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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LDWF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00695

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245522**

2.STATE VENDOR OR MEDICAID NO.
(L2) **443343200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER MEMORIAL HOME**
(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/07/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel	___ 6. Scope of Services Limit
___ 3. 24 Hour RN	___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF)	___ 8. Patient Room Size
___ 5. Life Safety Code	___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 08/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/17/2014 (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
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245522

August 19, 2014

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

Dear Ms. Campbell:

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 August 3, 2014 the above facility is certified for:

61 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 61 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 19, 2014

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

RE: Project Number S5522024

Dear Ms. Campbell:

On July 15, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective July 20, 2014. (42 CFR 488.422)

On July 15, we also informed you that we would be recommending the enforcement remedies listed below to the CMS Region V Office for imposition.

- Civil money penalty for the deficiency cited at F323, effective May 25, 2014 (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 26, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on June 26, 2014. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On August 7, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 26, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 3, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on June 26, 2014, as of August 7, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 7, 2014.

However, as we notified you in our letter of July 15, 2014, in accordance with Federal law, as

specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 26, 2014.

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 26, 2014 be rescinded as of August 7, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245522	A. Building B. Wing	8/7/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0224** Reg. # **483.13(c)** LSC	Correction Completed **08/07/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **08/07/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **08/07/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/07/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/07/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/07/2014**
ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **08/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	08/15/2014	28651	08/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2014			

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245522	A. Building / B. Wing: **01 - MAIN BUILDING 01**	8/4/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**08/03/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	08/15/2014	19251	08/04/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
6/25/2014	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 19, 2014

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

Re: Reinspection Results - Project Number S5522024

Dear Ms. Campbell:

On August 7, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 26, 2014, with orders received by you on July15, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00695	A. Building B. Wing	8/7/2014

Name of Facility	Street Address, City, State, Zip Code
LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **08/07/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **08/07/2014**	ID Prefix **20870** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **08/07/2014**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **08/07/2014**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **08/07/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	08/15/2014	28651	08/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/26/2014				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: LDWF

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00695

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245522**

2.STATE VENDOR OR MEDICAID NO.
(L2) **443343200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LUTHER MEMORIAL HOME**
(L4) **221 6TH STREET SOUTHWEST**
(L5) **MADELIA, MN** (L6) **56062**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/26/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **61** (L18)

13.Total Certified Beds **61** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	61			
(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 :
Connie Brady, HFE NE II 07/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 9/4/2014 (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
11/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
July 15, 2014

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

RE: Project Number S5522024

Dear Ms. Campbell:

On June 26, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less

than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on June 26, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective July 20, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323, effective May 25, 2014 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Luther Memorial Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 26, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 September 26, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 26, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	06/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST MADELIA, MN 56062**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's electronic plan of correction (ePOC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted by the Minnesota Department of Health on 6/23, 6/24, 6/25 and 6/26/14. An extended survey was conducted. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to provide assessment and appropriate interventions to prevent elopement off the facility campus for R3 which resulted in the high potential for harm or death. Facility staff were notified of the IJ which began on 5/25/14, during a conversation at 1:00 p.m. on 6/25/14. The IJ was removed on 6/26/14, at 4:20 p.m., however non-compliance remained at the lower scope and severity level of a D, isolated, with no actual harm with a potential for no more than minimal harm.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224		8/3/14

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

Electronically Signed | 07/25/2014

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

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F 224	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide the appropriate supervision for 1 of 1 resident (R3) who left the campus premises without staff knowledge and failed to prevent alleged misappropriation of resident money for 1 of 1 resident (R56) reviewed who reported money missing from his wallet. Findings include: The following documentation related to R3's elopements were noted in progress notes in the medical record. These elopements had not been reported to the State agency, nor was there evidence an investigation had occurred: (1) Progress note documentation from 5/25/14, described as during the evening shift, indicated R3 had independently wheeled outside himself out of the facility, and blocks away from the facility. During interview with the social service designee (SSD) on 6/24/14, at 2:00 p.m., the SSD stated R3 had wheeled himself to the Cenex gas station on 5/25/14, and a community member had contacted the facility to inform them of his location. Staff had been summoned to bring R3 back to the facility. [The Cenex store was noted to be approximately one-half mile from the facility on a busy street with a moderate incline from the facility to the store. Due to R3's limited ability to propel the wheelchair, it would have taken a	F 224	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F224 1) To address the concerns related to R3, hourly checks by nursing personnel were implemented in combination of adding Code Alert to the wheelchair. When R3 goes outdoors, he is supervised by a staff member or volunteer who would be able to summon assistance should it be needed. R56 will be encouraged to continue informing staff of complaints, including missing personal items like money, and will be reminded of the availability of the Resident Trust Account. R56 will also be discouraged from keeping cash in his room, emphasizing	

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F 224	Continued From page 2 significant amount of time to propel this distance]; (2) Another nurses' note, dated 5/28/14, at 9:06 p.m., identified that R3 had again been returned to the facility at 7:00 p.m. after having been located a block from the facility. The medical record lacked any further documentation about the incident. An assessment related to the safety of R3 leaving the premises unsupervised was not evident in the record. (3) Progress notes from 6/19/14, at 3:59 p.m. indicated the charge nurse had informed the SSD that R3 had been found in the alley a couple blocks away, near the house of someone who knew R3. According to the documentation, the community member had assisted R3 back to the facility because it was starting to rain. R3 was reportedly stuck in his wheelchair in the community member's yard and needed assistance to free his wheelchair. Documentation indicated the community member had reported R3 was unable to find his way back to the facility. R3's medical record lacked a thorough investigation of the elopement. During interview on 6/23/14, at 10:19 a.m. R56 reported that money had been taken from his wallet located in his room in January 2014. R56 stated he was missing two (2) $20.00 bills, two (2) $10.00 bills, four (4) $5.00 bills and some $1.00 bills. R56 stated he had reported the missing money to the nurse. R56 stated his left his wallet in his night stand and when he took it out the money was missing. During interview on 6/24/14, at 1:53 p.m. the social worker (SW) indicated she had a written report related to missing money that R56 had	F 224	the ease of using the Resident Trust Account. Staff will investigate any future report by R56 of missing personal items and will keep a complete record of each investigation. Staff will notify the Administrator and Director of Nursing of investigations and corresponding incident reports. 2) All residents have the potential of fitting the profiles of both R3 and R56. 3) An all-staff inservice was held on July 2, 2014. One of the agenda items focused on reviewing the procedure on "reporting suspected abuse or neglect of residents". The review of the procedure included how to document investigations and follow-up and notify the Administrator and Director of Nursing of incidents. 4) The Administrator and Director of Nursing will continue to be kept informed about incident reports and other types of facility reports, identifying instances when cases should be reported to the State Agency (SA), which will be referred to in the future of this plan as the Office of Health Facility Complaints (OHFC). The interdisciplinary team will continue to meet Mondays through Fridays, reviewing incidents/notes, also responsible for identifying instances when cases should be reported to OHFC. The Charge Nurses will continue to be responsible for submitting reports of suspected abuse and neglect to OHFC, regardless of time of day or day of the week. Staff will be trained periodically on reporting suspected abuse, neglect, or misappropriation of residents.	

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F 224	Continued From page 3 reported. The SW stated that $70 had been reported as missing from his wallet so she had searched R56's room and questioned staff about the missing money. During review of the documentation related to the investigation of the missing money, dated 1/23/14, it indicated that R56 had reported around $70.00 missing from his wallet that was left in his night stand drawer in his room. The report further identified that nursing staff were questioned about the missing money and the family was notified. The investigation did not identify which staff were interviewed nor if any follow-up had occurred related to the missing money. The SW stated R56's family member (FM)-A had been contacted and was the SW was informed by FM-A that the amount of missing money reported was questionable. Further, during the interview the SW verified there had been no reports to outside agencies related to R3's elopement from the facility. The SW verified R3 left the facility campus without knowledge of staff and without anyone signing him out. She was unsure why there had not been a report filed for potential neglect related to R3's elopement. During interview with FM-A on 6/23/14, at 8:00 p.m. FM-A stated, "If [R56] stated he had $70.00 missing I would believe him. He is very aware of money and would know if it was missing." FM-A indicated the report was believable. During review of the incident report related to the missing money it was noted that a thorough investigation had not been completed. Evidence was lacking to indicate the potential misappropriation of money had been reported in accordance with the facility's abuse prohibition plan. There was no evidence the facility had notified the administrator, common entry point	F 224	Completion date: August 3, 2014	

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F 224	Continued From page 4 (CEP) or Office of Health Facility Complaints (OHFC) as directed by facility policy. During interview with the SW on 5/24/14, at 2:00 p.m. it was verified there was no report filed to any outside agencies related to the missing money. The facility policy for abuse prohibition, revised 1/16/2012, identified maltreatment as physical abuse, emotional abuse, sexual abuse, verbal abuse, personal exploitation, financial exploitation, or neglect by anyone. The procedure for reporting such maltreatment was identified as follows: "(1.) Employees of Luther Memorial are mandated reporters and must report any situations that are defined as abuse, neglect or injuries of unknown origin to the nurse in charge. The Nurse in Charge will: a. Immediately assess the situation to determine if any emergency treatment is required. b. Notify the physician. c. Notify the administrator, Director of Nursing and Social Services. d. Fill out a Resident Incident Report, noting that the type of incident is potential abuse or a suspected crime. (2.) Incidents that occur when the designated reporter is on site, the charge nurse shall notify the designated reporter. The designated reporter will: a. Report the incident electronically to the Office of Health Facility Complaints (OHFC) immediately. Print a copy of submission to OHFC. b. Report incident to the Common Entry Point (CEP) which is Watonwan County Human Services by faxing them a copy of the OHFC	F 224		

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F 224	Continued From page 5 electronic submission. If the incident involves criminal activity (e.g. assault, sexual assault, serious bodily injury), the CEP must be notified by telephone. c. Notify the Madelia police department in cases of a suspected crime (e.g.) assault, sexual assault, theft, forgery, robbery, burglary etc.) d. Notify the family of the incident. (3.) Incidents that occur while the designated reporter is off duty, the nurse in charge will complete the steps described in 3a through 3d. (4.) The nurse in charge will document: a. A detailed description of the incident in the medical record of each resident involved. Residents will be identified by their medical record number rather than name when mentioned in another resident's chart. b. Notification of family and physician. (5.) The investigative team (i.e. at minimum, Administrator, Director of Nursing (DON), Social Services Director) will initiate investigation of incident reports regarding injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion. a. The investigation may include interviewing staff, residents and other witnesses to the incident b. The results of investigation must be reported to the administrator or designated representative and to OHFC within five working days of the initial report of incident."	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have	F 225		8/3/14

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F 225	Continued From page 6 had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure an investigation was conducted when there were allegations of misappropriation of resident money for 1 of 1	F 225	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a	

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F 225	Continued From page 7 resident (R56) reviewed who reported money missing from his wallet. Findings include: During interview on 6/23/14, at 10:19 a.m. R56 reported that money had been taken from his wallet located in his room in January 2014. R56 stated he was missing two (2) $20.00 bills, two (2) $10.00 bills, four (4) $5.00 bills and some $1.00 bills. R56 stated he had reported the missing money to the nurse. R56 stated his left his wallet in his night stand and when he took it out the money was missing. During interview on 6/24/14, at 1:53 p.m. the social worker (SW) indicated she had a written report related to missing money that R56 had reported. The SW stated that $70 had been reported as missing from his wallet so she had searched R56's room and questioned staff about the missing money. During review of the documentation related to the investigation of the missing money, dated 1/23/14, it indicated that R56 had reported around $70.00 missing from his wallet that was left in his night stand drawer in his room. The report further identified that nursing staff were questioned about the missing money and the family was notified. The investigation did not identify which staff were interviewed nor if any follow-up had occurred related to the missing money. The SW stated R56's family member (FM)-A had been contacted and was the SW was informed by FM-A that the amount of missing money reported was questionable. During interview with FM-A on 6/23/14, at 8:00 p.m. FM-A stated, "If [R56] stated he had $70.00 missing I would believe him. He is very aware of	F 225	credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F225 1) R56 will be encouraged to continue informing staff of complaints, including missing personal items like money. R56 will also be discouraged from keeping cash in his room and will be reminded of the availability of the Resident Trust Account. Staff will investigate any future report by R56 of missing personal items and will keep a complete record of each investigation. Staff will notify the Administrator and Director of Nursing of investigations and corresponding incident reports. 2) All residents have the potential of fitting the profile of R56. 3) An all-staff inservice was held on July 2, 2014. One of the agenda items focused on reviewing the procedure on "reporting suspected abuse or neglect of residents". The review of the procedure included how to document investigations and follow-up and notify the Administrator and Director of Nursing of incidents. 4) The Administrator and Director of Nursing will continue to be kept informed	

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F 225	Continued From page 8 money and would know if it was missing." FM-A indicated the report was believable. During review of the incident report related to the missing money it was noted that a thorough investigation had not been completed. Evidence was lacking to indicate the potential misappropriation of money had been reported in accordance with the facility's abuse prohibition plan. There was no evidence the facility had notified the administrator, common entry point (CEP) or Office of Health Facility Complaints (OHFC) as directed by facility policy. During interview with the SW on 5/24/14, at 2:00 p.m. it was verified there was no report filed to any outside agencies related to the missing money. The facility policy for abuse prohibition, revised 1/16/2012, identified maltreatment as physical abuse, emotional abuse, sexual abuse, verbal abuse, personal exploitation, financial exploitation, or neglect by anyone. The procedure for reporting such maltreatment was identified as follows: "(1.) Employees of Luther Memorial are mandated reporters and must report any situations that are defined as abuse, neglect or injuries of unknown origin to the nurse in charge. The Nurse in Charge will: a. Immediately assess the situation to determine if any emergency treatment is required. b. Notify the physician. c. Notify the administrator, Director of Nursing and Social Services. d. Fill out a Resident Incident Report, noting that the type of incident is potential abuse or a	F 225	about incident reports and other types of facility reports, identifying instances when cases should be reported to the State Agency (SA), which will be referred to in the future of this plan as the Office of Health Facility Complaints (OHFC). The interdisciplinary team will continue to meet Mondays through Fridays, reviewing incidents/notes, also responsible for identifying instances when cases should be reported to OHFC. The Charge Nurses will continue to be responsible for submitting reports of suspected abuse and neglect to OHFC, regardless of time of day or day of the week. The Social Services Director or designee will continue to be responsible for conducting an investigation and reporting the findings to OHFC. Completion date: August 3, 2014	

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F 225	Continued From page 9 suspected crime. (2.) Incidents that occur when the designated reporter is on site, the charge nurse shall notify the designated reporter. The designated reporter will: a. Report the incident electronically to the Office of Health Facility Complaints (OHFC) immediately. Print a copy of submission to OHFC. b. Report incident to the Common Entry Point (CEP) which is Watonwan County Human Services by faxing them a copy of the OHFC electronic submission. If the incident involves criminal activity (e.g. assault, sexual assault, serious bodily injury), the CEP must be notified by telephone. c. Notify the Madelia police department in cases of a suspected crime (e.g.) assault, sexual assault, theft, forgery, robbery, burglary etc.) d. Notify the family of the incident. (3.) Incidents that occur while the designated reporter is off duty, the nurse in charge will complete the steps described in 3a through 3d. (4.) The nurse in charge will document: a. A detailed description of the incident in the medical record of each resident involved. Residents will be identified by their medical record number rather than name when mentioned in another resident's chart. b. Notification of family and physician. (5.) The investigative team (i.e. at minimum, Administrator, Director of Nursing (DON), Social Services Director) will initiate investigation of incident reports regarding injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion. a. The investigation may include interviewing staff, residents and other witnesses to the incident b. The results of investigation must be reported to	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	06/26/2014

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F 225	Continued From page 10 the administrator or designated representative and to OHFC within five working days of the initial report of incident."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their written abuse prohibition policy which included notification of the administrator and other officials in accordance with State law through established procedures (including to the State survey and certification agency) when there were allegations of misappropriation of resident money for 1 of 1 resident (R56) reviewed who reported money missing from his wallet; and failed to report and thoroughly investigate elopement incidents for 1 of 1 resident (R3) who left the campus premises without staff knowledge. Findings include: The facility policy for abuse prohibition, revised 1/16/2012, identified maltreatment as physical abuse, emotional abuse, sexual abuse, verbal abuse, personal exploitation, financial exploitation, or neglect by anyone. The procedure for reporting such maltreatment	F 226	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F226 1) Situations that are identified as suspected abuse or neglect will be reported according to the procedure in the Abuse & Neglect Prevention Policy for R3, R56, and every resident of LMH.	8/3/14

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F 226	Continued From page 11 was identified as follows: (1.) Employees of Luther Memorial are mandated reporters and must report any situations that are defined as abuse, neglect or injuries of unknown origin to the nurse in charge. The Nurse in Charge will: a. Immediately assess the situation to determine if any emergency treatment is required. b. Notify the physician. c. Notify the administrator, Director of Nursing and Social Services. d. Fill out a Resident Incident Report, noting that the type of incident is potential abuse or a suspected crime. (2.) Incidents that occur when the designated reporter is on site, the charge nurse shall notify the designated reporter. The designated reporter will: a. Report the incident electronically to the Office of Health Facility Complaints (OHFC) immediately. Print a copy of submission to OHFC. b. Report incident to the Common Entry Point (CEP) which is Watonwan County Human Services by faxing them a copy of the OHFC electronic submission. If the incident involves criminal activity (e.g. assault, sexual assault, serious bodily injury), the CEP must be notified by telephone. c. Notify the Madelia police department in cases of a suspected crime (e.g.) assault, sexual assault, theft, forgery, robbery, burglary etc.) d. Notify the family of the incident. (3.) Incidents that occur while the designated reporter is off duty, the nurse in charge will complete the steps described in 3a through 3d. (4.) The nurse in charge will document: a. A detailed description of the incident in the medical record of each resident involved. Residents will be identified by their medical	F 226	Specifically, the facility will report any future elopement incidents or allegations of misappropriation that are determined to be suspected abuse or neglect to the state agency in accordance with the policy and procedure for reporting suspected abuse, neglect, or misappropriation of property. 2) All residents have the potential of fitting the profile of R3 and R56. 3) An all-staff inservice was held on July 2, 2014. One of the agenda items focused on reviewing the procedure on "reporting suspected abuse or neglect of residents", including the need to inform the Administrator and the requirements for immediate reporting in compliance with state law. 4) The Administrator and Director of Nursing will continue to be kept informed about incident reports and other types of facility reports, identifying instances when cases should be reported to the State Agency (SA), which will be referred to in the future of this plan as the Office of Health Facility Complaints (OHFC). The interdisciplinary team will continue to meet Mondays through Fridays, reviewing incidents/notes, also responsible for identifying instances when cases should be reported to OHFC. The Charge Nurses will continue to be responsible for submitting reports of suspected abuse and neglect to OHFC, regardless of time of day or day of the week. The Social Services Director or designee will continue to be responsible for conducting an investigation and reporting the findings to OHFC. Staff will be trained	

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F 226	Continued From page 12 record number rather than name when mentioned in another resident's chart. b. Notification of family and physician. (5.) The investigative team (i.e. at minimum, Administrator, Director of Nursing (DON), Social Services Director) will initiate investigation of incident reports regarding injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion. a. The investigation may include interviewing staff, residents and other witnesses to the incident b. The results of investigation must be reported to the administrator or designated representative and to OHFC within five working days of the initial report of incident. The following documentation related to R3's elopements were noted in progress notes in the medical record. These elopements had not been reported to the State agency, nor was there evidence an investigation had occurred: (1) Progress note documentation from 5/25/14, described as during the evening shift, indicated R3 had independently wheeled outside himself out of the facility, and blocks away from the facility. During interview with the social service designee (SSD) on 6/24/14, at 2:00 p.m., the SSD stated R3 had wheeled himself to the Cenex gas station on 5/25/14, and a community member had contacted the facility to inform them of his location. Staff had been summoned to bring R3 back to the facility. [The Cenex store was noted to be approximately one-half mile from the facility on a busy street with a moderate incline from the facility to the store. Due to R3's limited ability to propel the wheelchair, it would have taken a significant amount of time to propel this distance];	F 226	periodically on reporting suspected abuse, neglect, or misappropriation of residents to the Administrator and immediately in accordance with state law. Completion date: August 3, 2014	

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F 226	Continued From page 13	F 226		

(2) Another nurses' note, dated 5/28/14, at 9:06 p.m., identified that R3 had again been returned to the facility at 7:00 p.m. after having been located a block from the facility. The medical record lacked any further documentation about the incident. An assessment related to the safety of R3 leaving the premises unsupervised was not evident in the record.

(3) Progress notes from 6/19/14, at 3:59 p.m. indicated the charge nurse had informed the SSD that R3 had been found in the alley a couple blocks away, near the house of someone who knew R3. According to the documentation, the community member had assisted R3 back to the facility because it was starting to rain. R3 was reportedly stuck in his wheelchair in the community member's yard and needed assistance to free his wheelchair. Documentation indicated the community member had reported R3 was unable to find his way back to the facility. R3's medical record lacked a thorough investigation of the elopement.

During interview on 6/23/14, at 10:19 a.m. R56 reported that money had been taken from his wallet located in his room in January 2014. R56 stated he was missing two (2) $20.00 bills, two (2) $10.00 bills, four (4) $5.00 bills and some $1.00 bills. R56 stated he had reported the missing money to the nurse. R56 stated his left his wallet in his night stand and when he took it out the money was missing.

During interview on 6/24/14, at 1:53 p.m. the social worker (SW) indicated she had a written report related to missing money that R56 had reported. The SW stated that $70 had been

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F 226	Continued From page 14	F 226		

reported as missing from his wallet so she had searched R56's room and questioned staff about the missing money. During review of the documentation related to the investigation of the missing money, dated 1/23/14, it indicated that R56 had reported around $70.00 missing from his wallet that was left in his night stand drawer in his room. The report further identified that nursing staff were questioned about the missing money and the family was notified. The investigation did not identify which staff were interviewed nor if any follow-up had occurred related to the missing money. The SW stated R56's family member (FM)-A had been contacted and was the SW was informed by FM-A that the amount of missing money reported was questionable. Further, during the interview the SW verified there had been no reports to outside agencies related to R3's elopements from the facility. The SW verified R3 left the facility campus without knowledge of staff and without anyone signing him out. She was unsure why there had not been a report filed for potential neglect related to R3's elopement.

During interview with FM-A on 6/23/14, at 8:00 p.m. FM-A stated, "If [R56] stated he had $70.00 missing I would believe him. He is very aware of money and would know if it was missing."

During review of the incident report related to the missing money it was noted that a thorough investigation had not been completed. Evidence was lacking to indicate the potential misappropriation of money had been reported in accordance with the facility's abuse prohibition plan. There was no evidence the facility had notified the administrator, common entry point (CEP) or Office of Health Facility Complaints

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F 226	Continued From page 15 (OHFC) as directed by facility policy. During interview with the SW on 5/24/14, at 2:00 p.m. it was verified there was no report filed to any outside agencies related to the missing money.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services as directed by the individualized care plan for 1 of 1 residents (R3) in the sample who utilized chewing tobacco and required personal hygiene assistance. Findings include: R3 had diagnoses that included: aphasia, history of cardiovascular accident (CVA)-with right sided weakness), hypertension, aggressive behavior and depression. R3's care plan, identified a problem which had been initiated 4/3/13 including: "Disruptive behavior: Resident refuses to follow tobacco free facility policy." The goal was identified as: "Resident will remain clean,..." The interventions included: "Offer to assist with cleaning of tobacco off face and hands."	F 282	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F282 1) R3's care plan was modified to "Wash his face and hands in the morning and before and after meals as he allows". The	8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 16 During observation of R3's cares on 6/23/14 at 11:13 a.m., R3 was observed to have a dark brown substance under his fingernails. R3 was also noted to have chewing tobacco smeared on his face and hands and was wearing heavily soiled gray sweat pants. During observation of R3 on 6/23/14 at 3:11 p.m., R3 was observed to have cake frosting covering the right side of his face and in his beard. R3 was also observed to have frosting on the entire right side of his face, and the pants and shirt he was wearing were observed to be heavily soiled. The resident had been observed at an activity eating cake and drinking coffee just prior to this observation. During observation of R3 on 6/24/14 at 4:59 p.m., R3 was observed seated in the dining room with chewing tobacco running down the sides of his mouth, chin and left hand. Licensed practical nurse (LPN)-A was interviewed on 6/24/14 at 5:00 p.m., and she stated R3 often refused to let staff wash his face or hands. LPN-A stated R3 did have some staff that he would let wash him, nursing assistant (NA)-A who was working on the shift, was identified as one of those NAs. During continued observations in the dining room at 5:00 p.m. on 6/24/14, it was observed that multiple staff walked by R3 without offering him assistance with washing his hands or face. At 5:03 p.m. dietary assistant (DA)-A was observed to serve R3 his coffee. DA-A was noted to make eye contact with resident but did not assist him with washing up or ask anyone else to assist him prior to walking away from table. At 5:07 p.m. the dietary manager (DM)	F 282	care plan will include notes to staff on how to successfully approach the situation by all staff. 2) All residents have the potential to have their appearance marred by the presence of food, drink, etc. on their faces, clothing, hands, etc. All residents' care plans will address how ongoing grooming and cleanliness will be addressed through the day. 3) LMH will continue to support the philosophy of Person-Centered Care. Personal preferences and approaches will be noted in each resident's care plan, including instances whereby a resident's personal preference may not be in agreement with another person's standards (e.g. personal cleanliness). An all staff inservice was held on July 2, 2014. An agenda item focused on residents' grooming, cleanliness, and dignity. The importance of following the care plan was emphasized along with the importance of informing the Charge Nurse and other nursing administration when care needs improve/deteriorate to the level that the care plan needs to be revised. Care plans will continue to be reviewed at least quarterly and will be updated PRN. 4) The Director of Nursing and her delegates will continue to be responsible for ensuring that each resident's care plan reflects as accurately as feasibly possible the problems, goals, and approaches of each resident. Care Plans will continue to be developed with input from the resident, family members/primary caregivers, primary physician, and	

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F 282	Continued From page 17 was observed to walk by R3 and communicate to him but did not offer assistance. At 5:09 p.m. NA-H walked by the resident without offering any assistance. It was clearly evident from a far distance there was brown substance all around R3's mouth. During interview with NA-A on 6/24/14 at 5:12 p.m. she stated R3 would seldom let staff change his clothes until the end of the day but stated R3 did let staff wash his face sometimes if approached in a manner that was not threatening or "pushy". NA-A stated R3 was resistive but did have periods of compliance. NA-A stated R3 definitely had certain staff he responded to better than others. On 6/24/14 at 5:50 p.m., DA-E was observed to serve R3 his evening meal which consisted of pea salad, ham and potato, and mandarin oranges. R3 was also served coffee, milk, and juice. When DA-E served R3 his meal he continued to have brown substance around his mouth, on his chin and on his left hand. DA-E did not offer to assist R3 with washing his hands or face, nor did she request any other staff to assist him. R3 was observed to have the brown substance (chewing tobacco) dripping from his left fingers while eating.	F 282	information/observations from the interdisciplinary care team. The Director of Nursing and her delegates will implement a monitoring form for R3's cleanliness before and after meals for a least one month with the option to extend the monitoring timeframe as needed. A review of the care plans of those residents with goals specific to cleanliness and personal hygiene to ensure the care plan addresses cleanliness and personal hygiene as appropriate will also be conducted. Completion date: August 3, 2014	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	06/26/2014

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F 312	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in a manner that promoted personal hygiene for 1 of 3 residents (R3) reviewed who required extensive assistance with daily grooming needs. Findings include: R3 had diagnoses that included a history of cardiovascular accident (CVA-with right sided hemi-paresis), hypertension, aggressive behavior and depression. R3's care plan, identified a problem which had been initiated 4/3/13 including: "Disruptive behavior: Resident refuses to follow tobacco free facility policy." The goal was identified as: "Resident will remain clean,..." The interventions included: "Offer to assist with cleaning of tobacco off face and hands." During observation of R3's cares on 06/23/14, at 11:13 a.m. it was noted that R3 had a dark brown substance under his fingernails. R3 was also noted to have chewing tobacco smeared on his face and hands and was wearing heavily soiled gray sweat pants. During observation of R3 on 6/23/14, at 3:11 p.m. it was observed that R3 exited the front door of the building. R3 had been involved an activity just prior to leaving, which including consuming cake and drinking coffee. During this observation R3 was noted to have cake frosting covering the right side of his face and in his beard. R3 also wore heavily soiled pants and shirt.	F 312	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F312 1) R3's care plan was modified to "Wash his face and hands in the morning and before and after meals as he allows". The care plan will include notes to staff on how to successfully approach the situation by all staff. 2) All residents have the potential to have their appearance marred by the presence of food, drink, etc. on their faces, clothing, hands, etc. All residents' care plans will address how ongoing grooming and cleanliness will be addressed through the day. 3) LMH will continue to support the philosophy of Person-Centered Care. Personal preferences and approaches will be noted in each resident's care plan, including instances whereby a resident's	

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	245522	A. BUILDING _____ B. WING _____	06/26/2014

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F 312	Continued From page 19 During an observation on 6/24/14, at 4:59 p.m. R3 was observed seated in the dining room and had chewing tobacco running down the both sides of his mouth, chin and left hand. Licensed practical nurse (LPN)-A was interviewed on 6/24/14, at 5:00 p.m. and stated R3 often refused to let staff wash his face or hands. LPN-A also stated that R3 allowed some staff to wash him. LPN-A indicated that nursing assistant (NA)-A who was working on the shift, was one of the staff who was able to assist R3. During observations in the dining room on 6/24/14, at 5:00 p.m. it was noted that several staff walked by R3 without offering assistance with hand and/or facial washing. At 5:03 p.m. dietary assistant (DA)-A was observed to serve R3 his coffee and walk from the area without alerting staff to his grooming needs. At 5:07 p.m. the dietary manager (DM) was observed to walk by R3, communicate with him but failed to offer assistance. It was noted that at 5:09 p.m. NA-H walked by resident and did not assist him. It was evident that R3 had brown substance all around his mouth. During an interview on 6/24/14, at 5:12 p.m. NA-A stated R3 would seldom let staff change his clothes until the end of the day but stated R3 did allow staff to wash his face sometimes if approached in a manner that was not threatening or "pushy". NA-A stated that although R3 was resistive at times, he did have periods of compliance. NA-A stated R3 definitely had certain staff he responded to better than others. On 6/24/14, at 5:50 p.m. DA-E was observed to serve R3 his evening meal which consisted of	F 312	personal preference may not be in agreement with another person's standards (e.g. personal cleanliness). An all staff inservice was held on July 2, 2014. An agenda item focused on residents' grooming, cleanliness, and dignity. The importance of following the care plan was emphasized along with the importance of informing the Charge Nurse and other nursing administration when care needs improve/deteriorate to the level that the care plan needs to be revised. 4) The Director of Nursing and her delegates will continue to be responsible for providing ongoing training, education, and enforcing the expectation that the services be provided to all residents that promotes personal hygiene, especially in the area of daily grooming needs. The Director of Nursing and her delegates will implement a monitoring form for R3's cleanliness before and after meals for a least one month with the option to extend the monitoring timeframe as needed. A review of the care plans of those residents with goals specific to cleanliness and personal hygiene to ensure the care plan addresses cleanliness and personal hygiene as appropriate will also be conducted. Completion date: August 3, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	06/26/2014

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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) COMPLETION DATE
F 312	Continued From page 20 pea salad, ham and potato, and mandarin oranges. R3 was also served coffee, milk and juice. When served the evening meal, it was noted that R3 continued to have a notable brown substance (chewing tobacco) around his mouth, on his chin and left hand. DA-E did not offer R3 assistance with washing his hands or face nor find another staff to offer assistance. R3 was observed to have the brown substance (chewing tobacco) dripping from his left fingers while eating. The facility failed to provide services in accordance with R3's care plan which indicated that staff should assist R3 to wash his hands and face as needed.	F 312		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assessment and appropriate interventions to prevent elopement off the facility campus for 1 of 1 resident reviewed (R3) who had a history of elopement. The potential risk of serious harm or injury was determined to place R3 in immediate jeopardy (IJ).	F 323	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under	8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING _____ B. WING _____	06/26/2014

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F 323	Continued From page 21 The IJ began on 5/25/14, when R3 wheeled himself to the Cenex gas station and a community member had to contact the facility, informed them of his location and staff were summoned to bring R3 back to the facility and was identified on 6/25/14. The administrator was informed of the immediate jeopardy (IJ) at 1:00 p.m. on 6/25/14. The immediate jeopardy was removed on 6/26/14, but noncompliance remained at the lower scope and severity level of D-isolated scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R3 had multiple incidents of elopement off the facility campus, which was located on a busy roadway (recent: 5/25/14, 5/28/14 & 6/19/14 and historically: 6/30/13 & 7/4/13). Facility staff were aware of R3's exit attempts; however, the facility failed to assess, monitor and provide interventions to reduce the risk of elopement for R3. R3 had been admitted to the facility on 10/2/01, had diagnoses as identified on the care plan including: history of cardiovascular accident (CVA) with right sided paralysis, aphasia, aggressive behavior, and depression. R3's quarterly Minimum Data Set (MDS) dated 3/10/14, identified that R3 required extensive assistance with transfers, dressing, hygiene and toileting. The MDS identified R3 was unable to ambulate but was independent with mobility in the wheelchair. The MDS further identified R3 had modified independence with decision making and	F 323	the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F323 1) To address the concerns related to R3, hourly checks by nursing personnel were implemented in combination of adding Code Alert to the wheelchair. When R3 goes outdoors, he is supervised by a staff member or volunteer who would be able to summon assistance should it be needed. An Elopement assessment was completed for R3 by the Social Service Director (SSD) on 6/30/14. An Allen Cognitive Levels assessment was completed on 7/16/2014 by a staff member in occupational therapy to determine R3's ability to make daily decisions. The facility staff and R3□s licensed health care professionals determined that at this period of time, it's appropriate to maintain the interventions that are currently in place (including those described in this Plan of Correction). His primary physician's opinion would agree with this decision as noted in her notes on 6/26/14. 2) All residents have the potential to be affected because all residents are required to have their cognition assessed at least quarterly via the Minimum Data Set Assessment (MDS). 3) Elopement Risk Assessments will be	

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F 323	Continued From page 22 had limited communication/speech capabilities due to the CVA. Documentation was lacking in the medical record to indicate that a comprehensive assessment, including assessment of R3's physical and cognitive abilities related to his unsafe practice of leaving the premises without staff supervision, had been conducted. During observation on 6/24/14, at 6:35 p.m. R3 was observed to be seated in his wheelchair in the center of the staff parking lot on the west side of the facility. R3 was observed to be leaning significantly forward with his forehead near his lap. R3 was also observed to have difficulty wheeling his wheelchair due to the forward/right leaning position, and his right sided paralysis of upper and lower extremities. R3 was observed to utilize only his left hand when he propelled the wheelchair. On 6/24/14, at 7:00 p.m. licensed practical nurse (LPN)-A was questioned whether she knew the wherabouts of R3. LPN-A stated that sometimes R3 went outside but she was not currently aware of his location. LPN-A stated, "Staff kind of watch him, they should try to toilet him every two hours. There is not a specific plan to monitor his whereabouts." LPN-A stated she thought nursing assistant (NA)-A had checked on R3 earlier that shift. During another observation on 6/24/14, at 7:05 p.m. R3 was observed to be still seated in the wheelchair, sitting outside the facility near the road, in the staff parking lot drive-way which leads to a busy street. On 6/24/14, at 7:10 p.m. NA-A was interviewed	F 323	completed on all residents at a frequency of "initial, annual, and PRN". Individuals identified as at risk for elopement will be monitored with Code Alert and other appropriate interventions will be implemented. Risk assessments will be conducted on a quarterly basis and PRN. Primary caregivers, including family members, and primary physicians will be consulted when interventions are not successful. The ombudsman will be consulted as needed. An inservice was held on July 2, 2014 for all staff. An agenda item focused on reviewing the definition of an elopement and missing person. The procedure for reporting such situations was reviewed, including a review of CODE GRAY, and will be reviewed periodically with all staff as described in paragraph 4 below. 4) The Administrator and Director of Nursing will continue to be responsible for the ongoing education of all staff, ensuring that procedures are followed correctly for when an elopement/missing person situation occurs. The DON will continue to be responsible for ensuring that the necessary assessments (e.g. elopement assessment, safety assessments, other risk assessments) are completed and successful interventions are in place that promote safety and the resident's freedom of choice. Completion date: August 3, 2014	

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F 323	Continued From page 23	F 323		

about R3. NA-A stated, "I looked for [R3] after supper but could not find him, then I had to get back and help the other residents so they could get ready for bed." NA-A stated she had not reported to any other staff that she had been unable to locate R3.

On 6/24/14, at 7:20 p.m. NA-B and NA-C were interviewed and stated R3 often went outside by himself. NA-A stated that at times they had been unable to locate R3 when they looked for him. The NAs stated that sometimes, due to R3's leaning position in the wheelchair, he could be seated next to the shrubs around the facility and would be unable to be seen because the shrubs there are taller. NA-B and NA-C both stated they were aware that R3 had left the facility campus in the past and had been returned with the help of community members.

On 6/24/14, at 7:30 p.m. LPN-B stated R3 frequently went outside of the building but was unaware of any specific plan to monitor R3's whereabouts. At that time, LPN-A stated she thought R3 had an agreement to stay on the facility campus but verified the resident sometimes did not honor the agreement. LPN-B stated R3 was non-compliant and made unsafe decisions at times.

During an interview on 6/24/14 at 7:50 p.m., the administrator verified R3 frequently went outside the facility and that he had been found off campus multiple times and had been brought back to the facility by community members. The administrator stated R3 did not listen to directions and did not always make good decisions. The administrator verified she was aware R3 had sustained a fall from his wheelchair while off

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F 323	Continued From page 24	F 323		

campus when unsupervised. The administrator stated she was aware R3 had crossed the busy road adjacent to the facility and had also been found lying in the street in the past. The administrator also verified she was aware that R3 had experienced episodes of getting stuck in his wheelchair off of the facility grounds. When informed about the staff not knowing R3's whereabouts, the administrator stated, "If it were another resident identified as missing, the facility would initiate their missing person plan. I am not sure why staff did not do that when [R3] was noted to be missing". The administrator stated staff should know where R3 is located at all times and when his location is unknown, staff should initiate a search.

During document review it was noted that R3 had recently left the facility unsupervised on 5/25/14, 5/28/14 and 6/19/14. Further record review revealed the resident had a history of leaving the facility unsupervised on 6/30 and 7/4/13. The following documentation was noted in the resident's progress notes:

(1) An entry dated 6/30/13, at 10:50 p.m. indicated that during the evening shift, R3 had wheeled himself outside after supper. The documentation further indicated at 6:05 p.m. a community member had knocked on the facility door and a NA had answered the door to find six community members standing around R3 who had fallen out of his wheelchair and was laying in the street next to the sidewalk. The documentation indicated R3 had wheeled off the sidewalk and had fallen out of his wheelchair into the street. [The street where R3 had fallen was a busy street on the east side of the facility with moderate traffic and a commercial factory located

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F 323	Continued From page 25 across the street where semi-trucks frequently load/unload goods]. The nurse's notes described the sidewalk curb as uneven and raised at one end, not even, or flat with the road; (2) Progress notes dated 7/4/13, at 9:40 p.m. identified that R3 had been brought back to the facility by a couple of community members who had stated R3 had crossed the street located by the factory on the east side of the facility and that R3 had been found stuck in his wheelchair on the street corner. [To get to the corner R3 had to cross a busy road and maneuver many environmental obstacles (i.e. curbs, vehicles, uneven pavement, and small inclines)]; (3) Progress note documentation from 5/25/14, described as during the evening shift, indicated R3 had independently wheeled outside himself out of the facility, and blocks away from the facility. During interview with the social service designee (SSD) on 6/24/14, at 2:00 p.m., the SSD stated R3 had wheeled himself to the Cenex gas station on 5/25/14, and a community member had contacted the facility to inform them of his location. Staff had been summoned to bring R3 back to the facility. [The Cenex store was noted to be approximately one-half mile from the facility on a busy street with a moderate incline from the facility to the store. Due to R3's limited ability to propel the wheelchair, it would have taken a significant amount of time to propel this distance]; (4) Another nurses' note, dated 5/28/14, at 9:06 p.m., identified that R3 was again returned to the facility at 7:00 p.m. after having been located a block from the facility. The medical record lacked any further documentation about the incident. An assessment related to the safety of R3 leaving	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 26 the premises unsupervised was not evident in the record. (5) Progress notes from 6/19/14, at 3:59 p.m. indicated the charge nurse had informed the SSD that R3 had been found in the alley a couple blocks away, near the house of someone who knew R3. According to the documentation, the community member had assisted R3 back to the facility because it was starting to rain. R3 was reportedly stuck in his wheelchair in the community member's yard and needed assistance to free his wheelchair. Documentation indicated the community member had reported R3 was unable to find his way back to the facility. R3's medical record lacked a thorough investigation and assessment of the elopement. R3's record was reviewed. It was noted that although documentation dated 7/9/13, at 4:25 p.m. indicated that social services had discussed with R3 the risk of crossing the street unsupervised, and the importance of informing staff, R3 had found "what this writer was talking about to be funny." The documentation indicated that at that time discussion had also occurred related to R3 using a name card, or use of a button similar to life line, so he could summon help if required. The documentation indicated R3 had indicated he would be okay with either option. Documentation by the SSD dated 6/19/14, indicated that R3 had been spoken with about remaining on the facility campus to ensure his safety, but that R3 had found the conversation amusing and laughed. No additional follow-up, assessment, nor interventions were evident in the medical record.	F 323		

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F 323	Continued From page 27 On 6/25/14, at 10:37 a.m. registered nurse (RN)-A was interviewed and stated she was unaware if there had been an assessment to identify whether R3 was capable of safely leaving the facility campus independently. RN-A verified the care plan lacked any guidance to staff related to R3's elopements and/or safety abilities when out of the facility. RN-A stated she would have expected R3's care plan to have had interventions developed which included monitoring his whereabouts. RN-A verified R3 did not always make safe decisions and was at risk for injury, and RN-A stated the SSD should have conducted a safety/elopement assessment due to R3's history of elopements. During an interview on 6/25/14, at 12:50 p.m. the SSD stated R3 had a history of making poor decisions but stated R3 did have some cognitive awareness. The SSD stated she had instructed R3 regarding the need to stay on the facility property, verified R3 had laughed when the situation was addressed. The SSD confirmed she had not conducted any further assessments related to the resident's elopements. The SSD stated she was a new employee so had been unaware of the earlier elopements and falls that R3 had experienced.The SSD also verified the care plan lacked planned interventions related to R3's safety risks. She further stated that R3 had poor judgement related to safety, describing him as carefree. During an interview with R3's primary physician on 6/26/14, at 11:20 a.m., the primary physician stated that R3 would not be safe if given the opportunity to be off the premises unsupervised. The physician confirmed R3 should not leave the premises unsupervised. The physician also	F 323		

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F 323	Continued From page 28	F 323		

stated she had been unaware that R3 had eloped on 5/25/14 and 5/28/14.

The immediate jeopardy that began on 5/25/14 was removed on 6/26/14 when the facility initiated an IJ removal plan which included: providing one on one supervision for R3 while awake; documented hourly checks with Code Gray (missing person protocol) initiation if unable to locate R3; aplication of a code alert to the wheelchair frame to alert staff when R3 exited the building; initiation of an elopement assessment related to R3's cognitive status; and when they had provided education to all staff regarding reporting all resident elopements to ensure tracking, assessment, monitoring and interventions were implemented; Direct care staff and licensed nurses were interviewed to determine whether they were aware of their responsibilities to monitor and report resident elopements, and to ensure they were aware of the plan to assure the safety of R3. The administrator was notified the IJ was removed on 6/26/14 at 4:20 p.m., but the noncompliance remained at the lower scope and severity level of a D, no actual harm with a potential for no more than minimal harm, isolated because a comprehensive assessment related to R3's physical safety and cognitive abilities had not been thoroughly completed.

The facility policy Elopement, dated 1/2003, identified the following procedures to be implemented for a missing resident:
1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as possible
2. Should an employee observe a resident

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F 323	Continued From page 29 leaving the premises, he/she should: a. Attempt to prevent departure; b. Obtain assistance from other staff members in the immediate vicinity, if necessary; c. Instruct another staff member to notify the charge nurse or director of nursing that the resident has left the premises. 3. Upon return of the resident to the facility ' the director of nursing or charge nurse should: a. Examine the resident for injuries; b. Contact the attending physician and report what happened; c. Contact the legal representative and inform them of the incident d. Complete and file an incident report; and e. Make appropriate notations in the resident ' s medical record. 4. Should an employee discover that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. If not: b. Make a thorough search of the building and premises. If not located: c. Notify the administrator and the director of nursing, social worker first if unable to reach the director of nursing or nurse manager on duty; d. Notify the residents legal representative e. Notify the attending physician; f. Notify law enforcement officials g. If necessary, notify volunteer agencies-law enforcement will make that determination; h. Provide search teams with resident identification information; and i. Make an extensive search of the surrounding area.	F 323		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE	F 497		8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 497	Continued From page 30 The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were conducted for 5 of 5 employees (E1, E2, E3, E4 & E5) reviewed who have worked at the facility for greater than 12 months. This had the ability to affect all 56 residents in the facility. Findings include: Review of employee personnel files revealed employee performance evaluations had not been completed annually: (1) E1 had been employed by the facility since 7/16/83. E1's last performance evaluation was dated 7/21/11 (3yrs). (2) E2 had been employed by the facility since 12/16/97. E2's last performance evaluation was dated 12/15/05 (7 yrs +). (3) E3 had been employed by the facility since 2/4/12 . E3 did not have any performance	F 497	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves its right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. F497 1) Annual evaluations of nursing assistants will be completed in the month of their employment anniversary. The five	

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F 497	Continued From page 31 evaluations in her file. (4) E4 had been employed by the facility since 9/6/01. E4's last performance evaluation was dated 10/10/11 (2 1/2 yrs). (5) E5 had been employed by the facility since 8/1/91. E5's last performance evaluation was dated 1/26/12 (1 1/2 yrs). During interview on 6/26/14, at 12:02 p.m. the director of nurses verified that all 5 employees (E1, E2, E3, E4 & E5) whose files were reviewed did not have current performance evaluations.	F 497	employees identified in the survey will have their evaluations completed before August 3, 2014. 2) The Director of Nursing and Administrator will update the nursing assistant annual evaluation form. The Director of Nursing and her delegates will complete the annual evaluation and meet with each nursing assistant to discuss the findings, set goals, etc. The policy/procedure addressing employee evaluations will be reviewed and revised. 3) The Administrator will be responsible for ensuring that evaluations are completed annually. Completion date: August 3, 2014	

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LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST** **MADELIA, MN 56062**

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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 FORM CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 25, 2014. At the time of this survey, Luther Memorial Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/25/2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHER MEMORIAL HOME	**221 6TH STREET SOUTHWEST** **MADELIA, MN 56062**

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Luther Memorial Home was constructed as follows: The original building was constructed in 1958, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 1st addition was constructed in 1973, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 2nd addition was constructed in 1993, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The 3rd addition was constructed in 2001, it is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction. The facility has a fire alarm system with smoke detection throughout the corridor system. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 71 beds and had a census of 57 at time of survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245522	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/25/2014**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient practice could affect 25 residents, staff and visitors as smoke from a fire in these rooms could enter the corridor making it untenable. Findings include: On facility tour between 9:30 AM and 12:30 PM on 6/25/2014, it was observed that the boiler room corridor side wall had (2) 3"x 3" round openings, penetrations around sprinkler piping and conduits not fire caulked in accordance with 19.3.2.1.	K 029	The penetrations around the sprinkler piping and conduits will be fire caulked in accordance with 19.3.2.1. The Director of Environmental Services and Administrator will continue to be responsible for ensuring the correction is completed and monitoring the situation to prevent a reoccurrence.	8/3/14

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K 029	Continued From page 3 This deficient practice was verified by the Administrator at time of discovery.	K 029		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 15, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5522024

Dear Ms. Campbell:

The above facility was surveyed on June 23, 2014 through June 26, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00695	A. BUILDING: _____ B. WING _____	06/26/2014

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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: 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 attached Minnesota	2 000	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.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 6/23/14, 6/24/14, 6/25/14 and 6/26/14 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services as directed by the individualized care plan for 1 of 1 residents (R3) in the sample who utilized chewing tobacco and required personal hygiene assistance. Findings include: R3 had diagnoses that included: aphasia, history of cardiovascular accident (CVA)-with right sided weakness), hypertension, aggressive behavior and depression. R3's care plan, identified a problem which had been initiated 4/3/13 including: "Disruptive behavior: Resident refuses to follow tobacco free facility policy." The goal was identified as: "Resident will remain clean,..." The interventions included: "Offer to assist with cleaning of tobacco off face and hands."	2 565		

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2 565	Continued From page 3 During observation of R3's cares on 6/23/14 at 11:13 a.m., R3 was observed to have a dark brown substance under his fingernails. R3 was also noted to have chewing tobacco smeared on his face and hands and was wearing heavily soiled gray sweat pants. During observation of R3 on 6/23/14 at 3:11 p.m., R3 was observed to have cake frosting covering the right side of his face and in his beard. R3 was also observed to have frosting on the entire right side of his face, and the pants and shirt he was wearing were observed to be heavily soiled. The resident had been observed at an activity eating cake and drinking coffee just prior to this observation. During observation of R3 on 6/24/14 at 4:59 p.m., R3 was observed seated in the dining room with chewing tobacco running down the sides of his mouth, chin and left hand. Licensed practical nurse (LPN)-A was interviewed on 6/24/14 at 5:00 p.m., and she stated R3 often refused to let staff wash his face or hands. LPN-A stated R3 did have some staff that he would let wash him, nursing assistant (NA)-A who was working on the shift, was identified as one of those NAs. During continued observations in the dining room at 5:00 p.m. on 6/24/14, it was observed that multiple staff walked by R3 without offering him assistance with washing his hands or face. At 5:03 p.m. dietary assistant (DA)-A was observed to serve R3 his coffee. DA-A was noted to make eye contact with resident but did not assist him with washing up or ask anyone else to assist him prior to walking away from table. At 5:07 p.m. the dietary manager (DM) was observed to walk by R3 and communicate to	2 565		

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2 565	Continued From page 4 him but did not offer assistance. At 5:09 p.m. NA-H walked by the resident without offering any assistance. It was clearly evident from a far distance there was brown substance all around R3's mouth. During interview with NA-A on 6/24/14 at 5:12 p.m. she stated R3 would seldom let staff change his clothes until the end of the day but stated R3 did let staff wash his face sometimes if approached in a manner that was not threatening or "pushy". NA-A stated R3 was resistive but did have periods of compliance. NA-A stated R3 definitely had certain staff he responded to better than others. On 6/24/14 at 5:50 p.m., DA-E was observed to serve R3 his evening meal which consisted of pea salad, ham and potato, and mandarin oranges. R3 was also served coffee, milk, and juice. When DA-E served R3 his meal he continued to have brown substance around his mouth, on his chin and on his left hand. DA-E did not offer to assist R3 with washing his hands or face, nor did she request any other staff to assist him. R3 was observed to have the brown substance (chewing tobacco) dripping from his left fingers while eating. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		

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2 830	Continued From page 5	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services in a manner that promoted good grooming for 1 of 3 residents (R3) reviewed who required extensive assistance with daily grooming needs. Findings include: R3 had diagnoses that included a history of cardiovascular accident (with right sided hemi-paresis), hypertension, aggressive behavior and depression. R3's care plan, dated 9/27/13, identified that R3 used chewing tobacco and required staff assistance to wash his face. The grooming section of the care plan indicated staff should wash R3's hands and face daily but did not address R3's history of refusing cares and	2 830		

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2 830	Continued From page 6	2 830		

grooming needs. R3 was observed several times on 6/23, 6/24 and 6/25 with dried food and/or chewing tobacco on his face and clothing. Staff were noted to walk past R3 and not offer any assistance with grooming needs.

During observation of R3's cares on 06/23/14, at 11:13 a.m. it was noted that R3 had a dark brown substance under his fingernails. R3 was also noted to have chewing tobacco smeared on his face and hands and was wearing heavily soiled gray sweat pants.

During observation of R3 on 6/23/14, at 3:11 p.m. it was observed that R3 exited the front door of the building. R3 had been involved an activity just prior to leaving, which including consuming cake and drinking coffee. During this observation R3 was noted to have cake frosting covering the right side of his face and in his beard. R3 also wore heavily soiled pants and shirt.

During an observation on 6/24/14, at 4:59 p.m. R3 was observed seated in the dining room and had chewing tobacco running down the both sides of his mouth, chin and left hand. Licensed practical nurse (LPN)-A was interviewed on 6/24/14, at 5:00 p.m. and stated R3 often refused to let staff wash his face or hands. LPN-A also stated that R3 allowed some staff to wash him. LPN-A indicated that nursing assistant (NA)-A who was working on the shift, was one of the staff who was able to assist R3.

During observations in the dining room on 6/24/14, at 5:00 p.m. it was noted that several staff walked by R3 without offering assistance with hand and/or facial washing. At 5:03 p.m. dietary assistant (DA)-A was observed to serve R3 his coffee and walk from the area without

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2 830	Continued From page 7 alerting staff to his grooming needs. At 5:07 p.m. the dietary manager (DM) was observed to walk by R3, communicate with him but failed to offer assistance. It was noted that at 5:09 p.m. NA-H walked by resident and did not assist him. It was evident that R3 had brown substance all around his mouth. During an interview on 6/24/14, at 5:12 p.m. NA-A stated R3 would seldom let staff change his clothes until the end of the day but stated R3 did allow staff to wash his face sometimes if approached in a manner that was not threatening or "pushy". NA-A stated that although R3 was resistive at times, he did have periods of compliance. NA-A stated R3 definitely had certain staff he responded to better than others. On 6/24/14, at 5:50 p.m. DA-E was observed to serve R3 his evening meal which consisted of pea salad, ham and potato, and mandarin oranges. R3 was also served coffee, milk and juice. When served the evening meal, it was noted that R3 continued to have a notable brown substance (chewing tobacco) around his mouth, on his chin and left hand. DA-E did not offer R3 assistance with washing his hands or face nor find another staff to offer assistance. R3 was observed to have the brown substance (chewing tobacco) dripping from his left fingers while eating. The facility failed to provide services in accordance with R3's care plan which indicated that staff should assist R3 to wash his hands and face as needed. SUGGESTED METHOD FOR CORRECTION: The DON could ensure that staff are	2 830		

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	00695	A. BUILDING: _____ B. WING _____	06/26/2014

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LUTHER MEMORIAL HOME	221 6TH STREET SOUTHWEST MADELIA, MN 56062

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2 830	Continued From page 8 re-inserviced as to their responsibility to provide dependent residents with assistance with personal care per facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Based on observation, interview and document review, the facility failed to provide assessment and appropriate interventions to prevent elopement off the facility campus for 1 of 1 resident reviewed (R3) who had a history of elopement without supervision. The potential risk of serious harm or injury was determined to place R3 in immediate jeopardy. Findings include: R3 had multiple incidents of elopement off the facility campus, which was located on a busy roadway (recent: 5/25/14, 5/28/14 & 6/19/14 and historically: 6/30/13 & 7/4/13). Facility staff were aware of R3's exit attempts; however, there were no interventions implemented to reduce the risk of elopement. R3, a 79 yr. old resident admitted on 10/2/01 had diagnoses as identified on the Minimum Data Set (MDS) that included: history of cardiovascular accident (CVA) with right sided paralysis, aphasia, aggressive behavior, and depression. R3's quarterly Minimum Data Set (MDS) dated 3/10/14, identified that R3 required extensive assistance with transfers, dressing, hygiene and toileting. The MDS identified R3 was unable to ambulate but was independent with mobility in the wheelchair. The MDS further identified R3 had	2 830		

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2 830	Continued From page 9 modified independence with decision making and had limited communication/speech capabilities due to a CVA (cerebral vascular accident). Documentation was lacking in the medical record to indicate that a comprehensive assessment had included R3's physical and cognitive abilities related to his unsafe practice of leaving the premises without staff supervision. During observation on 6/24/14, at 6:35 p.m. R3 was observed to be located in a wheelchair in the center of the staff parking lot on the west side of facility. R3 was observed to lean significantly forward with his forehead near his lap. R3 was also observed to have some difficulty wheeling his wheelchair due to the forward/right leaning position and his right sided paralysis of upper and lower extremities. R3 utilized only his left hand when he propelled the wheelchair. On 6/24/14, at 7:00 p.m., licensed practical nurse (LPN)-A was questioned whether she knew the wherabouts of R3. LPN-A stated that sometimes R3 went outside but she was not currently aware of his location. LPN-A stated "Staff kind of watch him, they should try to toilet him every two hours. There is not a specific plan to monitor his whereabouts." LPN-A stated she thought nursing assistant (NA)-A had checked on him earlier. During another observation on 6/24/14, at 7:05 p.m., R3 was still seated in the wheelchair, outside the facility near the road in the staff parking lot drive-way which leads to a busy street. On 6/24/14, at 7:10 p.m. NA-A was interviewed about R3. NA-A stated, "I looked for [R3] after supper but could not find him, I had to get back and help the other residents so they can get ready for bed." NA-A stated she had not reported	2 830		

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2 830	Continued From page 10 to any other staff that she was unable to locate R3. On 6/24/14, at 7:20 p.m. NA-B and NA-C were interviewed and stated R3 often went outside by himself. NA-A stated that at times they have been unable to locate R3 when they have looked for him. The NAs stated that sometimes, due to his leaning position in the wheelchair, he could be seated next to the shrubs around the facility and they would be unable to be seen because the shrubs are taller. NA-B and NA-C both stated they were aware that R3 had left the facility campus in the past and had been returned with the help of community members. On 6/24/14 at 7:30 p.m., LPN-B stated R3 frequently went outside of the building but was unaware of any specific plan to monitor R3's whereabouts. LPN-A stated she thought R3 had an agreement to stay on the facility campus but he sometimes did not honor the agreement. LPN-B stated R3 was non-compliant and made unsafe decisions at times. During an interview on 6/24/14 at 7:50 p.m., the administrator verified R3 frequently went outside the facility and that he had been found off campus multiple times and had been returned by community members. The administrator stated R3 did not listen to directions and did not always make good decisions. The administrator verified she was aware R3 had sustained a fall from his wheelchair while off campus when unsupervised. The administrator indicated she was aware R3 had crossed the busy road adjacent to the facility and had also been found lying in the street in the past. The administrator verified she was aware that R3 had episodes of getting stuck in his wheelchair off of the facility grounds. When	2 830		

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2 830	Continued From page 11	2 830		

informed about staff not knowing of R3's whereabouts the administrator stated, "If it were another resident identified as missing the facility would initiate their missing person plan. I am not sure why staff had not done that when [R3] was noted to be missing". The administrator indicated staff should know where R3 is located at all times and when his location in unknown, staff should initiate a search.

During document review it was noted that R3 had left the facility unsupervised on 5/25/14, 5/28/14 & 6/19/14 and in the past on 6/30/13 & 7/4/13. The following documentation was noted in the progress notes:

(1) On 6/30/13, at 10:50 p.m. during the evening shift, R3 had wheeled himself outside after supper. The documentation indicated at 6:05 p.m. a community member had knocked on the facility door and a nursing assistant (NA) answered the door and saw 6 community members standing around R3 who had fallen out of his wheelchair and was laying in the street next to the sidewalk. The documentation indicated R3 had wheeled off of the sidewalk and fell out of his wheelchair into the street. [The street where R3 had fallen was a busy street on the east side of the facility with moderate traffic and a commercial factory located across the street where semi-trucks frequently load/unload goods]. The nurse's note identified the sidewalk curb as uneven and raised at one end and not even or flat with the road;

(2) Progress notes dated 7/4/13, at 9:40 p.m. identified that R3 had been brought back to the facility by a couple of community members who stated R3 had crossed the street located by the factory on the east side of the facility and R3 had been found stuck in his wheelchair on the street

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2 830	Continued From page 12	2 830		

corner. [To get to the corner R3 had to cross a busy road and maneuver many environmental obstacles (i.e. curbs, vehicles, uneven pavement, and small inclines)];

(3) On 5/25/14, during the evening shift, R3 independently wheeled outside the facility, blocks away from the facility. During interview with the social service designee (SSD) on 6/24/14, at 2:00 p.m. it was indicated that R3 had wheeled himself to the Cenex gas station and a community member had contacted the facility and informed them of his location. Staff had been summoned to bring R3 back to the facility. [The Cenex store was noted to be approximately one-half mile from the facility on a busy street with a moderate incline from the facility to the store. Due to R3's limited ability to propel the wheelchair, it would have taken a significant amount of time to propel this distance];

(4) Three days later, a nurses' note dated 5/28/14, at 9:06 p.m., identified that R3 was again returned to the facility at 7:00 p.m. as he had been located a block from the facility. The medical record lacked any further documentation about the incident. An assessment related to the safety of R3 leaving the premises unsupervised was not evident in the record; and

(5) On 06/19/14, at 3:59 p.m. the medical record had documentation which indicated the charge nurse informed SSD that R3 had been found in the alley a couple blocks away, near the house of someone who knew R3. The community member assisted R3 back to the facility as it was starting to rain. R3 was reportedly stuck in his wheelchair in the community members yard and needed assistance to free his wheelchair. The community member stated R3 was unable to find

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2 830	Continued From page 13 his way back to the facility. R3's medical record lacked a thorough investigation into the elopement nor was any assessment evident related to his safety needs. It was noted that although documentation dated 7/9/13, at 4:25 p.m. indicated that social services had discussed with R3 the risk of crossing the street unsupervised and the importance of informing staff, R3 found "what this writer was talking about to be funny". Documentation indicated that a discussion had occurred related to R3 using a name card or the use of an available button similar to life line so he could summon help if required. Documentation indicated R3 was okay with either option. It was again noted in social service documentation dated 6/19/14, (a year later) that R3 had been spoken with about remaining on the facility campus for safety but that R3 found the conversation amusing and laughed. No follow-up and/or further assessment nor interventions were evident in the medical record. On 6/25/14, at 10:37 a.m. registered nurse (RN)-A was interviewed and stated she was unaware if there had been an assessment to identify whether R3 was capable of safely leaving the facility campus independently. RN-A verified the care plan lacked any guidance to staff related to R3's elopements and/or safety abilities when out of facility. RN-A stated she would expect R3's care plan should have had interventions developed which included monitoring his whereabouts. RN-A verified R3 did not always make safe decisions and was at risk for injury. RN-A stated SS should have conducted a safety/elopement assessment due to R3's history of elopements.	2 830		

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2 830	Continued From page 14 During an interview on 6/25/14, at 12:50 p.m. the SSD stated R3 had a history of making poor decisions but stated R3 had some cognitive awareness. SS indicated she instructed R3 regarding the need to stay on the facility property but stated R3 laughed when the situation was addressed. SS confirmed she had not conducted any further assessments related to this. The SS indicated she was a new employee so had been unaware of the elopements and subsequent falls that had occurred previously. The SS verified the care plan lacked planned interventions related to his safety risks. She further stated that R3 had poor judgement related to safety, indicating he was carefree. During interview on 6/26/14, at 11:20 a.m. with R3's primary physician, it was stated that R3 would not be safe if given the opportunity to be off the premises unsupervised and confirmed R3 should not leave the premises unsupervised. The physician indicated she had not been unaware that R3 had eloped on 5/25/14 and 5/28/14. The facility policy dated 1/2003, Elopement, identified the following procedures for missing resident: 1. It is the responsibility of all personnel to report any resident attempting to leave the premises, or suspected of being missing, to the charge nurse as soon as possible 2. Should an employee observe a resident leaving the premises, he/she should: a. Attempt to prevent departure; b. Obtain assistance from other staff members in the immediate vicinity, if necessary; c. Instruct another staff member to notify the charge nurse or director of nursing that the resident has left the premises. 3. Upon return of the resident to the facility ' the	2 830		

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2 830	Continued From page 15 director of nursing or charge nurse should: a. Examine the resident for injuries; b. Contact the attending physician and report what happened; c. Contact the legal representative and inform them of the incident d. Complete and file an incident report; and e. Make appropriate notations in the resident ' s medical record. 4. Should an employee discover that a resident is missing from the facility, he/she should: a. Determine if the resident is out on an authorized leave or pass. If not: b. Make a thorough search of the building and premises. If not located: c. Notify the administrator and the director of nursing, social worker first if unable to reach the director of nursing or nurse manager on duty; d. Notify the residents legal representative e. Notify the attending physician; f. Notify law enforcement officials g. If necessary, notify volunteer agencies-law enforcement will make that determination; h. Provide search teams with resident identification information; and i. Make an extensive search of the surrounding area. SUGGESTED METHOD FOR CORRECTION: The DON or Deginee could reassess all residents for elopement. The DON or Designee could conduct audits to ensure that all residents have been reassessed for elopement and interventions have been implemented for those residents who are at risk for elopement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 870	Continued From page 16	2 870		
2 870	MN Rule 4658.0520 Subp. 2 H. Adequate & Proper Nursing Care-CleanClothing Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: H. Clean clothing and a neat appearance. Residents must be dressed during the day whenever possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in a manner that promoted personal hygiene for 1 of 3 residents (R3) reviewed who required extensive assistance with daily grooming needs. Findings include: R3 had diagnoses that included a history of cardiovascular accident (CVA-with right sided hemi-paresis), hypertension, aggressive behavior and depression. R3's care plan, identified a problem which had been initiated 4/3/13 including: "Disruptive behavior: Resident refuses to follow tobacco free facility policy." The goal was identified as: "Resident will remain clean,..." The interventions included: "Offer to assist with cleaning of tobacco off face and hands." During observation of R3's cares on 06/23/14, at 11:13 a.m. it was noted that R3 had a dark brown substance under his fingernails. R3 was also noted to have chewing tobacco smeared on his face and hands and was wearing heavily soiled gray sweat pants.	2 870		

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2 870	Continued From page 17 During observation of R3 on 6/23/14, at 3:11 p.m. it was observed that R3 exited the front door of the building. R3 had been involved an activity just prior to leaving, which including consuming cake and drinking coffee. During this observation R3 was noted to have cake frosting covering the right side of his face and in his beard. R3 also wore heavily soiled pants and shirt. During an observation on 6/24/14, at 4:59 p.m. R3 was observed seated in the dining room and had chewing tobacco running down the both sides of his mouth, chin and left hand. Licensed practical nurse (LPN)-A was interviewed on 6/24/14, at 5:00 p.m. and stated R3 often refused to let staff wash his face or hands. LPN-A also stated that R3 allowed some staff to wash him. LPN-A indicated that nursing assistant (NA)-A who was working on the shift, was one of the staff who was able to assist R3. During observations in the dining room on 6/24/14, at 5:00 p.m. it was noted that several staff walked by R3 without offering assistance with hand and/or facial washing. At 5:03 p.m. dietary assistant (DA)-A was observed to serve R3 his coffee and walk from the area without alerting staff to his grooming needs. At 5:07 p.m. the dietary manager (DM) was observed to walk by R3, communicate with him but failed to offer assistance. It was noted that at 5:09 p.m. NA-H walked by resident and did not assist him. It was evident that R3 had brown substance all around his mouth. During an interview on 6/24/14, at 5:12 p.m. NA-A stated R3 would seldom let staff change his clothes until the end of the day but stated R3 did allow staff to wash his face sometimes if	2 870		

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2 870	Continued From page 18 approached in a manner that was not threatening or "pushy". NA-A stated that although R3 was resistive at times, he did have periods of compliance. NA-A stated R3 definitely had certain staff he responded to better than others. On 6/24/14, at 5:50 p.m. DA-E was observed to serve R3 his evening meal which consisted of pea salad, ham and potato, and mandarin oranges. R3 was also served coffee, milk and juice. When served the evening meal, it was noted that R3 continued to have a notable brown substance (chewing tobacco) around his mouth, on his chin and left hand. DA-E did not offer R3 assistance with washing his hands or face nor find another staff to offer assistance. R3 was observed to have the brown substance (chewing tobacco) dripping from his left fingers while eating. The facility failed to provide services in accordance with R3's care plan which indicated that staff should assist R3 to wash his hands and face as needed. SUGGESTED METHOD FOR CORRECTION: The DON could ensure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with personal care per facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 870		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control	21426		

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21426	Continued From page 19 (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. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement their infection control program to ensure all employees were free of communicable disease. The facility failed to conduct a two step tuberculin skin test for 1 of 5 employees (E5) reviewed who required pre-employment tuberculin skin testing. Findings include: During review of the facility schedule for staffing on 6/25/14 it was identified E5 was on the schedule and working with residents. During review of the employee medical files for verification of tuberculin skin tests (TST) it was	21426		

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21426	Continued From page 20 noted E5 had a first step TST conducted on 4/28/14 and the results were read on 4/30/14. On 5/14/14, E5 had the 2nd step administered but documentation was lacking to indicate the results had been read. During interview with the director of nurses (DON) on 6/25/14, at 2:15 p.m. it was verified there was no evidence the 2nd step had been read for E5. The DON stated upon completion of a tuberculin skin test, documentation of the finding is kept at the nurses station until both steps are completed and then the documentation is transferred into the employee health record. The DON verified the form lacked documentation to indicate it had been completed and read. The facility policy for Employee PPD (Mantoux) Tuberculin test and/or Chest X-ray, dated 3/2004 identified the following procedures: 1. A negative PPD will be required before new employees begin orientation. PPD test must be done before employment and read within 48-72 hours. A week later the employee is to again have the Mantoux test done and read by the nurse in 48-72 hours. A negative PPD will be required before new employee begins orientation. 4. A list of employees requiring a PPD or chest X-ray will be posted on the door by the time clock the first week of the month they are done. It will be the responsibility of staff members to get their PPD in the month required. If the PPD or X-ray is not done in the month it is required, some form of disciplinary action will be taken. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could	21426		

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	00695	A. BUILDING: _____ B. WING _____	06/26/2014

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21426	Continued From page 21 in-service employees responsible for giving and monitoring TB status of new employees the current standard for giving TB. The DON or designee could perform audits to assure the TB status of new employees is correct. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement their written abuse prohibition policy which included notification of the administrator and other officials in accordance with State law through established procedures	21990		

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21990	Continued From page 22 (including to the State survey and certification agency) when there were allegations of misappropriation of resident money for 1 of 1 resident (R56) reviewed who reported money missing from his wallet and failed to report and thoroughly investigate elopement incidents for 1 of 1 resident (R3) who left the campus premises without staff knowledge. Findings include: The facility policy for abuse prohibition, revised 1/16/2012, identified maltreatment as physical abuse, emotional abuse, sexual abuse, verbal abuse, personal exploitation, financial exploitation, or neglect by anyone. The procedure for reporting such maltreatment was identified as follows: (1.) Employees of Luther Memorial are mandated reporters and must report any situations that are defined as abuse, neglect or injuries of unknown origin to the nurse in charge. The Nurse in Charge will: a. Immediately assess the situation to determine if any emergency treatment is required. b. Notify the physician. c. Notify the administrator, Director of Nursing and Social Services. d. Fill out a Resident Incident Report, noting that the type of incident is potential abuse or a suspected crime. (2.) Incidents that occur when the designated reporter is on site, the charge nurse shall notify the designated reporter. The designated reporter will: a. Report the incident electronically to the Office of Health Facility Complaints (OHFC) immediately. Print a copy of submission to OHFC. b. Report incident to the Common Entry Point	21990		

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21990	Continued From page 23 (CEP) which is Watonwan County Human Services by faxing them a copy of the OHFC electronic submission. If the incident involves criminal activity (e.g. assault, sexual assault, serious bodily injury), the CEP must be notified by telephone. c. Notify the Madelia police department in cases of a suspected crime (e.g.) assault, sexual assault, theft, forgery, robbery, burglary etc.) d. Notify the family of the incident. (3.) Incidents that occur while the designated reporter is off duty, the nurse in charge will complete the steps described in 3a through 3d. (4.) The nurse in charge will document: a. A detailed description of the incident in the medical record of each resident involved. Residents will be identified by their medical record number rather than name when mentioned in another resident's chart. b. Notification of family and physician. (5.) The investigative team (i.e. at minimum, Administrator, Director of Nursing (DON), Social Services Director) will initiate investigation of incident reports regarding injury of unknown origin, abuse, neglect, misappropriation of resident property, or involuntary seclusion. a. The investigation may include interviewing staff, residents and other witnesses to the incident b. The results of investigation must be reported to the administrator or designated representative and to OHFC within five working days of the initial report of incident. The following documentation related to R3's elopements were noted in the medical record and were not reported to the State agency, nor was there evidence an investigation had occurred: (1) On 5/25/14, during the evening shift, R3 independently wheeled outside the facility, blocks	21990		

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21990	Continued From page 24	21990		

away from the facility. During interview with the social service designee (SSD) on 6/24/14, at 2:00 p.m. it was indicated that R3 had wheeled himself to the Cenex gas station and a community member had contacted the facility and informed them of his location. Staff had been summoned to bring R3 back to the facility. [The Cenex store was noted to be approximately one-half mile from the facility on a busy street with a moderate incline from the facility to the store. Due to R3's limited ability to propel the wheelchair, it would have taken a significant amount of time to propel this distance];

(2) Three days later, a nurses' note dated 5/28/14, at 9:06 p.m., identified that R3 was again returned to the facility at 7:00 p.m. as he had been located a block from the facility. The medical record lacked any further documentation about the incident; and

(3) On 06/19/14, at 3:59 p.m. the medical record had documentation which indicated the charge nurse informed SSD that R3 had been found in the alley a couple blocks away, near the house of someone who knew R3. The community member assisted R3 back to the facility as it was starting to rain. R3 was reportedly stuck in his wheelchair in the community members yard and needed assistance to free his wheelchair. The community member stated R3 was unable to find his way back to the facility. R3's medical record lacked a thorough investigation into the elopement.

During interview on 6/23/14, at 10:19 a.m. R56 reported that money had been taken from his wallet located in his room in January 2014. R56 stated he was missing two (2) $20.00 bills, two (2) $10.00 bills, four (4) $5.00 bills and some

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21990	Continued From page 25 $1.00 bills. R56 stated he had reported the missing money to the nurse. R56 stated his left his wallet in his night stand and when he took it out the money was missing. During interview on 6/24/14, at 1:53 p.m. the social worker (SW) indicated she had a written report related to missing money that R56 had reported. The SW stated that $70 had been reported as missing from his wallet so she had searched R56's room and questioned staff about the missing money. During review of the documentation related to the investigation of the missing money, dated 1/23/14, it indicated that R56 had reported around $70.00 missing from his wallet that was left in his night stand drawer in his room. The report further identified that nursing staff were questioned about the missing money and the family was notified. The investigation did not identify which staff were interviewed nor if any follow-up had occurred related to the missing money. The SW stated R56's family member (FM)-A had been contacted and was the SW was informed by FM-A that the amount of missing money reported was questionable. Further, during the interview the SW verified there had been no reports to outside agencies related to R3's elopement from the facility. The SW verified R3 left the facility campus without knowledge of staff and without anyone signing him out. She was unsure why there had not been a report filed for potential neglect related to R3's elopement. During interview with FM-A on 6/23/14, at 8:00 p.m. FM-A stated, "If [R56] stated he had $70.00 missing I would believe him. He is very aware of money and would know if it was missing." During review of the incident report related to the missing money it was noted that a thorough	21990		

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21990	Continued From page 26 investigation had not been completed. Evidence was lacking to indicate the potential misappropriation of money had been reported in accordance with the facility's abuse prohibition plan. There was no evidence the facility had notified the administrator, common entry point (CEP) or Office of Health Facility Complaints (OHFC) as directed by facility policy. During interview with the SW on 5/24/14, at 2:00 p.m. it was verified there was no report filed to any outside agencies related to the missing money. Suggested Method of Correction: The director of nursing (DON) could work with the administrator to ensure the abuse prohibiton policy was implemented as written to meet Federal requriements, and then could educate staff. The DON or designee could also perform audits to ensure reports to the SA occurred in the requried timeframes. Time Period for Correction: Twenty-one (21) days.	21990		