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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KLHQ

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 **6/5/2019** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
X 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 :
Nicole Osterloh, Supervisor 6/7/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 6/7/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245259

June 7, 2019

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Dear Administrator:

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

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

Effective June 5, 2019 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 7, 2019

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Project Number S5259027

Dear Administrator:

On June 5, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 20, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KLHQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00062

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(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 **04/05/2019** (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

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From (a) :
To (b) :

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13.Total Certified Beds **90** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
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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 :
Lois Boerboom, HFE NE II 05/07/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/04/2019 (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)

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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
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 25, 2019

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

RE: Project Numbers S5259027, H5259015

Dear Administrator:

On April 5, 2019, 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the April 5, 2019 standard survey, the Minnesota Department of Health, completed an investigation of complaint number H5259015 that was found to be unsubstantiated.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is May 15, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

- 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 (488.456(b)).

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:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 July 5, 2019 (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).

In addition, if substantial compliance with the regulations is not verified by October 5, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 04/05/2019

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/1/19 through 4/5/19, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00062	A. BUILDING: _____ B. WING _____	C 04/05/2019

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) COMPLETE DATE
2 000	Continued From page 1 In addition, a complaint investigation(s) was/were also completed at the time of the licensing survey. The following complaint (s) was/were found to be UNSUBSTANTIATED: H5259015 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have an infection control program that had an ongoing analysis of surveillance data, and use of evidence based surveillance criteria to define infections. This had the potential to affect all 78 residents in the facility. The facility also failed to ensure appropriate hand hygiene while caring for 2 of 2 residents (R51 and R12) observed for incontinence care. Findings include: INFECTION PREVENTION During an interview on 4/4/19, at 8:10 a.m. the	21375	See F880	5/15/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21375	Continued From page 2 director of nursing (DON) who was identified as infection preventionist, indicated she used the monthly infection control log looking for trends and patterns of infections and the McGeer's was used to monitor and provide evidence based criteria to define infections. The monthly infection control logs were reviewed from April 2018 to March 2019. The infection control log included residents name, admit date, type, body site. Under header of infection type, body site, symptoms and date of onset were listed. Under the header of culture, the date taken, organism and antibiotic resistant was listed. Under the header of antibiotic, type, start date, pre-admit, healthcare acquired infections, and ordered by was listed. The last two columns included date resolved and isolated. The monthly infection control log was missing symptoms on 17 of 148 reviewed. Date of onset was missing information on 12 out of 148 reviewed. Date resolved was missing on 25 out of 148 reviewed. On the top of the monthly infection control log, total # of infections, # of health care acquired infections, prophylactic antibiotic treatment and types of infection were listed. Seven of thirty-four were completed. During an interview on 4/04/19, at 2:22 p.m. registered nurse (RN)-E indicated the only criteria she was aware of for infections was one for urinary tract infections titled "Symptom free pee, let it be". RN-E further indicated they keep a log on each unit where they document new onset of respiratory or gastrointestinal (GI) symptoms that include date and shift of onset of symptoms, symptoms present, temperature, MD updated and new orders if received. RN-E indicated she was not aware of use of the McGeer criteria.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LUTHER HAVEN	1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 3	21375		

During an interview on 4/04/19, at 2:24 p.m. RN-D indicated they have a sign they use for urinary tract infection for when to collect a urine specimen that included symptoms. RN-D indicated for GI or respiratory issues, they document signs and symptom on a tracking form that was turned into the DON at the end of each month.

During an interview on 4/04/19, at 2:30 p.m. the DON indicated she did not know how the McGeer's criteria fit into their infection program. The DON further indicated she thought she had sent an e-mail with the criteria to staff. A copy of the e-mail was requested and was not received. The DON indicated the logs that staff complete should be shredded when they are done with them and she did not review them. The DON stated she tried to keep up with the monthly infection control log, but a lot of the infections are diagnosed at the hospital and she doesn't always have all the information she needed. The DON indicated it was up to the nursing staff on the floor to call for further information such as culture results or signs and symptoms.

A Luther Haven Infection Control Program dated 8/25/17, included the implementation of evidence based infection control practices including those mandated by regulatory and licensing agencies.

R51's quarterly Minimum Data Set (MDS) assessment dated 2/20/19 indicated R51 required extensive assistance with toileting, personal hygiene and was always incontinent of bladder.

R51's care plan indicated R51 required one staff to assist R51 to toilet every 2 to 3 hours while awake with staff needing to provide peri cares after each incontinent episode.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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) COMPLETE DATE
21375	Continued From page 4 On 4/3/19, at 8:48 a.m. nursing assistant (NA)-H was observed to assist R51 into bathroom where she donned her gloves and cued R51 to lock her breaks and grab the bar next to the toilet to stand as NA-H removes R51 pants and soiled incontinent product before R51 sits down on toilet. NA-H then hands R51 a Kleenex with her gloves still on and asks R51 if she needs to blow her nose. NA-H obtains a clean incontinent product and sat it on the wheelchair, obtained wet wipe and had R51 stand to clean her peri area. NA-H continued by placing a clean incontinent product on R51, pulled up her pants, flushed the toilet and removed her gloves. NA-H washed her hands, emptied the garbage, and assisted R51 out of the bathroom. On 4/3/19, at 9:00 a.m., NA-H indicated they do have yearly infection control training and competencies. NA-H stated the last time they ever went over training related to changing gloves after removing dirty incontinent product would of been years ago and verified she should have changed her gloves before placing a clean product on or doing anything else. On 4/4/19, at 2:51 p.m. the director of nursing (DON) stated she expected staff to change gloves after removing a dirty incontinent product and providing incontinent care before placing clean incontinent product on a resident. R12 was observed during personal cares on 4/03/19, at 9:28 a.m. nursing assistant (NA)-F assisted R12 to the toilet with a sit to stand lift. When R12 was finished using the toilet NA-F wiped the front area of her bottom using upward strokes with a wet wipe, and then cleansed her bottom area with a washcloth-using front to back	21375		

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	00062	A. BUILDING: _____ B. WING _____	C 04/05/2019

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21375	Continued From page 5	21375		

technique. NA-F removed her gloves, applied clean brief, pulled up R12's pants and transferred her to the wheelchair. Without washing hands, NA-F donned clean gloves, washed R12's under arms and cleansed under her breasts. NA-F assisted R12 to don her shirt, applied footrests to the wheelchair and combed her hair. NA-F placed R12's call light within reach, emptied the trash, exited the room and opened the soiled utility room door. NA-F placed soiled clothing in bag, disposed of trash, and washed her hands.

On 4/3/19 at 9:54 a.m. NA-F stated staff wash their hands before and after donning gloves, and after direct contact with residents.

Luther Haven Infection Control Policy dated 8/25/17, indicated the policy exists to assure a safe, sanitary and comfortable environment designed to help prevent the development and transmission of infection. The policy indicated staff will use the most appropriate hand hygiene professional practices to prevent transmission and infection through various points of entry including incontinent care. The policy also indicated staff will receive training to identify the most common symptoms of infection and protocols to prevent the spread of infections.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and that policies are appropriately implemented. The

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21375	Continued From page 6 DON could inservice staff regarding proper infection control measures are implemented. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. In addition, the director of nursing (DON) or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		5/15/19

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21426	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to appropriately screen 4 of 6 newly admitted residents (R41, R58, R40, R77) for symptoms of tuberculosis (TB) and failed to ensure 1 (R41) of 6 residents (R45, R58, R2, R40, R77) received a two-step tuberculin skin test (TST) to prevent the risk of spread of tuberculosis. Findings include: R41 was admitted to the facility 3/15/17. A review of the TB test results identified no two step tuberculin skin test (TST) was completed. No symptom screen was found in the medical record. R58 was admitted to the facility 3/2/18. A review of the TB test results identified R58 had a chest x-ray on admission date. A symptom screening was found in the medical record but lacked date of completion. R40 was admitted to the facility 9/7/16. A review of the TB test results identified a two step TST was completed 9/7/16 and 9/21/16. A symptom screening was found in the medical record but lacked date of completion. R77 was admitted to the facility 3/14/18. A review of the TB test results identified a two step TST was completed 3/14/18 and 3/28/18. A symptom screening was found in the medical record but lacked date of completion. When interviewed on 4/4/19, at 08:03 a.m., the director of nursing (DON) verified that dates were	21426	See F880	

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21426	Continued From page 8 missing on tuberculosis screening forms and indicated "they should be dated". Requested copy of R41's screen and mantoux results from the DON who indicated it isn't in R41's medical record and they do not know where it is. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the TB screening process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure in-use multi-dose vials of tuberculin skin test (TST) solution and in-use medication, stored in stored in 1 of 2 medication storage rooms and 1 of 3 medication carts, were labeled according to manufacturer's guidelines upon use. Findings include: During an observation of the Unit 2 medication room refrigerator on 4/4/19, at 8:55 a.m. with	21620	See F761	5/15/19

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21620	Continued From page 9	21620		

registered nurse (RN)-A, had one vial of TST solution with an opened date of 11/30/(no year), and three opened vials of TST solution did not identify an date the vials were opened. The vials were stored together and had solution remaining in the vials.
(1) Vial number 1's manufacturer's expiration date was 10/29/20, and was labeled with an opened date 11/30 (no year).
(2) Vial 2's manufacturer's expiration date was 10/29/20, and had no opened date.
(3) Vial 3's manufacturer's expiration date was 10/29/20, and had no opened-on or used-by date.
(4) Vial 4's manufacturer's expiration date was 4/8/21, and had no opened date or use-by date.

Interview on 4/4/19, at 9:00 a.m., with RN-A identified vial 1 had an opened date 11/30/(no year), and vials 2, 3, and 4 had no use-by dates. RN-A was unable to verify when the vials were opened. TST solution was good for 30 days after opened.

The facility's Baseline TB Screening Tool for Patients and the Baseline TB Screening Tool for Healthcare Workers (HCWs) identified the following residents and employees had received tuberculin skin tests from vials 1, 2, or 3 with number with an manufacturer's expiration date of 10/29/20, but no used-by date after it had been opened. R10 on 1/10/19, R59 on 3/15/19, R78 on 2/27/19, R80 on 1/3/19, R378 on 4/3/19, R379 on 3/28/19, RN-B on 12/18/18 and 1/5/19, nursing assistant (NA)-A on 2/26/19, NA-B on 2/25/19, and NA-D on 1/15/19.

The Facility's Baseline TB Screening Tool For Patients and Healthcare Workers (HCWs) identified the following residents and employees received TSTs from vial 4: R65 on 3/6/19 and

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21620	Continued From page 10 3/19/19, R68 on 3/12/19, R76 on 3/19/19, NA-A on 3/25/19, NA-D on 3/19/19 and 3/28/19, NA-E on 3/20/19, and NA-F on 3/25/19. During an observation of the Unit 2 medication cart on 4/04/19 at 9:06 a.m. RN-A identified a bottle of calcitonin belonging to R51. RN-A identified the pharmacy filled the medication on 12/14/18. The bottle was sent to the facility with her when she returned following a hospital stay on 12/15/18. The bottle had no opened date and was currently in use. The packaging indicated the medication was good for 35 days after opening. RN-A was unable to identify when the bottle was opened. Interview and document review on 4/4/19 at 9:25 a.m. with RN-A identified R51's calcitonin was stored in the upper drawer of the medication cart and was lying on its side. RN-A verified the calcitonin was in use and had no opened date. The bottle had a pharmacy fill date of 12/14/18, and was received by the facility without an opened date on 12/15/18, after R51 returned from a hospital stay. The bottle's manufacturer packaging identified the medication was good for 35 days after opening and should be stored in an upright position. Review of the Medication Expiration Date pharmacy list identified calcitonin was good for 35 days after opening. On 4/04/19, at 10:52 a.m. nurse manager (RN)-C verified TST solution was good for 30 days after the vial was in-use. RN-C stated she assumed medications were used until the manufacturer date on the container, was unaware of storage recommendations for calcitonin, and thought the pharmacist had directed to use medications until the manufacturer's expiration date on the bottle.	21620		

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21620	Continued From page 11 On 4/4/19, at 12:21 p.m. the director of nursing (DON) expected multi-use medications be dated when opened. Nurses and trained medication aides (TMA)s were expected to look for expired medication dates when dispensing medications, and when expired, remove and reorder medications. Medication should not be used after the opened date expiration and expired medications were expected to be placed in the destruction bin to be destroyed by designated staff. Medication rooms and medication carts have green reference sheets with expiration times for medications used to identify medication opened-date expiration times. Medications should be stored according to the manufacturer's recommendations. The Medication Storage Policy dated 8/13/16, indicated no discontinued, outdated, or deteriorated medications were to be available for use in this facility. All such medications were to be destroyed. Review of Tuberculin Purified Protein Derivitive (Mantoux) Tubersol manufacturer sheet indicated a vial of Tubersol, which was entered, and in-use for 30 days should be discarded and not used. Review of Calcitonin manufacturer package insert indicated to store the bottle in an upright position for up to 35 days. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure medications are dated when opened. The director of nursing could educate nursing staff. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21620		

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21620	Continued From page 12 (21) days.	21620		

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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 . 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 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/03/2019

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 St Paul, MN 55101-5145, or By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Luther Haven is a 1-story building with partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1974, an addition was added that was determined to be of Type II(000) construction. The most recent addition was constructed in 1992 and was determined to be of Type II(000) construction. Because the original building and the two additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system that is monitored for automatic fire department notification. The facility has a capacity of 90 beds and had a census of 78 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to maintain the cooking equipment, as stated in the Life Safety Code (NFPA 101) 2012 edition section 9.2.3 & NFPA 96 section 11.2. This deficient practice could allow for the spread of fire if the hood suppression system did not operate properly, affecting an undetermined amount of staff and visitors.	K 324	K324 Cooking Facilities The hydro inspection was completed on April 17, 2019 by Summit Companies. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	5/15/19

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K 324	Continued From page 3 Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 documentation review revealed the kitchen hood extinguishing system was due for a hydro inspection and there was no record of completion. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 324		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames	K 363		5/15/19

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

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K 363	Continued From page 4 shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide one corridor door with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 16 of the 90 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 observations revealed the door to resident room 181 could not resist the passage of smoke and did not properly latch. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 363	K363 Corridor Doors The corridor door will be fixed and door frame seal will be added to ensure the door closes and resists the passage of smoke. Quarterly audits will be completed. Those results will be brought to QAPI. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101	K 711		5/15/19

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	245259	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2019**

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

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K 711	Continued From page 5 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 90 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 documentation review revealed the fire safety plan did not address all 9 items listed in NFPA 101. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 711	K711 Evacuation and Relocation Plan The fire safety plan was reviewed and updated on April 8, 2019 to include all nine areas of the plan. The plan will be reviewed annually. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101	K 901		5/15/19

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K 901	Continued From page 6 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentaton review and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all residents, as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 documentation review revealed there was no risk assessment available at the time of inspection. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 901	K901 Fundamentals-Building System Categories The risk assessment was reviewed and updated on April 15, 2019. The risk assessment will be reviewed annually. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	
K 911 SS=F	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99	K 911		5/15/19

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K 911	Continued From page 7 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain electrical equipment in accordance with NFPA 101, the Life Safety Code (12) section 9.1.2 and NFPA 70 (11) The National Electrical Code, section 408.38. This deficient practice could allow for unauthorized access to electrical circuits, affecting an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 observations revealed the electrical panels in the corridors were accessible to unauthorized persons and not locked. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 911	K911 Electrical Systems-Other The electrical panels had locks installed on them on April 10, 2019. Quarterly audits will be completed to ensure the panels are locked. Those results will be brought to QAPI. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity	K 920		5/15/19

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K 920	Continued From page 8 may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect an undetermined amount of residents, staff and visitors. Findings include: On the facility tour between 8:00 am to 12:30 pm on 04/02/2019 observations revealed; 1. Medical equipment connected to power taps not listed for that use in resident rooms 174 and 153. 2. An unlisted power tap in use in resident room 162. This deficient condition was confirmed by the facility Administrator and the Director of Maintenance.	K 920	K920 Electrical Equipment- Power Cords and Extens The unlisted power tap was removed on April 2, 2019. The medical equipment connected to the power taps were switched to a wall outlet on April 2, 2019. The facility has created tags for the medical equipment to remind staff not to plug electrical equipment into a power tap. Quarterly audits will be completed to ensure medical equipment is plugged into a wall outlet. Results will be brought to QAPI. The maintenance director will be responsible for this correction and will monitor to prevent a reoccurrence of the deficiency.	

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Electronically delivered
April 25, 2019

Administrator
Luther Haven
1109 East Highway 7
Montevideo, MN 56265

Re: State Nursing Home Licensing Orders - Project Number S5259027, H5259015

Dear Administrator:

The above facility was surveyed on April 1, 2019 through April 5, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5259015 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
1400 East Lyon Street, Suite 102
Marshall, MN 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

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	00062	A. BUILDING: _____ B. WING _____	04/05/2019

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/1/19 through 4/5/19, a survey was conducted to determine compliance for state licensure. The following correction orders are issued. Please indicate your electronic plan of correction that you have reviewed these order, and identify the date when they will be corrected.	2 000		

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2 000	Continued From page 1 In addition, a complaint investigation(s) was/were also completed at the time of the licensing survey. The following complaint (s) was/were found to be UNSUBSTANTIATED: H5259015 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to have an infection control program that had an ongoing analysis of surveillance data, and use of evidence based surveillance criteria to define infections. This had the potential to affect all 78 residents in the facility. The facility also failed to ensure appropriate hand hygiene while caring for 2 of 2 residents (R51 and R12) observed for incontinence care. Findings include: INFECTION PREVENTION During an interview on 4/4/19, at 8:10 a.m. the	21375	See F880	5/15/19

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director of nursing (DON) who was identified as infection preventionist, indicated she used the monthly infection control log looking for trends and patterns of infections and the McGeer's was used to monitor and provide evidence based criteria to define infections.

The monthly infection control logs were reviewed from April 2018 to March 2019. The infection control log included residents name, admit date, type, body site. Under header of infection type, body site, symptoms and date of onset were listed. Under the header of culture, the date taken, organism and antibiotic resistant was listed. Under the header of antibiotic, type, start date, pre-admit, healthcare acquired infections, and ordered by was listed. The last two columns included date resolved and isolated. The monthly infection control log was missing symptoms on 17 of 148 reviewed. Date of onset was missing information on 12 out of 148 reviewed. Date resolved was missing on 25 out of 148 reviewed. On the top of the monthly infection control log, total # of infections, # of health care acquired infections, prophylactic antibiotic treatment and types of infection were listed. Seven of thirty-four were completed.

During an interview on 4/04/19, at 2:22 p.m. registered nurse (RN)-E indicated the only criteria she was aware of for infections was one for urinary tract infections titled "Symptom free pee, let it be". RN-E further indicated they keep a log on each unit where they document new onset of respiratory or gastrointestinal (GI) symptoms that include date and shift of onset of symptoms, symptoms present, temperature, MD updated and new orders if received. RN-E indicated she was not aware of use of the McGeer criteria.

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During an interview on 4/04/19, at 2:24 p.m. RN-D indicated they have a sign they use for urinary tract infection for when to collect a urine specimen that included symptoms. RN-D indicated for GI or respiratory issues, they document signs and symptom on a tracking form that was turned into the DON at the end of each month.

During an interview on 4/04/19, at 2:30 p.m. the DON indicated she did not know how the McGeer's criteria fit into their infection program. The DON further indicated she thought she had sent an e-mail with the criteria to staff. A copy of the e-mail was requested and was not received. The DON indicated the logs that staff complete should be shredded when they are done with them and she did not review them. The DON stated she tried to keep up with the monthly infection control log, but a lot of the infections are diagnosed at the hospital and she doesn't always have all the information she needed. The DON indicated it was up to the nursing staff on the floor to call for further information such as culture results or signs and symptoms.

A Luther Haven Infection Control Program dated 8/25/17, included the implementation of evidence based infection control practices including those mandated by regulatory and licensing agencies.

R51's quarterly Minimum Data Set (MDS) assessment dated 2/20/19 indicated R51 required extensive assistance with toileting, personal hygiene and was always incontinent of bladder.

R51's care plan indicated R51 required one staff to assist R51 to toilet every 2 to 3 hours while awake with staff needing to provide peri cares after each incontinent episode.

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21375	Continued From page 4 On 4/3/19, at 8:48 a.m. nursing assistant (NA)-H was observed to assist R51 into bathroom where she donned her gloves and cued R51 to lock her breaks and grab the bar next to the toilet to stand as NA-H removes R51 pants and soiled incontinent product before R51 sits down on toilet. NA-H then hands R51 a Kleenex with her gloves still on and asks R51 if she needs to blow her nose. NA-H obtains a clean incontinent product and sat it on the wheelchair, obtained wet wipe and had R51 stand to clean her peri area. NA-H continued by placing a clean incontinent product on R51, pulled up her pants, flushed the toilet and removed her gloves. NA-H washed her hands, emptied the garbage, and assisted R51 out of the bathroom. On 4/3/19, at 9:00 a.m., NA-H indicated they do have yearly infection control training and competencies. NA-H stated the last time they ever went over training related to changing gloves after removing dirty incontinent product would of been years ago and verified she should have changed her gloves before placing a clean product on or doing anything else. On 4/4/19, at 2:51 p.m. the director of nursing (DON) stated she expected staff to change gloves after removing a dirty incontinent product and providing incontinent care before placing clean incontinent product on a resident. R12 was observed during personal cares on 4/03/19, at 9:28 a.m. nursing assistant (NA)-F assisted R12 to the toilet with a sit to stand lift. When R12 was finished using the toilet NA-F wiped the front area of her bottom using upward strokes with a wet wipe, and then cleansed her bottom area with a washcloth-using front to back	21375		

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technique. NA-F removed her gloves, applied clean brief, pulled up R12's pants and transferred her to the wheelchair. Without washing hands, NA-F donned clean gloves, washed R12's under arms and cleansed under her breasts. NA-F assisted R12 to don her shirt, applied footrests to the wheelchair and combed her hair. NA-F placed R12's call light within reach, emptied the trash, exited the room and opened the soiled utility room door. NA-F placed soiled clothing in bag, disposed of trash, and washed her hands.

On 4/3/19 at 9:54 a.m. NA-F stated staff wash their hands before and after donning gloves, and after direct contact with residents.

Luther Haven Infection Control Policy dated 8/25/17, indicated the policy exists to assure a safe, sanitary and comfortable environment designed to help prevent the development and transmission of infection. The policy indicated staff will use the most appropriate hand hygiene professional practices to prevent transmission and infection through various points of entry including incontinent care. The policy also indicated staff will receive training to identify the most common symptoms of infection and protocols to prevent the spread of infections.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could review applicable policies and procedures to ensure the comprehensive infection control (IC) program contains on-going analysis of collected data to prevent potential spread of illness and that policies are appropriately implemented. The

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(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) COMPLETE DATE
21375	Continued From page 6 DON could inservice staff regarding proper infection control measures are implemented. The DON or designee could implement audits to ensure ongoing compliance and report those results to the quality assurance group. In addition, the director of nursing (DON) or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		5/15/19

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	00062	A. BUILDING: _____ B. WING _____	04/05/2019

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21426	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to appropriately screen 4 of 6 newly admitted residents (R41, R58, R40, R77) for symptoms of tuberculosis (TB) and failed to ensure 1 (R41) of 6 residents (R45, R58, R2, R40, R77) received a two-step tuberculin skin test (TST) to prevent the risk of spread of tuberculosis. Findings include: R41 was admitted to the facility 3/15/17. A review of the TB test results identified no two step tuberculin skin test (TST) was completed. No symptom screen was found in the medical record. R58 was admitted to the facility 3/2/18. A review of the TB test results identified R58 had a chest x-ray on admission date. A symptom screening was found in the medical record but lacked date of completion. R40 was admitted to the facility 9/7/16. A review of the TB test results identified a two step TST was completed 9/7/16 and 9/21/16. A symptom screening was found in the medical record but lacked date of completion. R77 was admitted to the facility 3/14/18. A review of the TB test results identified a two step TST was completed 3/14/18 and 3/28/18. A symptom screening was found in the medical record but lacked date of completion. When interviewed on 4/4/19, at 08:03 a.m., the director of nursing (DON) verified that dates were	21426	See F880	

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21426	Continued From page 8 missing on tuberculosis screening forms and indicated "they should be dated". Requested copy of R41's screen and mantoux results from the DON who indicated it isn't in R41's medical record and they do not know where it is. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and the TB screening process. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure in-use multi-dose vials of tuberculin skin test (TST) solution and in-use medication, stored in stored in 1 of 2 medication storage rooms and 1 of 3 medication carts, were labeled according to manufacturer's guidelines upon use. Findings include: During an observation of the Unit 2 medication room refrigerator on 4/4/19, at 8:55 a.m. with	21620	See F761	5/15/19

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21620	Continued From page 9	21620		

registered nurse (RN)-A, had one vial of TST solution with an opened date of 11/30/(no year), and three opened vials of TST solution did not identify an date the vials were opened. The vials were stored together and had solution remaining in the vials.
(1) Vial number 1's manufacturer's expiration date was 10/29/20, and was labeled with an opened date 11/30 (no year).
(2) Vial 2's manufacturer's expiration date was 10/29/20, and had no opened date.
(3) Vial 3's manufacturer's expiration date was 10/29/20, and had no opened-on or used-by date.
(4) Vial 4's manufacturer's expiration date was 4/8/21, and had no opened date or use-by date.

Interview on 4/4/19, at 9:00 a.m., with RN-A identified vial 1 had an opened date 11/30/(no year), and vials 2, 3, and 4 had no use-by dates. RN-A was unable to verify when the vials were opened. TST solution was good for 30 days after opened.

The facility's Baseline TB Screening Tool for Patients and the Baseline TB Screening Tool for Healthcare Workers (HCWs) identified the following residents and employees had received tuberculin skin tests from vials 1, 2, or 3 with number with an manufacturer's expiration date of 10/29/20, but no used-by date after it had been opened. R10 on 1/10/19, R59 on 3/15/19, R78 on 2/27/19, R80 on 1/3/19, R378 on 4/3/19, R379 on 3/28/19, RN-B on 12/18/18 and 1/5/19, nursing assistant (NA)-A on 2/26/19, NA-B on 2/25/19, and NA-D on 1/15/19.

The Facility's Baseline TB Screening Tool For Patients and Healthcare Workers (HCWs) identified the following residents and employees received TSTs from vial 4: R65 on 3/6/19 and

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21620	Continued From page 10 3/19/19, R68 on 3/12/19, R76 on 3/19/19, NA-A on 3/25/19, NA-D on 3/19/19 and 3/28/19, NA-E on 3/20/19, and NA-F on 3/25/19. During an observation of the Unit 2 medication cart on 4/04/19 at 9:06 a.m. RN-A identified a bottle of calcitonin belonging to R51. RN-A identified the pharmacy filled the medication on 12/14/18. The bottle was sent to the facility with her when she returned following a hospital stay on 12/15/18. The bottle had no opened date and was currently in use. The packaging indicated the medication was good for 35 days after opening. RN-A was unable to identify when the bottle was opened. Interview and document review on 4/4/19 at 9:25 a.m. with RN-A identified R51's calcitonin was stored in the upper drawer of the medication cart and was lying on its side. RN-A verified the calcitonin was in use and had no opened date. The bottle had a pharmacy fill date of 12/14/18, and was received by the facility without an opened date on 12/15/18, after R51 returned from a hospital stay. The bottle's manufacturer packaging identified the medication was good for 35 days after opening and should be stored in an upright position. Review of the Medication Expiration Date pharmacy list identified calcitonin was good for 35 days after opening. On 4/04/19, at 10:52 a.m. nurse manager (RN)-C verified TST solution was good for 30 days after the vial was in-use. RN-C stated she assumed medications were used until the manufacturer date on the container, was unaware of storage recommendations for calcitonin, and thought the pharmacist had directed to use medications until the manufacturer's expiration date on the bottle.	21620		

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21620	Continued From page 11 On 4/4/19, at 12:21 p.m. the director of nursing (DON) expected multi-use medications be dated when opened. Nurses and trained medication aides (TMA)s were expected to look for expired medication dates when dispensing medications, and when expired, remove and reorder medications. Medication should not be used after the opened date expiration and expired medications were expected to be placed in the destruction bin to be destroyed by designated staff. Medication rooms and medication carts have green reference sheets with expiration times for medications used to identify medication opened-date expiration times. Medications should be stored according to the manufacturer's recommendations. The Medication Storage Policy dated 8/13/16, indicated no discontinued, outdated, or deteriorated medications were to be available for use in this facility. All such medications were to be destroyed. Review of Tuberculin Purified Protein Derivitive (Mantoux) Tubersol manufacturer sheet indicated a vial of Tubersol, which was entered, and in-use for 30 days should be discarded and not used. Review of Calcitonin manufacturer package insert indicated to store the bottle in an upright position for up to 35 days. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure medications are dated when opened. The director of nursing could educate nursing staff. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21620		

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21620	Continued From page 12 (21) days.	21620		