DEPARTMENT OF HEALTH AND HUM	AN SERVICES	CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	CARE/MEDICAID CERTIFICATION		ID: KLHQ
PART I	- TO BE COMPLETED BY THE ST	ATE SURVEY AGENCY	Facility ID: 00062
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245259 	3. NAME AND ADDRESS OF FACILITY (L3) LUTHER HAVEN		4. TYPE OF ACTION: $\underline{7}$ (L8)
2.STATE VENDOR OR MEDICAID NO.	(L4) 1109 EAST HIGHWAY 7		1. Initial2. Recertification3. Termination4. CHOW
(L2) 677040100	(L5) MONTEVIDEO, MN	(L6) 56265	5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY	<u>02</u> (L7)	8. Full Survey After Complaint
(L9)	01 Hospital 05 HHA 09 ESR	D 13 PTIP 22 CLIA	
6. DATE OF SURVEY 6/5/2019 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/		12/31
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OPT/SP 12 RHC	C 16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:		
From (a):	A. In Compliance With		The Following Requirements:
To (b):	X Program Requirements Compliance Based On:	2. Technical Personnel	
	*	3. 24 Hour RN	7. Medical Director
12.Total Facility Beds 90 (L18)	1. Acceptable POC	4. 7-Day RN (Rural SN	, <u> </u>
13. Total Certified Beds 90 (L17)	B. Not in Compliance with Program	5. Life Safety Code	9. Beds/Room
	Requirements and/or Applied Waivers:	* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF	ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
90			
(L37) (L38) (L39)	(L42) (L43)		
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:
Nicole Osterloh, Supervisor	6/7/2019 (L19)		(L20)
PART II - TO BE	COMPLETED BY HCFA REGION	AL OFFICE OR SINGLE S	STATE AGENCY
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL RIGHTS ACT:		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to Participate	Rombher.	3. Both of the Above	
2. Facility is not Eligible (L21)			
22. ORIGINAL DATE 23. LTC AGRE	EMENT 24. LTC AGREEMENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION BEGINNIN	IG DATE ENDING DATE	VOLUNTARY 00	INVOLUNTARY
01/01/1975		01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburs	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNA	TIVE SANCTIONS	03-Risk of Involuntary Terminatio	on <u>OTHER</u>
A. Suspensi	on of Admissions:	04-Other Reason for Withdrawal	07-Provider Status Change
(L27) B. Rescind	(L44) Suspension Date:		00-Active
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	03001		
(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE		
(L32)	(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improvingthe 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,

Kumala Fiske Downing

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



Protecting, Maintaining and Improvingthe 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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPARTMENT OF HEALTH A	ND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDI	CAID SERVICES
	MEDIC	ARE/MEDICAI	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: KLHQ
	PART I -	TO BE COMP	LETED BY I	THE STAT	FE SURVEY AGENCY		Facility ID: 00062
 MEDICARE/MEDICAID PROVIDER N (L1) 245259 STATE VENDOR OR MEDICAID NO. (L2) 677040100 	Ο.	3. NAME AND AI (L3) LUTHER H (L4) 1109 EAST (L5) MONTEVII	IAVEN HIGHWAY 7	CILITY	(L6) 56265	 TYPE OF ACTINE Initial Termination Validation 	DN: <u>2</u> (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN	EDCUID		,	ODV	<u>02</u> (L7)	7. On-Site Visit	9. Other
(L9) 6. DATE OF SURVEY 04/05/201		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	<u> </u>	8. Full Survey Afte	er Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC		FISCAL YEAR END 12/31	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	Y IS CERTIFIED	AS:			
From (a): To (b):			ance With equirements e Based On:		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN	e 1	ervices Limit
12.Total Facility Beds	90 (L18)	1. A	acceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	NF) 8. Patient Roo 9. Beds/Room	
13.Total Certified Beds	90 (L17)	X B. Not in Cor Requirements	npliance with Prog and/or Applied V	-	* Code: B *	(L12)	1
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS		
18 SNF 18/19 SNF 90	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
17. SURVEYOR SIGNATURE	NE II	Date :)5/07/2019	_(L19) K	18. STATE SURVEY AGENCY (amala Fiske-Downing, E		Date: <u>alist</u> 06/04/2019 (L20
PART	II - TO BE	COMPLETED	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	TATE AGENCY	
 19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partic 2. Facility is not Eligible 	ipate (L21)		APLIANCE WITH HTS ACT:	H CIVIL	 Statement of Finan Ownership/Control Both of the Above 	ol Interest Disclosure Stm	
22. ORIGINAL DATE 23	. LTC AGREE	MENT 2	4. LTC AGREEN	/IENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION 01/01/1975	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure		NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		Meet Agreement
25. LTC EXTENSION DATE: 27	. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		ler Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active	
			(L45)				
28. TERMINATION DATE:	29	0. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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,

Kumala 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: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00062	B. WING		04/0) 5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	TATE, ZIP CODE		
LUTHER	HAVEN	1109 EAS	T HIGHWAY IDEO, MN 56	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted to detern licensure. The follor issued. Please indi correction that you	FS: 4/5/19, a survey was mine compliance for state wing correction orders are icate your electronic plan of have reviewed these order, e when they will be corrected.				
Minnesota D	epartment of Health					
	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NAIURE	TITLE		(X6) DATE 05/03/19

Electronically Signed

6899

If continuation sheet 1 of 13

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING	:		
		00062	B. WING			C 05/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY /IDEO, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
		laint investigation(s) was/were he time of the licensing				
	The following comp	plaint (s) was/were found to be ED: H5259015				
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correction uired that the facility of the electronic documents.				
21375	MN Rule 4658.0800 Program	0 Subp. 1 Infection Control;	21375			5/15/19
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview facility failed to have that had an ongoing and use of evidence define infections. T all 78 residents in the failed to ensure app	ent is not met as evidenced and document review, the e an infection control program g analysis of surveillance data, e based surveillance criteria to his had the potential to affect he facility. The facility also propriate hand hygiene while sidents (R51 and R12) inence care.		See F880		
	Findings include:					
	INFECTION PREV	ENTION				
	During an interview	on 4/4/19, at 8:10 a.m. the				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIPI F	CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			PLETED
		00062	B. WING			C 05/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
LUTHER	HAVEN		T HIGHWAY 7			
			IDEO, MN 562	PROVIDER'S PLAN OF CO		(NE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 2	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 					
	control log included type, body site. Un- body site, symptom listed. Under the he taken, organism an listed. Under the he date, pre-admit, hea and ordered by was included date resolv infection control log of 148 reviewed. D information on 12 o resolved was missin On the top of the m total # of infections, infections, prophyla types of infection w were completed.	March 2019. The infection residents name, admit date, der header of infection type, s and date of onset were eader of culture, the date d antibiotic resistant was eader of antibiotic, type, start althcare acquired infections, s listed. The last two columns ved and isolated. The monthly was missing symptoms on 17 ate of onset was missing ut of 148 reviewed. Date ng on 25 out of 148 reviewed. onthly infection control log, # of health care acquired ctic antibiotic treatment and ere listed. Seven of thirty-four				
	registered nurse (R she was aware of fo urinary tract infection let it be". RN-E furt on each unit where respiratory or gastro include date and sh symptoms present, and new orders if re	on 4/04/19, at 2:22 p.m. N)-E indicated the only criteria or infections was one for ons titled "Symptom free pee, her indicated they keep a log they document new onset of pintestinal (GI) symptoms that ift of onset of symptoms, temperature, MD updated eccived. RN-E indicated she se of the McGeer criteria.				

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	PLETED
		00062	B. WING			05/2019
NAME OF I	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: C 00062 IB WING C 04/05/2 ME OF PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 C METY 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265 PROVIDERS PLAN OF CORRECTION C METY ESUMMARY STATEMENT OF DEPREMICES PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE C METY ESUMMARY STATEMENT OF DEPREMIENCES PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE C METY ESUMMARY STATEMENT OF DEPREMIENCES PROVIDERS PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIATE C 21375 Continued From page 3 21375 21375 Continued from page 3 21375 21375 Continued Into the Infection program. RN-D indicated the yave a sign they use for unine specimen that included symptoms. RN-D indicated she did not know how the McGeer's criteria fit into the infection program. The DON indicated she did not know how the McGeer's criteria fit into the infection program. During an interview on 4/04/19, at 2:30 p.m. the DON indicated the logs that staff complete should be streaded when they are done with the areal she did not review them. The DON indicated she did not to thore indicion program. The DON indicated the longs t					
LUTHER	HAVEN					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE		(EACH CORRECTIVE AC CROSS-REFERENCED TO	ACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE		
21375	Continued From pa	age 3	21375			
	RN-D indicated the urinary tract infection specimen that inclu- indicated for GI or in document signs an that was turned into month. During an interview DON indicated she McGeer's criteria fit The DON further in sent an e-mail with the e-mail was requ The DON indicated should be shredded them and she did in stated she tried to R infection control log diagnosed at the ho have all the informa indicated it was up to call for further inter	y have a sign they use for on for when to collect a urine ided symptoms. RN-D respiratory issues, they d symptom on a tracking form o the DON at the end of each of the the of the infection program. I the logs that staff complete d when they are done with not review them. The DON keep up with the monthly g, but a lot of the infections are pospital and she doesn't always ation she needed. The DON to the nursing staff on the floo formation such as culture				
	8/25/17, included the based infection cor mandated by regula	ne implementation of evidence ntrol practices including those atory and licensing agencies.				
	assessment dated extensive assistance	2/20/19 indicated R51 required ce with toileting, personal	E			
	to assist R51 to toil	et every 2 to 3 hours while eding to provide peri cares				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00062	B. WING			C 05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
LUTHER		1109 EAS	6T HIGHWAY 7	,		
LUTHER		MONTEV	IDEO, MN 562	265		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21375	Continued From pa	ge 4	21375			
	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.					
	have yearly infectio competencies. NA- ever went over train after removing dirty been years ago and	a.m., NA-H indicated they do n control training and H stated the last time they ning related to changing gloves incontinent product would of d verified she should have s before placing a clean anything else.				
	(DON) stated she e gloves after removi and providing incon	o.m. the director of nursing expected staff to change ng a dirty incontinent product tinent care before placing roduct on a resident.				
	4/03/19, at 9:28 a.n assisted R12 to the When R12 was finis wiped the front area strokes with a wet w	during personal cares on n. nursing assistant (NA)-F toilet with a sit to stand lift. shed using the toilet NA-F a of her bottom using upward vipe, and then cleansed her washcloth-using front to back				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	Сом	E SURVEY PLETED C
		00062	B. WING		04/	05/2019
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S			
LUTHER	HAVEN		ST HIGHWAY 7 IDEO, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	technique. NA-F rep clean brief, pulled u her to the wheelchar NA-F donned clean arms and cleansed assisted R12 to dor the wheelchair and placed R12's call lig trash, exited the roo utility room door. N bag, disposed of tra On 4/3/19 at 9:54 a their hands before a after direct contact Luther Haven Infect 8/25/17, indicated th safe, sanitary and o designed to help pr transmission of infe staff will use the mo professional practic and infection throug including incontiner indicated staff will re	moved her gloves, applied p R12's pants and transferred air. Without washing hands, gloves, washed R12's under under her breasts. NA-F n her shirt, applied footrests to combed her hair. NA-F ght within reach, emptied the om and opened the soiled IA-F placed soiled clothing in ash, and washed her hands. .m. NA-F stated staff wash and after donning gloves, and	21375			
	The director of nurs review applicable p ensure the comprel program contains o data to prevent pote	HOD OF CORRECTION: sing (DON) or designee could olicies and procedures to nensive infection control (IC) n-going analysis of collected ential spread of illness and propriately implemented. The				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00062	B. WING			C 05/2019
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21375	DON could inservice infection control me DON or designee control me ensure ongoing cor results to the quality addition, the director designee could revi to ensure proper in followed. Facility st	ige 6 e staff regarding proper easures are implemented. The could implement audits to mpliance and report those y assurance group. In or of nursing (DON) or iew policies and procedures fection control techniques are taff could be reeducated and developed to ensure	21375			
21426	(21) days. MN St. Statute 144. Prevention And Cor (a) A nursing home	e provider must establish and	21426			5/15/19
	infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	nensive tuberculosis ogram according to the most is infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of e technical assistance intation of the guidelines.	t			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BOILDING	·		С
		00062	B. WING		DRRECTION IN SHOULD BE E APPROPRIATE	05/2019
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
UTHER	HAVEN		ST HIGHWAY IDEO, MN 5			
(X4) ID			ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	EAPPROPRIATE	COMPLET DATE
21426	Continued From pa	ige 7	21426			
		ent is not met as evidenced				
		and document review the ropriately screen 4 of 6 newly		See F880		
	admitted residents symptoms of tubero	(R41, R58, R40, R77) for culosis (TB) and failed to				
		o residents (R45, R58, R2, I a two-step tuberculin skin tes e risk of spread of	t			
	Findings include:					
	of the TB test resul tuberculin skin test	to the facility 3/15/17. A review ts identified no two step (TST) was completed. No as found in the medical record				
	of the TB test resul x-ray on admission	to the facility 3/2/18. A review ts identified R58 had a chest date. A symptom screening edical record but lacked date				
	of the TB test resul was completed 9/7/	to the facility 9/7/16. A review ts identified a two step TST /16 and 9/21/16. A symptom ind in the medical record but pletion.				
	of the TB test result was completed 3/14	to the facility 3/14/18. A review ts identified a two step TST 4/18 and 3/28/18. A symptom nd in the medical record but pletion.	,			
		on 4/4/19, at 08:03 a.m., the (DON) verified that dates were				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	СОМ	E SURVEY PLETED
		00062	B. WING			C 05/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	HAVEN		T HIGHWAY IDEO, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	ge 8	21426			
	indicated "they shou copy of R41's scree the DON who indica record and they do SUGGESTED MET The director of nurs could review policie the components of monitoring program educated on the TE screening process.	losis screening forms and uld be dated". Requested en and mantoux results from ated it isn't in R41's medical not know where it is. THOD OF CORRECTION: sing (DON) and/or designee is and procedures related to the infection control and TB a. Facility staff could be B regulations and the TB The director of nursing and/or relop a monitoring system to npliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21620	MN Rule 4658.134	5 Labeling of Drugs	21620			5/15/19
	Drugs used in the r in accordance with	ursing home must be labeled part 6800.6300.				
	by: Based on observati review, the facility f multi-dose vials of t solution and in-use 1 of 2 medication s medication carts, w manufacturer's guid	ent is not met as evidenced on, interview, and document ailed to ensure in-use uberculin skin test (TST) medication, stored in stored in torage rooms and 1 of 3 ere labeled according to delines upon use.		See F761		
	Findings include:	ion of the Unit 2 mediantics				
		ion of the Unit 2 medication n 4/4/19, at 8:55 a.m. with				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00062	B. WING			C 05/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21620	solution with an ope and three opened v identify an date the were stored togethe	age 9 RN)-A, had one vial of TST ened date of 11/30/(no year), vials of TST solution did not vials were opened. The vials er and had solution remaining	21620			
	 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. 					
	identified vial 1 had year), and vials 2, 3 RN-A was unable to	, at 9:00 a.m., with RN-A I an opened date 11/30/(no 3, and 4 had no use-by dates. o verify when the vials were on was good for 30 days after				
	Patients and the Ba Healthcare Worker following residents tuberculin skin tests number with an ma 10/29/20, but no us opened. R10 on 1/7 2/27/19, R80 on 1/3 3/28/19, RN-B on	ine TB Screening Tool for aseline TB Screening Tool for s (HCWs) identified the and employees had received s from vials 1, 2, or 3 with unufacturer's expiration date of sed-by date after it had been 10/19, R59 on 3/15/19, R78 on 3/19, R378 on 4/3/19, R379 on 12/18/18 and 1/5/19, nursing n 2/26/19, NA-B on 2/25/19, 19.	1			
	Patients and Health identified the follow	line TB Screening Tool For ncare Workers (HCWs) ring residents and employees n vial 4: R65 on 3/6/19 and				

STATEMENT	Department of Hea					
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		LETED
	00062 B. WING				C 04/0	; 5/2019
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LUTHER H	AVEN		T HIGHWAY DEO, MN 56			
(X4) ID	SUMMARY STAT			PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETE DATE
21620 C	Continued From pag	ge 10	21620			
3 0	8/19/19, R68 on 3/1	2/19, R76 on 3/19/19, NA-A 3/19/19 and 3/28/19, NA-E				
cb ic 1 how trob Ir asacTaofr p3 uEw Cvttrndrep	art on 4/04/19 at 9: bottle of calcitonin b dentified the pharm 2/14/18. The bottle per when she return on 12/15/18. The b vas currently in use he medication was opening. RN-A was bottle was opened. Interview and docum the medication was opening. RN-A was bottle was opened. Interview and docum the medication was opening. RN-A was bottle was opened. Interview and docum the was opened. Interview and docum the was opened. Interview and docum the was opened. Interview and docum the upper of the bottle had a pha and was received by opened date on 12/ from a hospital stay. Deackaging identified 05 days after openin opening identified 05 days after openin opening identified 05 days after openin opening the position. Re Expiration Date pha vas good for 35 day On 4/04/19, at 10:52 verified TST solution he vial was in-use. Interview and the contained ecommendations for opharmacist had dire	on of the Unit 2 medication 06 a.m. RN-A identified a elonging to R51. RN-A acy filled the medication on e was sent to the facility with led following a hospital stay bottle had no opened date and . The packaging indicated good for 35 days after unable to identify when the nent review on 4/4/19 at 9:25 tified R51's calcitonin was drawer of the medication cart side. RN-A verified the e and had no opened date. armacy fill date of 12/14/18, y the facility without an 15/18, after R51 returned . The bottle's manufacturer the medication was good for ng and should be stored in an wiew of the Medication rmacy list identified calcitonin ys after opening. 2 a.m. nurse manager (RN)-C n was good for 30 days after RN-C stated she assumed sed until the manufacturer er, was unaware of storage or calcitonin, and thought the cted to use medications until expiration date on the bottle.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00062	B. WING			05/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
UTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21620	 (DON) expected mu when opened. Nurs aides (TMA)s were medication dates w and when expired, n medications. Medic the opened date ex medications were e destruction bin to be staff. Medication ro have green reference for medications use opened-date expira be stored according recommendations. The Medication Sto indicated no discon deteriorated medica use in this facility. A be destroyed. Review of Tuberculi (Mantoux) Tubersol a vial of Tubersol, w for 30 days should I Review of Calcitonin indicated to store th for up to 35 days. SUGGESTED MET The director of nurs policies and proced are dated when ope could educate nursi 	p.m. the director of nursing ulti-use medications be dated ses and trained medication expected to look for expired hen dispensing medications, remove and reorder cation should not be used after piration and expired xpected to be placed in the e destroyed by designated borns and medication carts ce sheets with expiration times d to identify medication tion times. Medications should g to the manufacturer's rage Policy dated 8/13/16,	5	DEFICIENC	εΥ)	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED	
		00062	B. WING			C 04/05/2019	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
UTHER	HAVEN		ST HIGHWAY 7 VIDEO, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21620	Continued From pa	age 12	21620				
	(21) days.						

DEPARTMENT OF HEALTH AND HUMAN SI	ERVICES

F5259028

PRINTED: 05/10/2019 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	r		1	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245259	B. WING		04/	02/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265	h.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs	K OC	00		
	FIRE SAFETY					
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFIC UPON RECEIPT O ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA ACCORDANCE W A Life Safety Code Minnesota Departm Fire Marshal Divisio	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Survey was conducted by the nent of Public Safety, State on . At the time of this survey,				
	the requirements for Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) Standard 10 Chapter 19 Existing	found not in compliance with or participation in at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care Occupancies n of NFPA 99, Health Care			,	
	DEFICIENCIES (K-TAGS) TO:	R THE FIRE SAFETY		EPOC		
	Health Care Fire Ins State Fire Marshal 1 445 Minnesota St.,	Division				
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE
Electroni	ically 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.

		AND HUMAN SERVICES		FORM): 05/10/201 APPROVEI). 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1. · ·	IULTIPLE CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245259	B. WING	NG 04	/02/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE
	DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the deficie 2. The actual, or pro 3. The name and/or responsible for corre prevent a reoccurre Luther Haven is a 1 basement. The build different times. The constructed in 1963 Type II(000) constru- was added that was II(000) construction. was constructed in 1 be of Type II(000) co original building and construction type all	5145, or @state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE RMATION: what has been, or will be, done ency.	ΚO	\$ 000	
	fire alarm system the fire department notif	sprinklered. The facility has a at is monitored for automatic ication. The facility has a and had a census of 78 at			
	The requirement at a NOT MET as eviden	42 CFR, Subpart 483,70(a) is ced by:			

If continuation sheet Page 2 of 10

		AND HUMAN SERVICES			FORM	05/10/201 APPROVE 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT	E SURVEY PLETED
		245259	B. WING		04/	02/2019
NAME OF I	PROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	V-1/	02/2010
LUTHER	HAVEN			109 EAST HIGHWAY 7 NONTEVIDEO, MN 56265		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101		K 324			5/15/19
	with NFPA 96, Stan- and Fire Protection Operations, unless: * residential cooking appliances such as toasters) are used f cooking in accordar * cooking facilities of compartments with with the conditions to or * cooking facilities in 30 or fewer patients 18.3.2.5.4, 19.3.2.5. Cooking facilities pri- per 9.2.3 are not red hazardous areas, bu corridor.	g equipment (i.e., small microwaves, hot plates, or food warming or limited nee with 18.3.2.5.2, 19.3.2.5.2 open to the corridor in smoke 30 or fewer patients comply under 18.3.2.5.3, 19.3.2.5.3, a smoke compartments with comply with conditions under 4. otected according to NFPA 96 quired to be enclosed as ut shall not be open to the 8.3.2.5.4, 19.3.2.5.1 through				
	by: Based on documen interview the facility equipment, as state (NFPA 101) 2012 ed section 11.2. This d for the spread of fire system did not opera	T is not met as evidenced tation review and staff failed to maintain the cooking of in the Life Safety Code lition section 9.2.3 & NFPA 96 eficient practice could allow if the hood suppression ate properly, affecting an int of staff and visitors.		K324 Cooking Facilities The hydro inspection was complete April 17, 2019 by Summit Companie The maintenance director will be responsible for this correction and w monitor to prevent a reoccurrence of deficiency.	es. vill	

Facility ID: 00062

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES			FORM): 05/10/201 1 APPROVE). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		TE SURVEY MPLETED
		245259	B. WING		04	/02/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		
LUTHER	HAVEN			1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE	(X5) COMPLETIO DATE
K 324	Continued From pa Findings include:	ge 3	КЗ	324		
	on 04/02/2019 docu the kitchen hood ex	between 8:00 am to 12:30 pm umentation review revealed tringuishing system was due on and there was no record of				
K 363		tion was confirmed by the r and the Director of	КЗ	863		5/15/19
	CFR(s): NFPA 101 Corridor - Doors					5/15/19
	Doors protecting co required enclosures hazardous areas re and are made of 1 3 wood or other mate at least 20 minutes.	rridor openings in other than of vertical openings, exits, or sist the passage of smoke 3/4 inch solid-bonded core rial capable of resisting fire for Doors in fully sprinklered ats are only required to resist				
	the passage of smo to rooms containing materials have positi latches are prohibite requirements do not do not contain flamr Clearance between	ke. Corridor doors and doors flammable or combustible tive latching hardware. Roller ed by CMS regulation. These t apply to auxiliary spaces that nable or combustible material. bottom of door and floor				
	complying with 7.2.1 with a device capab when a force of 5 lb impediment to the cl	eding 1 inch. Powered doors .9 are permissible if provided le of keeping the door closed f is applied. There is no losing of the doors. Hold open when the door is pushed or		2 2		
	pulled are permitted of unlimited height a	. Nonrated protective plates re permitted. Dutch doors are permitted. Door frames				

If continuation sheet Page 4 of 10

	RS FOR MEDICARE				O. 0938-039 ATE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		OMPLETED
		245259	B. WING	0	4/02/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LUTHER	HAVEN			109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 363	Continued From pa	ge 4	K 363		
	materials in complia smoke compartmen window assemblies sprinklered compar	d made of steel or other ance with 8.3, unless the nt is sprinklered. Fixed fire are allowed per 8.3. In tments there are no or fire resistance of glass or ssemblies.			
	and 485 Show in REMARKS protection ratings, a etc. This REQUIREMEN	arts 403, 418, 460, 482, 483, 6 details of doors such as fire automatics closing devices, NT is not met as evidenced			
	facility failed to prov means suitable for l resist the passage of the 2012 Life Safety 19.3.6.3.1 & 19.3.6. could allow for smo making it difficult to affecting 16 of the 9	ion and staff interview the vide one corridor door with a keeping the door closed and of smoke in accordance with v Code (NFPA 101) section 3.5. This deficient practice ke to enter the corridor exit in the case of fire, 00 residents and an unt of staff and visitors.		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 b responsible for this correction and will monitor to prevent a reoccurrence of the	
	Findings include:			deficiency.	
	on 04/02/2019 obse	between 8:00 am to 12:30 pm ervations revealed the door to could not resist the passage of properly latch.			
	This deficient condit	tion was confirmed by the			

Facility ID: 00062

If continuation sheet Page 5 of 10

		& MEDICAID SERVICES			B NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X 01 - MAIN BUILDING 01	3) DATE SURVEY COMPLETED
		245259	B. WING		04/02/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LUTHER	HAVEN		·	109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
K 711	Continued From pa	ge 5	K 711		
К 901	patients and for the an emergency. Employees are peri informed with their copy of the plan is r operator or with sec basic response required and provides for all components per 18 18.7.1.1 through 18 18.7.2.3, 19.7.1.1 th 19.7.2.2, 19.7.2.3 This REQUIREMENT by: Based on document interview the facility Safety Plan as required Code, 2012 edition deficient practice code emergency and affect undetermined amount Findings include: On the facility tour to on 04/02/2019 docu- the fire safety plan of listed in NFPA 101. This deficient condition facility Administration Maintenance.	lan for the protection of all ir evacuation in the event of odically instructed and kept duties under the plan, and a readily available with telephone curity. The plan addresses the uired of staff per 18/19.7.2.1.2 of the fire safety plan	K 901	K711 Evacuation and Relocation Pla The fire safety plan was reviewed an updated on April 8, 2019 to include a nine areas of the plan. The plan will k reviewed annually. The maintenance director will be responsible for this correction and will monitor to prevent reoccurrence of the deficiency.	d II De

Facility ID: 00062

If continuation sheet Page 6 of 10

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

PRINTED: 05/10/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	E SURVEY PLETED
		245259	B. WING			04/0	02/2019
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 109 EAST HIGHWAY 7 IONTEVIDEO, MN 56265		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 901	Fundamentals - Bu Building systems an 1 through 4 require Categories are dete	ilding System Categories re designed to meet Category ments as detailed in NFPA 99. ermined by a formal and sessment procedure ied personnel.	Κŝ	901			
	by: Based on document interview, the facility complete and current accordance with the Facilities Code" 207 deficient practice co	NT is not met as evidenced ntaton review and staff y has failed to provide a nt facility Risk Assessment in e NFPA 99 "Health Care 2 edition section 4.1. This puld affect all residents, as nined number of staff, and			K901 Fundamentals-Building Syste Categories The risk assessment was reviewed updated on April 15, 2019. The risk assessment will be reviewed annua The maintenance director will be responsible for this correction and of monitor to prevent a reoccurrence of deficiency.	and ally. will	
	on 04/02/2019 docu	between 8:00 am to 12:30 pm Imentation review revealed ssessment available at the					
K 911 SS=F	facility Administrato Maintenance. Electrical Systems - CFR(s): NFPA 101 Electrical Systems -		K	911			5/15/19

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00062

If continuation sheet Page 7 of 10

		AND HUMAN SERVICES		FOR	D: 05/10/201 MAPPROVE <u>0. 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245259	B. WING	0	4/02/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LUTHER	HAVEN			1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(XE)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
K 911	p-	ige 7 I Systems requirements that	K 911		
	are not addressed are deficient. This is applicable Life Safe citation, should be is Chapter 6 (NFPA 9) This REQUIREMEN by:	by the provided K-Tags, but nformation, along with the ety Code or NFPA standard included on Form CMS-2567. 9) NT is not met as evidenced			
	facility failed to mai accordance with NF (12) section 9.1.2 a Electrical Code, sec practice could allow	tion and staff interview the ntain electrical equipment in FPA 101, the Life Safety Code and NFPA 70 (11) The National ction 408.38. This deficient of runauthorized access to ffecting an undetermined s, staff and visitors.		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	
	Findings include:			reoccurrence of the deficiency.	
	on 04/02/2019 observed electrical panels in	between 8:00 am to 12:30 pm ervations revealed the the corridors were accessible sons and not locked.			
K 920	facility Administrato Maintenance.	tion was confirmed by the r and the Director of nt - Power Cords and Extens	K 920		5/15/19
SS=D	CFR(s): NFPA 101				
	Extension Cords Power strips in a pa used for componen patient-care-related (PCREE) assemble by qualified personr	nt - Power Cords and tient care vicinity are only ts of movable electrical equipment s that have been assembled hel and meet the conditions of ips in the patient care vicinity			

Event ID: KLHQ21

Facility ID: 00062

If continuation sheet Page 8 of 10

And in case of the local division of the loc	RS FOR MEDICARE	AND HUMAN SERVICES			20106/01/2	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01		E SURVEY PLETED
		245259	B. WING		04/	02/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 1109 EAST HIGHWAY 7	E	
LUTHER	HAVEN			MONTEVIDEO, MN 56265		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
К 920	electronics), except rooms that do not u PCREE meet UL 13 strips for non-PCRE (outside of vicinity) care rooms, power standards. All power precautions. Exten substitute for fixed v Extension cords use immediately upon c which it was installed 10.2.4. 10.2.3.6 (NFPA 99), (NFPA 70), 590.3(D This REQUIREMEN by: Based on observat facility failed to ensu are in accordance v 99 section 10.24.2 strips comply with 1 could affect an under residents, staff and Findings include: On the facility tour b on 04/02/2019 obse 1. Medical equipmen not listed for that us 153. 2. An unlisted power 162.	r non-PCREE (e.g., personal in long-term care resident se PCREE. Power strips for 363A or UL 60601-1. Power E in the patient care rooms meet UL 1363. In non-patient strips meet other UL er strips are used with general sion cords are not used as a wiring of a structure. ed temporarily are removed ompletion of the purpose for ed and meets the conditions of 10.2.4 (NFPA 99), 400-8 (NFPA 70), TIA 12-5 NT is not met as evidenced ion and staff interview the ure multiple outlet adapters with the 2012 edition of NFPA .1 and the use of power 0.2.3.6. This deficient practice etermined amount of visitors.	K 92	K920 Electrical Equipment- P and Extens The unlisted power tap was re April 2, 2019. The medical eco connected to the power taps v switched to a wall outlet on Ap The facility has created tags for medical equipment to remind plug electrical equipment into Quarterly audits will be comple ensure medical equipment is a wall outlet. Results will be to QAPI. The maintenance director responsible for this correction monitor to prevent a reoccurred deficiency.	emoved on uipment vere oril 2, 2019. or the staff not to a power tap. eted to olugged into rought to tor will be and will	

Facility ID: 00062

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPI MB NO. 093	ROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE SUR COMPLET	RVEY	
		245259	B, WING		04/02/20	019	
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP CODE			
LUTHER	HAVEN			1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56265			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COM	(X5) IPLETION DATE	
	25						

Event ID: KLHQ21

Facility ID: 00062

If continuation sheet Page 10 of 10



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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,

Kumala Fiske Downing

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

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00062	B. WING		04/0	5/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
LUTHER	HAVEN		T HIGHWAY IDEO, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	conducted to detern licensure. The follor issued. Please indi correction that you	FS: 4/5/19, a survey was mine compliance for state wing correction orders are icate your electronic plan of have reviewed these order, e when they will be corrected.				
Minnesota D	epartment of Health					
	r DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NAIURE	TITLE		(X6) DATE 05/03/19

If continuation sheet 1 of 13

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		00062	B. WING		04/	05/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
UTHER	HAVEN		ST HIGHWAY /IDEO, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 1	2 000			
		laint investigation(s) was/were he time of the licensing				
	The following comp	plaint (s) was/were found to be ED: H5259015				
	signature is not req page of state form. is required, it is req	ed in ePOC and therefore a uired at the bottom of the first Although no plan of correctior uired that the facility pt of the electronic documents	ו			
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			5/15/19
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on interview facility failed to hav that had an ongoing and use of evidenc define infections. T all 78 residents in the failed to ensure app	ent is not met as evidenced and document review, the e an infection control program g analysis of surveillance data, e based surveillance criteria to his had the potential to affect he facility. The facility also propriate hand hygiene while sidents (R51 and R12) tinence care.	,	See F880		
	Findings include:					
	INFECTION PREV	ENTION				
	During an interview	on 4/4/19, at 8:10 a.m. the				

STATE FORM

PREFIX (EACH DEFIC TAG REGULATORY	1109 EA	A. BUILDING:		04/	05/2019
LUTHER HAVEN (X4) ID PREFIX TAG (EACH DEFIC REGULATORY	1109 EA				
(X4) ID SUMMAR PREFIX (EACH DEFIC TAG REGULATORY			TATE, ZIP CODE		
TAG REGULATORY	MONTEN	ST HIGHWAY			
PREFIX (EACH DEFIC TAG REGULATORY	STATEMENT OF DEFICIENCIES	/IDEO, MN 56	265 PROVIDER'S PLAN OF CORRE	CTION	
04075 0 1	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLET DATE
21375 Continued From	n page 2	21375			
infection preve monthly infection and patterns of used to monito criteria to defin The monthly in from April 2018 control log inclu- type, body site. body site, symp listed. Under th date, pre-admit and ordered by included date r infection contro of 148 reviewe information on resolved was n On the top of th total # of infect infections, prop types of infected were complete During an inter registered nurs she was aware urinary tract inf let it be". RN-E on each unit wi	ection control logs were reviewed to March 2019. The infection ded residents name, admit date, Under header of infection type, toms and date of onset were he header of culture, the date in and antibiotic resistant was header of antibiotic, type, start healthcare acquired infections, was listed. The last two columns esolved and isolated. The monthly log was missing symptoms on 17 d. Date of onset was missing 12 out of 148 reviewed. Date issing on 25 out of 148 reviewed. hylactic antibiotic treatment and in were listed. Seven of thirty-four	7			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00062	B. WING		04/05/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S ⁻	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21375	Continued From pa	ige 3	21375			
	RN-D indicated the urinary tract infection specimen that inclu- indicated for GI or r document signs and that was turned into month. During an interview DON indicated she McGeer's criteria fit The DON further in sent an e-mail with the e-mail was requ The DON indicated should be shredded them and she did n stated she tried to k infection control log diagnosed at the ho have all the informa indicated it was up	r on 4/04/19, at 2:24 p.m. y have a sign they use for on for when to collect a urine ided symptoms. RN-D respiratory issues, they d symptom on a tracking form of the DON at the end of each of the DON at the end of each of a 4/04/19, at 2:30 p.m. the did not know how the t into their infection program. dicated she thought she had the criteria to staff. A copy of uested and was not received. the logs that staff complete d when they are done with ot review them. The DON keep up with the monthly g, but a lot of the infections are ospital and she doesn't always ation she needed. The DON to the nursing staff on the floor formation such as culture d symptoms.				
	8/25/17, included th based infection con mandated by regula	ection Control Program dated ne implementation of evidence atrol practices including those atory and licensing agencies. imum Data Set (MDS)				
	assessment dated extensive assistance	2/20/19 indicated R51 required ce with toileting, personal ways incontinent of bladder.	t			
	to assist R51 to toil	icated R51 required one staff et every 2 to 3 hours while eding to provide peri cares ent episode.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00062	B. WING		04/	05/2019
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		00/2010
UTHER	HAVEN		ST HIGHWAY 7			
			/IDEO, MN 562			(1.1-)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
21375	Continued From pa	age 4	21375			
	was observed to as she donned her glo breaks and grab th as NA-H removes I incontinent product toilet. NA-H then ha gloves still on and a her nose. NA-H ob product and sat it o wipe and had R51 NA-H continued by product on R51, put toilet and removed	a.m. nursing assistant (NA)-H ssist R51 into bathroom where oves and cued R51 to lock her e bar next to the toilet to stand R51 pants and soiled t before R51 sits down on ands R51 a Kleenex with her asks R51 if she needs to blow tains a clean incontinent on the wheelchair, obtained we stand to clean her peri area. placing a clean incontinent illed up her pants, flushed the her gloves. NA-H washed her e garbage, and assisted R51 n.	t			
	have yearly infection competencies. NA- ever went over train after removing dirty been years ago and	a.m., NA-H indicated they do on control training and -H stated the last time they ning related to changing gloves y incontinent product would of d verified she should have s before placing a clean g anything else.	5			
	(DON) stated she e gloves after remov and providing incor	p.m. the director of nursing expected staff to change ing a dirty incontinent product ntinent care before placing roduct on a resident.				
	4/03/19, at 9:28 a.r assisted R12 to the When R12 was fini wiped the front are strokes with a wet	during personal cares on n. nursing assistant (NA)-F e toilet with a sit to stand lift. shed using the toilet NA-F a of her bottom using upward wipe, and then cleansed her washcloth-using front to back				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00062	B. WING		04/	05/2019
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 56			
(X4) ID			ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLET DATE
21375	Continued From pa	age 5	21375			
		moved her gloves, applied				
		up R12's pants and transferred air. Without washing hands,				
		gloves, washed R12's under				
	arms and cleansed	under her breasts. NA-F				
		n her shirt, applied footrests to combed her hair. NA-F				
		ght within reach, emptied the				
	trash, exited the roo	om and opened the soiled				
	5	IA-F placed soiled clothing in ash, and washed her hands.				
		a.m. NA-F stated staff wash and after donning gloves, and with residents.				
	8/25/17, indicated t	tion Control Policy dated he policy exists to assure a				
		comfortable environment event the development and				
	e	ection. The policy indicated				
	staff will use the mo	ost appropriate hand hygiene				
		ces to prevent transmission				
		gh various points of entry nt care. The policy also				
	indicated staff will r	eceive training to identify the				
		ptoms of infection and				
	protocols to preven	It the spread of infections.				
		THOD OF CORRECTION:				
		sing (DON) or designee could olicies and procedures to				
	ensure the compre	hensive infection control (IC)				
		on-going analysis of collected				
		ential spread of illness and propriately implemented. The				
nnocota D	epartment of Health	propriatory implomented. The				

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				04/	05/2019
ROVIDER OR SUPPLIER					
HAVEN					
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 6	21375			
infection control me DON or designee c ensure ongoing cor results to the quality addition, the director designee could revi to ensure proper inf followed. Facility st an auditing system compliance.	easures are implemented. The ould implement audits to npliance and report those y assurance group. In or of nursing (DON) or ew policies and procedures fection control techniques are taff could be reeducated and developed to ensure				
		21426			5/15/19
maintain a compreh infection control pro- current tuberculosis issued by the Uniter Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of technical assistance				
	T OF DEFICIENCIES DF CORRECTION ROVIDER OR SUPPLIER HAVEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR LA Continued From pa DON could inservice infection control me DON or designee c ensure ongoing cor results to the quality addition, the directo designee could revit to ensure proper inf followed. Facility st an auditing system compliance. TIME PERIOD FOF (21) days. MN St. Statute 144. Prevention And Cor (a) A nursing home maintain a comprefi infection control pro current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volue regarding implement	OF CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER 00062 ROVIDER OR SUPPLIER STREET AI HAVEN 1109 EAS SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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.	TOF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING: B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST 1109 EAST HIGHWAY 7 MONTEVIDEO, MN 56. HAVEN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 6 21375 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. 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WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HAVEN 1109 EAST HIGHWAY 7 MONTEVIDEO, MIN 56265 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENC ODN 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. 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WING 04/ ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HAVEN 1109 EAST HIGHWAY 7 MONTEVIDEO, NN 56265 PROVIDER'S PLAN OF CORRECTION AND (EACH OPERCENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION DIE (EACH OBTECTURE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION DIE (EACH OBTECTURE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 6 21375 PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION THE PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 6 21375 PREFIX TAG PREFIX

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00062	B. WING		04/05/2019	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE	04/00/2010	
LUTHER	HAVEN		T HIGHWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET	
21426	Continued From pa	age 7	21426			
	by: Based on interview facility failed to app admitted residents symptoms of tuber ensure 1 (R41) of 6	ent is not met as evidenced and document review the propriately screen 4 of 6 newly (R41, R58, R40, R77) for culosis (TB) and failed to 5 residents (R45, R58, R2, d a two-step tuberculin skin test e risk of spread of		See F880		
	Findings include:					
	of the TB test resul tuberculin skin test	to the facility 3/15/17. A review ts identified no two step (TST) was completed. No as found in the medical record.				
	of the TB test resul x-ray on admission	to the facility 3/2/18. A review ts identified R58 had a chest date. A symptom screening edical record but lacked date				
	of the TB test resul was completed 9/7	to the facility 9/7/16. A review ts identified a two step TST /16 and 9/21/16. A symptom nd in the medical record but pletion.				
	of the TB test resul was completed 3/1	to the facility 3/14/18. A review ts identified a two step TST 4/18 and 3/28/18. A symptom nd in the medical record but pletion.				
		on 4/4/19, at 08:03 a.m., the (DON) verified that dates were				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		00062	B. WING		04/05/2019
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
UTHER	HAVEN		T HIGHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
21426	•	•	21426		
	indicated "they sho copy of R41's scree the DON who indica	losis screening forms and uld be dated". Requested en and mantoux results from ated it isn't in R41's medical not know where it is.			
	The director of nurs could review policie the components of monitoring program educated on the TE screening process.	HOD OF CORRECTION: sing (DON) and/or designee is and procedures related to the infection control and TB a. Facility staff could be regulations and the TB The director of nursing and/or relop a monitoring system to inpliance.			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21620	MN Rule 4658.134	5 Labeling of Drugs	21620		5/15/19
	Drugs used in the n in accordance with	ursing home must be labeled part 6800.6300.			
	by: Based on observati review, the facility fa multi-dose vials of t solution and in-use 1 of 2 medication so	ent is not met as evidenced on, interview, and document ailed to ensure in-use uberculin skin test (TST) medication, stored in stored in torage rooms and 1 of 3 ere labeled according to delines upon use.		See F761	
	Findings include:				
		ion of the Unit 2 medication n 4/4/19, at 8:55 a.m. with			

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00062	B. WING		04/05/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 IDEO, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21620	solution with an ope and three opened w identify an date the were stored togethe in the vials. (1) Vial number 1's date was 10/29/20, opened date 11/30 (2) Vial 2's manufac 10/29/20, and had (3) Vial 3's manufac (4) Vial 4's manufac 4/8/21, and had no Interview on 4/4/19	N)-A, had one vial of TST ened date of 11/30/(no year), vials of TST solution did not vials were opened. The vials er and had solution remaining manufacturer's expiration and was labeled with an (no year). cturer's expiration date was no opened date. cturer's expiration date was no opened-on or used-by date. cturer's expiration date was opened date or use-by date.	21620			
	year), and vials 2, 3 RN-A was unable to opened. TST soluti opened. The facility's Baseli Patients and the Ba Healthcare Worker following residents tuberculin skin tests number with an ma 10/29/20, but no us opened. R10 on 1/ 2/27/19, R80 on 1/3	an opened date 11/30/(no 3, and 4 had no use-by dates. 5 verify when the vials were on was good for 30 days after ne TB Screening Tool for aseline TB Screening Tool for s (HCWs) identified the and employees had received s from vials 1, 2, or 3 with nufacturer's expiration date of red-by date after it had been 10/19, R59 on 3/15/19, R78 on 8/19, R378 on 4/3/19, R379 on 12/18/18 and 1/5/19, nursing				
	assistant (NA)-A or and NA-D on 1/15/ The Facility's Base Patients and Health identified the follow	2/26/19, NA-B on 2/25/19,				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	A. BUILDING:			COMPLETED	
		00062	B. WING		04/	05/2019	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 562				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETE THE APPROPRIATE DATE		
TAG 21620	Continued From pa 3/19/19, R68 on 3/1 on 3/25/19, NA-D o on 3/20/19, and NA During an observati cart on 4/04/19 at 9 bottle of calcitonin k identified the pharm 12/14/18. The bottl her when she return on 12/15/18. The k was currently in use the medication was opening. RN-A was bottle was opened. Interview and docur a.m. with RN-A iden stored in the upper and was lying on its calcitonin was in us The bottle had a ph and was received b opened date on 12/ from a hospital stay packaging identified 35 days after openin upright position. Re Expiration Date pha was good for 35 day On 4/04/19, at 10:5 verified TST solutio the vial was in-use. medications were u date on the contain	ge 10 2/19, R76 on 3/19/19, NA-A n 3/19/19 and 3/28/19, NA-E -F on 3/25/19. on of the Unit 2 medication :06 a.m. RN-A identified a belonging to R51. RN-A nacy filled the medication on e was sent to the facility with hed following a hospital stay bottle had no opened date and action and the medication on e was sent to the facility with hed following a hospital stay bottle had no opened date and a The packaging indicated good for 35 days after unable to identify when the ment review on 4/4/19 at 9:25 htified R51's calcitonin was drawer of the medication cart side. RN-A verified the e and had no opened date. armacy fill date of 12/14/18, y the facility without an 15/18, after R51 returned the medication was good for ng and should be stored in an eview of the Medication armacy list identified calcitonin	21620			DATE	

Minnesota Department of He STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 04/05/2019	
		00062				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 /IDEO, MN 56			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21620	Continued From pa	ige 11	21620			
	(DON) expected me when opened. Nur- aides (TMA)s were medication dates w and when expired, medications. Medic the opened date ex medications were e destruction bin to b staff. Medication ro have green referen for medications use opened-date expiration	p.m. the director of nursing ulti-use medications be dated ses and trained medication expected to look for expired then dispensing medications, remove and reorder cation should not be used afte expected to be placed in the e destroyed by designated boms and medication carts ce sheets with expiration times ed to identify medication ation times. Medications should g to the manufacturer's	5			
	indicated no discon deteriorated medica	orage Policy dated 8/13/16, Itinued, outdated, or ations were to be available for All such medications were to				
	(Mantoux) Tuberso a vial of Tubersol, v	in Purified Protein Derivitive I manufacturer sheet indicated which was entered, and in-use be discarded and not used.				
		n manufacturer package inser ne bottle in an upright position	t			
	The director of nurs policies and proced are dated when ope could educate nurs	THOD OF CORRECTION: sing could review and revise dures to ensure medications ened. The director of nursing ing staff. The director of tor staff compliance.				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

Minneso	ta Department of He	ealth			FORM	APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
		00062	B. WING		04/	05/2019
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	TATE, ZIP CODE		
LUTHER	HAVEN		ST HIGHWAY 7 VIDEO, MN 562			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC' TAG CROSS-REFERENCED TO		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
0.4000				DEFICIENC	CY)	
21620	Continued From pa	age 12	21620			
	(21) days.					
1						