 mg (milligrams) every 6 hours as needed for anxiety or agitation, with diagnosis of dementia without behavioral disturbance. The order lacked a stop date,	F 758	Despite the facility's objection to the alleged Notice of Violation, the following isproposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will bein substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to assure as needed (PRN) psychotropic medication was reviewed for PRN psychotropic medication use. All staff educated that residents should be free of psychotropic medications unless they are ordered to treat a specific condition diagnosed and documented in their clinical records. And that they do not receive PRN orders for psychotropic drugs that are longer than 14 days duration. Luther Haven staff education included that any psychotropic medication should be the last intervention utilized and that non-pharmacologic interventions to manage conditions should be exhausted before medications are utilized.	

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 _____	06/28/2018

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 758	Continued From page 25 indicating "open ended." A Behavior-Medication Monitoring document, dated 4/10/18, indicated a pharmacist medication review was completed on 4/9/18. Pharmacist monthly drug review comment on psychoactive medication indicated following the initial 14 day period of PRN antianxiety medication use, an explanatory note must be written to continue the PRN order and the duration of the order specified. A physicians Nursing Home Note, dated 5/1/18, indicated pharmacy had concerns with PRN Lorazepam and it's indication for use. The note indicated R72 has approximately one episode a week of uncontrollable crying, in which Lorazepam 0.5 mg was used to relax R72. Diagnosis of End-stage dementia with episodes of uncontrolled anxiety. Recommended to continue the PRN Ativan at 0.5 mg for the comfort of R72. The note lacked a duration for the PRN Lorazepam order. R72's record lacked a physician statement or order for the duration of the PRN Lorazepam. Medication Adminsitration records (MAR) between 5/1/18 and 6/28/18 revealed the following: Between 5/1/18 and 5/31/18, R72 received Lorazepam 0.5 mg related to crying 13 times. Between 6/1/18 and 6/28/18, R72 received Lorazepam 0.5 mg related to crying. 9 times. The MAR's lacked the duration/stop date for the Lorazepam During an interview on 6/27/18, at 11:24 a.m. nursing assistant (NA)-B stated R72 sometimes had crying outbursts. NA-B stated this could	F 758	Luther Haven Standing orders are authorized by all providers at the CCMH clinic including our Medical Director to have a stop date of 14 days for all PRN psychotropic drug orders if no stop date given with the PRN order. DON will complete weekly x 4 PRN psychotropic drug audits and then monthly thereafter to assure compliance. QAPI Team was notified of this deficient practice and will review monthly audits for trends and problems and make recommendations as necessary. Pharmacist review of all resident medications monthly also identify problems. Pharmacist does bring any noted trends by providers to the QAPI team and discusses with the QAPI team which includes the Medical Director quarterly when he attends.	

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F 758	Continued From page 26 occur very quickly. NA-B stated when this occurred she attempted to re-direct the conversation to happy memories, if that did not work NA-B stated she would seek out the nurse. During an interview on 6/27/18, at 1:08 p.m. registered nurse (RN)-B stated R72 has had the Lorazepam order for a "long time" for inconsolable weeping. RN-B indicated she was unsure but thought the facility protocol for PRN orders for Lorazepam was "every 14 days need new order." During an interview on 6/28/18, at 8:40 a.m. the director of nursing (DON) stated a PRN psychotropic medication order would be good for 14 days. DON stated the order to restart the medication, a new order would be needed along with an indication for use. The facility's policy, undated, Medication Monitoring and Management indicated PRN orders need to have an indication for use. "The medication regimen is re-evaluated (periodically/every quarter) to determine whether prolonged or indefinite use of medication is indicated." The policy did not specifically address the duration of a PRN psychotropic medication.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/23/18

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F 761	Continued From page 27 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and 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 implement a system to ensure outdated medications were not available for use in 1 of 2 medications storage rooms (station one), and in 1 of 3 medication carts(Bridge) in the facility. Finding include: During observation on 6/26/18, at 11:03 a.m. Tylenol 500 mg was labeled with an expiration date of 5/20/18. The Tylenol had not been removed from the stock medication cabinet on station one, in the medication storage room. During interview on 6/26/18, at 11:16 a.m. registered nurse (RN)-D stated nursing staff checked medication storage every week, and used a book in the medication cart to sign when	F 761	Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will be in substantial compliance with standardsindicated by 08/07/2018. All staff educated on facility policy that requires weekly audit of medication and med rooms weekly with Nurse Manager audits weekly to assure compliance. All med carts, treatment carts and med rooms were audited on June 30th for expired drugs/biologicals. DON is completing weekly audits X 4 and then entered random audits on Outlook	

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F 761	Continued From page 28 an audit was completed. RN-D stated the audit must have gotten missed. During an observation on 6/28/18, at 8:39 a.m. with trained medication aide (TMA)-A of the Bridge medication cart, the narcotic drawer was found to have eight expired tramadol (narcotic pain medication) 50 mg tablets. The tramadol was labeled with an expiration date of 6/15/18. During an interview on 6/28/18, at 10:48 a.m. TMA-A stated narcotic checks for expired medications should be every Saturday on the evening shift. TMA-A stated nursing should be checking for expiration dates in the medication rooms and medication carts and documenting in a book called, medication cart audit for storage and expired medications. During interview on 6/28/18, at 12:05 p.m. nursing assistant (NA)-A stated expired medications were checked every Saturday evening and the facility had a log book to document expired medications. NA-A stated expired medications also should be checked every time medications were passed to residents. Review of the facility's form titled Med Cart Audit For Storage and Expired Medications form, identified an audit had been completed on 12/16/17, then not again until 3/2/18, then on 3/16/18. Further the form listed the last audit for expired medications had been completed on 5/9/18. During interview on 6/28/18, at 12:05 p.m. registered nurse (RN)-B stated she was unaware of when nurses checked for expired medications and stated she had not audited medications in log	F 761	calendar to be sure random audits occur every 5 weeks at a minimum thereafter. QAPI team was made aware of this deficient practice and will review monthly audits for trends/problems and make recommendations as needed.	

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F 761	Continued From page 29 book for "a while." During interview on 6/28/18, at 12:13 p.m. RN-C stated the Saturday evening shift nurse should be checking for expired medications. RN-C stated there was a red folder to write down expired medications and nursing should sign and date when the audit was completed. RN-C stated the case manager should follow up to see that the audits were completed by the cart nurses and the DON to follow up that case manager was tracking audits. During interview on 6/28/18, at 12:21 p.m. the Director of Nursing (DON) stated expired medications should be looked at every medication pass, and on a weekly audit of medication carts for expired medications, either on Fridays or Saturdays. The DON stated there was a red log book for nursing to fill out, then nurse managers should check it every Monday morning to ensure the audits had been done. The DON stated she herself should do random checks and stated she had not done the random checks in some time. Medication storage policy dated 9/10/17, reads: "licensed staff will audit medication carts weekly on Saturday evening shift and document compliance with dating, storage and expiration of medications. Audit book will be kept at each nursing station in the medication cart and nurse managers will check audit compliance weekly to assure they are being done. Random audits of medication carts/storage will be made by DON or designee".	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/23/18

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F 812	Continued From page 30 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain clean and sanitary air return ceiling screens (make-up air unit screens) to prevent contamination of foods and dishware in the main kitchen of the facility. In addition, the facility failed to ensure resident nutritional supplement drinks in 1 of 1 kitchenette refrigerators (station two kitchenette) refrigerator were dated when opened to prevent use of out dated supplements. Further, the facility failed to maintain 1 of 2 (station 2) water/ice machines to prevent potential contamination of the water and ice for residents in the facility . This deficient practice had the potential to affect all 77 residents who currently resided in the facility. Findings include:	F 812	Despite the facility's objection to the alleged Notice of Violation, the following is proposed as the plan of correction inaccordance with state and federalregulations: the facility alleges that it will be in substantial compliance with standardsindicated by 08/07/2018. Luther Haven failed to maintain clean and sanitary air return ceiling screens (make-up air unit screens) to prevent contamination of foods and dishware in the main kitchen. Luther Haven failed to ensure resident nutritional supplement drinks in kitchenette refrigerators were dated when	

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F 812	Continued From page 31 Make up air unit screens On 6/26/18, at 10:06 a.m. a tour of the main kitchen was completed with the director of dietary services (DS), who verified the following: - Six of the Eight make- up air unit screens in the ceiling, which returned air into the kitchen, had moderate to heavy amounts of a dark gray to black fuzzy substance on them. These unit screens blew air down from the ceiling toward food preparation areas, storage areas for prepared foods, entries of the refrigerator and freezer and areas where clean dishes were stored. The DS confirmed the air blowing through the soiled screens could potentially contaminate the facility residents' dishes and food. The DS indicated the maintenance staff managed the cleaning of the screens. On 6/26/18, at 10:16 a.m. a tour of the main kitchen make-up air unit screens was conducted with the maintenance director. The maintenance director confirmed the screens had a build up of debris on them and needed to be cleaned. Station two Kitchenette On 6/26/18, at 2:44 p.m. a review of the station two kitchenette was conducted with nursing assistant (NA)-A. The following was noted: -The refrigerator was noted to have three sixteen ounce cartons of Hormel plus 2, which were open but had not been labeled with a date when opened. -The water and ice machine was observed to have a white, crusted, hard water lime scale build up under the area where the ice was dispensed	F 812	opened to prevent use of outdated supplements. Further, the facility failed to maintain water/ice machines to prevent potential contamination of the water and ice for residents in the facility. Maintenance replaced the Make up air unit screens in the condition and will change every 6 months per guidelines. Visual check of the make up air unit screens will be added to the Luther Haven Environmental rounds checklist and will be completed every 4 months with the next scheduled rounds to occur by 08/06/18. Visual check of Ice and water machines added to Environmental Rounds checklist to be audited with facility environmental rounds monthly. Policy for environmental rounds is updated to observe vents in kitchen and all facility ice machines with the monthly environmental rounds in addition to that months designated area. Maintenance provided with manufacturer□s guidelines for cleaning schedule of ice and water machine and doing appropriate cleaning. When audits cleaned will turn in a copy to the infection preventionist. Dietary will do weekly checks of kitchenette refrigerators weekly x 4 then	

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F 812	Continued From page 32 from the machine. The area where the water was dispensed also had a white, crusted, hard water lime scale build up and the water spigot had a build up of tan colored stalactites which surrounded the edge of the spigot which dispensed water. The runoff collection tray had a thin layer of white lime scale on it. The grates on the collection tray also had areas with a heavier build up of white lime scale. On 6/26/18, at 2:49 p.m. registered nurse (RN)-A verified the station two kitchenette refrigerator contained three sixteen ounce cartons of Hormel plus 2, which had been opened but not dated. RN-A confirmed the undated open nutritional supplement containers in the fridge could potentially be used after the desired use date. On 0/26/18, at 3:00 p.m. the DS and the dietary manager (DM) confirmed the above findings and indicated the service manual would be reviewed with staff. On 6/28/18, at 8:13 a.m. the director of nursing (DON) stated she expected the kitchen to be maintained in a clean and sanitary manor, opened food items to be labeled with a dated when opened in order to ensure they are disposed of with in three days. The DON stated the water and ice machine should be cleaned on a routine schedule. The DON indicated the above findings these could cause contamination of residents' food and drink. The facility policy with a subject title, Open containers in Kitchenette refrigerators reviewed 2/1/15, identified, "When multi serving containers requiring refrigeration are opened they will be dated to prevent expired/contaminated	F 812	randomly thereafter. And turn in to Infection Preventionist. Infection Preventionist of Designee will track compliance with audits. Infection Preventionist will make monthly inspections of the vents in the kitchen and all ice machines in the facility to assure problems do not reoccur and do not develop in other areas of the facility than those noted in this tag. QAPI team informed of this deficient practice and will audit for trends & problems and make recommendations as needed.	

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F 812	Continued From page 33 foods/liquids. They will disposed of after 3 days". The facility policy titled Cleaning Instructions: Ice Machine and Equipment, dated 5/22/2017, Ice machines and equipment will be cleaned and sanitized on a regular basis. Follow manufacturer's cleaning and sanitizing instructions if available. The facility provided Symphony Plus 12 Series Ice and Water Dispensers, manufacturers Operation and Service Manual dated 4/17, identified the following: Periodic cleaning/de-scaling and sanitizing of Follett's ice and water dispenser and ice machine system is required to ensure peak performance and delivery of clean, sanitary ice. The recommended cleaning procedures should be performed at least as frequently as recommended and more often if environmental conditions dictate. Recommended cleaning/de-scaling and sanitizing intervals: -Drain line, weekly. -Exterior, as needed. -Dispenser and components, semi-annually -Transport tube, semi-annually	F 812		

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	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2018**

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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 June 27, 2018. At the time of this survey, Luther Haven was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/23/2018

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		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and
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

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K 000	Continued From page 2 fire alarm system that is monitored for automatic fire department notification. The facility has a capacity of 91 beds and had a census of 82 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect all residents.	K 353	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 standards indicated by 08/07/2018.	7/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/27/2018**

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
K 353	Continued From page 3 FINDINGS INCLUDE: On facility tour between 9:30 AM and 12:30 PM on 6/27/2018, during documentation review it was revealed that documentation could not be provided to indicate that the quarterly fire sprinkler inspection had taken place in 2017 and 2018. This deficient practice was verified by the Facility Maintenance Director.	K 353	No residents were affected by this alleged deficient practice when facility failed to maintain the automatic sprinkler system in accordance with NFPA25, 9.7.5, 9.7.7, 9.7.8. Specifically failing to provide documentation that the quarterly fire sprinkler inspection had taken place. The quarterly inspection will include inspection of the flow switches to assure proper operation and audio and visual alarms activate when the valve is open allowing water flow through the switched flow valve. The remote alarm company monitoring our fire and sprinkler systems will be notified prior to and following testing. Documentation of quarterly testing/inspection will be maintained in the fire book. The secure location is the business office which is readily available. Compliance with this standard will be August 7, 2018. The maintenance Director and Administrator will be responsible to assure compliance with the standard.	