#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### CENTERS FOR MEDICARE & MEDICAID SERVICES

					TE SURVEY AGENCY		ID: LDWF Facility ID: 00695
1. MEDICARE/MEDICAID PROVIDE (L1) 245522 2.STATE VENDOR OR MEDICAID N (L2) 443343200	ER NO.	3. NAME AND AD (L3) <b>LUTHER M</b> (L4) <b>221 6TH ST</b> (L5) <b>MADELIA</b> ,	DDRESS OF FACE  EMORIAL H  REET SOUTI	CILITY	(L6) <b>56062</b>	4. TYPE OF A  1. Initial 3. Terminatio 5. Validation 7. On-Site Vi	ACTION: 7 (L8)  2. Recertification on 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA		y After Complaint
6. DATE OF SURVEY <b>08/0</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>7/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR I	ENDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 61 (L37) (L38) 16. STATE SURVEY AGENCY REM See Attached Remarks 17. SURVEYOR SIGNATURE	61 (L18) 61 (L17) WN 19 SNF (L39)	Compliance	nce With equirements e Based On: cceptable POC upliance with Projects and/or Appli	gram ied Waivers:	And/Or Approved Waivers O  2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code  * Code: A  15. FACILITY MEETS  1861 (e) (1) or 1861 (j) (1):	el6. Scope 7. Medic NF)8. Patien 9. Beds/ (L12)	e of Services Limit cal Director at Room Size /Room
Connie Brady, HFE NE	II	0	8/15/2014	(L19)	Kamala Fiske-Downing,	Enforcement S	Specialist 10/17/2014 (L20
PA	RT II - TO BE (	COMPLETED E	BY HCFA RI	` '	L OFFICE OR SINGLE S	STATE AGENC	`
DETERMINATION OF ELIGIBIT     1. Facility is Eligible to I     2. Facility is not Eligible	Participate		PLIANCE WITI	H CIVIL	<ul><li>21. 1. Statement of Fin.</li><li>2. Ownership/Cont.</li><li>3. Both of the Abov.</li></ul>	rol Interest Disclosure	
22. ORIGINAL DATE OF PARTICIPATION 11/01/1987	23. LTC AGREEM BEGINNING		LTC AGREEN		26. TERMINATION ACTION  VOLUNTARY  01-Merger, Closure  02-Dissatisfaction W/ Reimbur	00 <u>INV</u> 05-F	(L30)  OLUNTARY  Fail to Meet Health/Safety  Fail to Meet Agreement
(L24) 25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS n of Admissions:	(L25) (L44) (L45)		03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	ion <u>OTH</u> 1 07-P	_
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		03001			-		
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	L DATE			

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00695

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS



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, Program Specialist

Kumala Fiske Downing

Licensing and Certification Program Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245522	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/7/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
LU	ITHER MEMORIAL HOME		221 6TH STREET SOUTHWES	Т

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) D	ate	(Y4) Item	(Y5	) Date	(Y4)	Item		(Y5)	Date
		Corr	ection			Correction					Correction
ID Prefix	F0224		npleted <b>7/2014</b>	ID Prefix	F0225	Completed 08/07/2014		ID Prefix	F0226		Completed <b>08/07/2014</b>
	483.13(c)		172014		483.13(c)(1)(ii)-(iii), (c)	_			483.13(c)		
	403.13(0)			LSC	403.13(0)(1)(11)-(111), (0)	(2) -		LSC	403.13(0)		_
		Corr	ection			Correction					Correction
ID Prefix	F0282		pleted <b>7/2014</b>	ID Prefix	F0312	Completed <b>08/07/2014</b>		ID Prefix	F0323		Completed <b>08/07/2014</b>
	483.20(k)(3)(ii)		.,		483.25(a)(3)	_			483.25(h)		
LSC				LSC		<del>-</del> -		LSC			<u> </u>
		Corr	ection			Correction					Correction
			pleted			Completed					Completed
ID Prefix	F0497		7/2014	ID Prefix		-		ID Prefix			
Reg. #	483.75(e)(8)			Reg. #				Reg. #			<u></u>
LSC				LSC		=		LSC			
		Corr	ection			Correction					Correction
			pleted	15.5 (		Completed					Completed
ID Prefix						_					
Reg. # LSC				Reg. # LSC		_		Reg. #			<u>—</u>
						_					
		Corr	ection			Correction					Correction
ID Prefix			pleted	ID Profix		Completed		ID Profix			Completed
Reg. #				Reg. #	_	=		Reg. #	-		_
						<del>-</del> -		LSC			<u> </u>
Reviewed E	By Rev	iewed By		Date:	Signature of Su	rveyor:				Date:	
State Agen	cy K	S/KFD		08/15/2	014	28	651				08/15/2014
Reviewed B	By Rev	iewed By		Date:	Signature of Su	rveyor:	_			Date:	
CMS RO											
Followup t	o Survey Comple				Check for any Unco Uncorrected Defi					•	
	6/26/201	4			Uncorrected Deti	ciencies (CIV	13-230	n j Sent to	ine racinty	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245522	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING 01	(Y3) Date of Revisit 8/4/2014	
Name of Facility		Street Address, City, State, Zip Code		
LUTHER MEMORIAL HOME		221 6TH STREET SOUTHWES' MADELIA, MN 56062	Т	

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		Correct Comple 08/03/2	eted		Correction Completed		ID Prefix		Correction Completed
	NFPA 101		Reg. #				D "		
LSC	K0029		LSC				LSC		
		Correct	ion		Correction				Correction
		Comple			Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg. #			Reg. #				Reg. #		
									<u>—</u>
		Correct	ion		Correction				Correction
ID Destin		Comple	eted		Completed		ID Deefee		Completed
Reg. #			Reg. #				Reg. #		
		Correct	ion		Correction				Correction
ID Prefix		Comple			Completed		ID Prefix		Completed
Reg. #			Dog #				Reg. #		
LSC			LSC				LSC		
		Correct	ion		Correction				Correction
		Comple	eted		Completed				Completed
ID Prefix			ID Prefix				ID Prefix		
Reg. #	-		Reg. #				Reg. #		
			LSC				LSC		
Reviewed E	By Re	eviewed By	Date:	Signature of Sur	veyor:			Date	:
State Agen	су	PS/kfd	08/15/2014			19251	1		08/04/2014
Reviewed E	By Re	eviewed By	Date:	Signature of Sur				Date	
CMS RO									
Followup t	o Survey Compl 6/25/20			Check for any Uncor Uncorrected Defic	rected Defi	cienci 1S-250	es. Was a 67) Sent to	Summary of the Facility?	NO



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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring

Kumalu Fiske Downing

Minnesota Department of Health

Telephone: (651) 201-4112

Fax: (651) 215-9697

	State Form: Revisit Report								
(Y1)	Provider / Supplier / CLIA / Identification Number 00695	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/7/2014					
Name	e of Facility		Street Address, City, State, Zip Code						
LU	THER MEMORIAL HOME		221 6TH STREET SOUTHWE MADELIA. MN 56062	EST					

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	(YS	5) Date	(Y4) Item	(	(5) Date	(Y4)	Item		(Y5)	Date
ID Prefix	20565	Correction Completed 08/07/2014	ID Prefix	20830	Correction Completed 08/07/2014		ID Prefix	20870		Correction Completed 08/07/2014
	MN Rule 4658.0405 Su			MN Rule 4658.0520				MN Rule 4658		
ID Prefix Reg. # LSC	21426 MN St. Statute 144A.0	Correction Completed 08/07/2014 4 Su	ID Prefix		Correction Completed 08/07/2014		<b>.</b>			
Reg. #			Reg. #				Reg. #			
Reg. #			Reg. #							Correction Completed
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed		ID Prefix			Correction Completed
Reviewed B			Date: 08/15/20	Signature of S	-	8651			<b>Date:</b> 08/1	5/2014
Reviewed B	By Reviewe	d By	Date:	Signature of	Surveyor:				Date:	
Followup to Survey Completed on: 6/26/2014				Check for any Un Uncorrected D					YES	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LDWF Facility ID: 00695

		10 22 001111			I DOINT I HODING	Tability ID: 00075	
MEDICARE/MEDICAID PROVI     (L1) 245522  2.STATE VENDOR OR MEDICAID		3. NAME AND AL (L3) <b>LUTHER M</b> (L4) <b>221 6TH ST</b>	IEMORIAL H	OME		4. TYPE OF ACTION: 2 (L8)  1. Initial 2. Recertification	
(L2) 443343200	NO.	(L5) MADELIA,		IWESI	(L6) <b>56062</b>	3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANGE O	F OWNERSHIP	7. PROVIDER/SU  01 Hospital		GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY <b>06/</b> 8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>26/2014</b> (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11LTC PERIOD OF CERTIFICATI	ON	10.THE FACILITY	/ IS CERTIFIED	AS:			
From (a):		X A. In Complia			And/Or Approved Waivers O	f The Following Requirements:	
To (b):			equirements e Based On:		2. Technical Personne	_ 1	
12.Total Facility Beds	<b>61</b> (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural Si 5. Life Safety Code	7. Medical Director NF)8. Patient Room Size 9. Beds/Room	
13.Total Certified Beds	<b>61</b> (L17)		npliance with Progents and/or Appli		_	(L12)	
14. LTC CERTIFIED BED BREAKE	OOWN	•			15. FACILITY MEETS		
18 SNF 18/19 SNI	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL Date:	
Connie Brady, I	HFE NE II		07/25/2014	(L19)	Kamala Fiske-Downing	g, Enforcement Specialist 9/4/2014	L20
P	ART II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBLE     1. Facility is Eligible to     2. Facility is not Eligible	) Participate		IPLIANCE WITI HTS ACT:	H CIVIL		ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513) /e:	
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	v: (L30)	
OF PARTICIPATION 11/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburg	č	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Terminati 04-Other Reason for Withdrawal	OTHER  07-Provider Status Change	
(L27)	B. Rescind St	uspension Date:	(L44) (L45)			00-Active	
28. TERMINATION DATE:	29	). INTERMEDIARY/	CARRIER NO.		30. REMARKS		_
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE			
	(L32)			(L33)	DETERMINATION APP	PROVAL	



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;

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

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

<u>Informal Dispute Resolution</u> - 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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm</a>

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 07/31/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245522	B. WING _		06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	will serve as your a the Department's a enrolled in ePOC, y at the bottom of the form. Your electror be used as verificated. Upon receipt of an on-site revisit of you validate that substate regulations has been your verification.  A recertification sur Minnesota Department of 25 and 6/26/14. A conducted. The sur Jeopardy (IJ) at F35 failure to provide as interventions to precampus for R3 which potential for harm of notified of the IJ what a conversation at 1	onic plan of correction (ePOC) llegation of compliance upon cceptance. Because you are your signature is not required a first page of the CMS-2567 hic submission of the POC will	F 00	,		
F 224	severity level of a I harm with a potenti harm. 483.13(c) PROHIB		F 22	24		8/3/14
SS=D	The facility must de policies and proced mistreatment, negle and misappropriation	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.		TITLE		(Xe) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/2	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	Continued From pa	age 1	F 224			
	by: Based on interview facility failed to provision for 1 of campus premises of failed to prevent all resident money for reviewed who repowallet.  Findings include: The following docuelopements were medical record. The reported to the Statevidence an investion (1) Progress note of described as during R3 had independent out of the facility, a facility. During interdesignee (SSD) on SSD stated R3 had gas station on 5/25 had contacted the flocation. Staff had back to the facility. to be approximately on a busy street wifacility to the store.	NT is not met as evidenced and document review the vide the appropriate in 1 resident (R3) who left the vithout staff knowledge and eged misappropriation of 1 of 1 resident (R56) red money missing from his mentation related to R3's oted in progress notes in the nese elopements had not been the agency, nor was there igation had occurred:  Socumentation from 5/25/14, of the evening shift, indicated on the holocks away from the eview with the social service 6/24/14, at 2:00 p.m., the wheeled himself to the Cenex in the electron of the community member facility to inform them of his been summoned to bring R3 in the Cenex store was noted by one-half mile from the facility to air, it would have taken a		This Plan of Correction and the responses to each F-Tag are submaintain certification in the Medical Medicaid programs and constitute credible allegation of compliance. Written responses do not constitute admission of noncompliance or agreement with any findings stated the F-Tags. The facility reserves it to dispute all findings and deficient any appropriate forum, including in independent dispute resolution, or, appealable remedies are subseque imposed, by timely appeal to the Departmental Appeals Board.  F224  1) To address the concerns related hourly checks by nursing personne implemented in combination of add Code Alert to the wheelchair. Whe goes outdoors, he is supervised by member or volunteer who would be to summon assistance should it be needed. R56 will be encouraged to continue informing staff of complai including missing personal items lil money, and will be reminded of the availability of the Resident Trust Ac R56 will also be discouraged from keeping cash in his room, emphas	re and a Free and a Fr	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245522	B. WING			06/2	26/2014	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00,1		
LUTHER	MEMORIAL HOME				21 6TH STREET SOUTHWEST			
				IV	MADELIA, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 224	significant amount of (2) Another nurses p.m., identified that to the facility at 7:00 located a block from record lacked any f the incident. An ass of R3 leaving the prevident in the record (3) Progress notes indicated the chargethat R3 had been for blocks away, near the knew R3. According community member facility because it were portedly stuck in locommunity member assistance to free hindicated the commental R3 was unable to fire R3's medical recordinated that mone wallet located in his stated he was miss (2) \$10.00 bills. R56 stamps money to the swallet in his nighout the money was During interview on puring interview on the swallet in his nighout the money was During interview on the states of the swallet in his nighout the money was During interview on the states of the swallet in his nighout the money was During interview on the states of the states of the swallet in his nighout the money was the states of	of time to propel this distance];  I note, dated 5/28/14, at 9:06 R3 had again been returned of p.m. after having been in the facility. The medical surther documentation about sessment related to the safety remises unsupervised was not in the distance of the safety remises unsupervised was not in the alley a couple he house of someone who in the documentation, the remaining to rain. R3 was his wheelchair in the r's yard and needed his wheelchair. Documentation aunity member had reported in this way back to the facility. I lacked a thorough relopement.  6/23/14, at 10:19 a.m. R56 by had been taken from his a room in January 2014. R56 ing two (2) \$20.00 bills, two refully \$5.00 bills and some atted he had reported the ne nurse. R56 stated his left int stand and when he took it	F 2	224	the ease of using the Resident Trus Account. Staff will investigate any freport by R56 of missing personal ir and will keep a complete record of investigation. Staff will notify the Administrator and Director of Nursin investigations and corresponding in reports.  2) All residents have the potential of the profiles of both R3 and R56.  3) An all-staff inservice was held on 2, 2014. One of the agenda items focused on reviewing the procedure "reporting suspected abuse or neglinesidents". The review of the procedure included how to document investigation and Director of Nursing of incidents 4) The Administrator and Director of Nursing will continue to be kept informational director of Nursing instances cases should be reported to the Staff Agency (SA), which will be referred the future of this plan as the Office Health Facility Complaints (OHFC), interdisciplinary team will continue to Mondays through Fridays, reviewing incidents/notes, also responsible for identifying instances when cases should reported to OHFC. The Charge Nurses will continue to be responsificulating reports of suspected about and neglect to OHFC, regardless of day or day of the week. Staff will trained periodically on reporting suspuse, neglect, or misappropriation residents.	tuture tems each ng of icident if fitting in July e on ect of edure ations strator is formed bes of it when ate to in of The ico meet g r nould ble for use if time I be spected		
		ssing money that R56 had			residents.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245522	B. WING		06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 121 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPROPERTY)	D BE	(X5) COMPLETION DATE
F 224	reported as missing searched R56's root the missing money documentation relamissing money, da R56 had reported awallet that was left room. The report for staff were question and the family was not identify which is follow-up had occumoney. The SW is (FM)-A had been conformed by FM-A money reported was during the interview been no reports to R3's elopement from R3 left the facility of staff and without an was unsure why the for potential neglection. During interview with p.m. FM-A stated, missing I would be money and would be money and would be indicated the report. During review of the missing money it with investigation had not was lacking to indicated the report.	stated that \$70 had been g from his wallet so she had om and questioned staff about. During review of the ated to the investigation of the ted 1/23/14, it indicated that around \$70.00 missing from his in his night stand drawer in his urther identified that nursing ared about the missing money notified. The investigation did staff were interviewed nor if any arred related to the missing tated R56's family member ontacted and was the SW was that the amount of missing as questionable. Further, we the SW verified there had outside agencies related to the facility. The SW verified campus without knowledge of myone signing him out. She ere had not been a report filed at related to R3's elopement.  Ath FM-A on 6/23/14, at 8:00 lieve him. He is very aware of know if it was missing." FM-A t was believable.	F 224	Completion date: August 3, 2014		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		245522	B. WING _		06	/26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 224	(CEP) or Office of I (OHFC) as directed (OHFC) as directed any outside agencimoney.  The facility policy for 1/16/2012, identifie abuse, emotional a abuse, personal exexploitation, or neg  The procedure for was identified as for "(1.) Employees of mandated reporters situations that are on injuries of unknown The Nurse in Charga. Immediately assif any emergency to b. Notify the physic c. Notify the adminimand Social Services d. Fill out a Resident the type of incident suspected crime.  (2.) Incidents that or reporter is on site, the designated repowill:  a. Report the incident the composition of the procedure of the composition of th	Health Facility Complaints by facility policy.  In the SW on 5/24/14, at 2:00 there was no report filed to es related to the missing or abuse prohibition, revised d maltreatment as physical buse, sexual abuse, verbal ploitation, financial lect by anyone.  Teporting such maltreatment and must report any defined as abuse, neglect or origin to the nurse in charge. The sexual abuse of a complete sexual abuse or a content of the sexual abuse of a content abuse or a cont	F 22	4		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIED/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245522	B. WING _		06/2	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224 F 225 SS=D	criminal activity (e.g serious bodily injury telephone. c. Notify the Madelia of a suspected crim assault, theft, forge d. Notify the family (3.) Incidents that or reporter is off duty, complete the steps (4.) The nurse in cla. A detailed descripmedical record of e Residents will be idrecord number rath in another resident's b. Notification of far (5.) The investigatin Administrator, Director of the control	on. If the incident involves a assault, sexual assault, or), the CEP must be notified by a police department in cases are (e.g.) assault, sexual ry, robbery, burglary etc.) of the incident. Occur while the designated the nurse in charge will described in 3a through 3d. In arge will document: oftion of the incident in the ach resident involved. The entified by their medical er than name when mentioned is chart. In an involved in the entified by their medical er than name when mentioned is chart. The entified investigation of arding injury of unknown for involuntary seclusion. In any include interviewing other witnesses to the restigation must be reported to a designated representative of the five working days of the initial oftic (c)(2) - (4)	F 22			8/3/14
	been found guilty of	t employ individuals who have abusing, neglecting, or as by a court of law; or have				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/26/2014		
	NAME OF PROVIDER OR SUPPLIER  LUTHER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062	, , ,	9,2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 225	registry concerning of residents or miss and report any kno court of law agains indicate unfitness f other facility staff to or licensing authori.  The facility must er involving mistreatm including injuries of misappropriation of immediately to the to other officials in through established State survey and countries. The facility must haviolations are thorough event further pote investigation is in processing the side of	ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a tran employee, which would or service as a nurse aide or of the State nurse aide registry ties.  Insure that all alleged violations ment, neglect, or abuse, frunknown source and fresident property are reported administrator of the facility and accordance with State lawed procedures (including to the ertification agency).  Insure that all alleged administrator of the facility and accordance with State lawed procedures (including to the ertification agency).  Insure evidence that all alleged aughly investigated, and must cential abuse while the progress.	F 225				
	to the administrator representative and with State law (includent certification agency incident, and if the appropriate correct This REQUIREMED by:  Based on interview facility failed to ensure conducted when the	vestigations must be reported r or his designated to other officials in accordance uding to the State survey and v) within 5 working days of the alleged violation is verified ive action must be taken.  NT is not met as evidenced w and document review the sure an investigation was ere were allegations of f resident money for 1 of 1		This Plan of Correction and the responses to each F-Tag are submaintain certification in the Medica Medicaid programs and constitute	re and		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245522	B. WING		06/26/2014	
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST MADELIA, MN 56062	00/20/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION	
F 225	missing from his war Findings include:  During interview on reported that mone wallet located in his stated he was miss (2) \$10.00 bills, fou \$1.00 bills. R56 stamissing money to this wallet in his nigliout the money was	ewed who reported money allet.  6/23/14, at 10:19 a.m. R56 y had been taken from his a room in January 2014. R56 ing two (2) \$20.00 bills, two r (4) \$5.00 bills and some ated he had reported the he nurse. R56 stated his left int stand and when he took it missing.	F 225	credible allegation of compliance. The written responses do not constitute admission of noncompliance or agreement with any findings stated the F-Tags. The facility reserves its to dispute all findings and deficient any appropriate forum, including in independent dispute resolution, or, appealable remedies are subseque imposed, by timely appeal to the Departmental Appeals Board.  F225  1) R56 will be encouraged to continuous and constitute and constitu	under s right ies in an if ently	
	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			informing staff of complaints, included missing personal items like money. Will also be discouraged from keeping cash in his room and will be remind the availability of the Resident Trust Account. Staff will investigate any report by R56 of missing personal if and will keep a complete record of investigation. Staff will notify the Administrator and Director of Nursi investigations and corresponding in reports.  2) All residents have the potential of the profile of R56.  3) An all-staff inservice was held on 2, 2014. One of the agenda items focused on reviewing the procedure "reporting suspected abuse or negline residents". The review of the procincluded how to document investigation and follow-up and notify the Adminitiand Director of Nursing of incidents 4) The Administrator and Director of Nursing will continue to be kept information.	R56 ing led of t v future tems each ing of incident if fitting in July e on ect of cedure ations strator is.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/26/2014	
	NAME OF PROVIDER OR SUPPLIER  LUTHER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
	During review of the missing money it w investigation had no was lacking to indice misappropriation of accordance with the plan. There was no notified the adminis (CEP) or Office of H (OHFC) as directed During interview with p.m. it was verified any outside agencie money.  The facility policy for 1/16/2012, identifie abuse, emotional a abuse, personal ex exploitation, or neg  The procedure for massidentified as for "(1.) Employees of mandated reporters situations that are conjuries of unknown The Nurse in Charga. Immediately assif any emergency trob. Notify the adminitiand Social Services	consider the series of the association of the assoc	F 225	about incident reports and other ty facility reports, identifying instance cases should be reported to the S Agency (SA), which will be referre the future of this plan as the Office Health Facility Complaints (OHFC interdisciplinary team will continue Mondays through Fridays, reviewi incidents/notes, also responsible fidentifying instances when cases be reported to OHFC. The Charg Nurses will continue to be responsible submitting reports of suspected all and neglect to OHFC, regardless of day or day of the week. The Sc Services Director or designee will continue to be responsible for continue to be responsible for continue to DHFC.  Completion date: August 3, 2014	es when tate d to in e of ). The to meet ng or should e sible for ouse or time orial ducting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06	06/26/2014	
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP COD 221 6TH STREET SOUTHWEST MADELIA, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 225	reporter is on site, the designated repowill:  a. Report the incide of Health Facility C immediately. Print a b. Report incident t (CEP) which is War Services by faxing electronic submissis criminal activity (e.g. serious bodily injuritelephone.  c. Notify the Madeli of a suspected crimassault, theft, forged. Notify the family (3.) Incidents that reporter is off duty, complete the steps (4.) The nurse in ca. A detailed descrimedical record of erecord number rath in another resident b. Notification of fair (5.) The investigation of fair (5.) The investigation of the cord of the cord number resident property, ca. The investigation staff, residents and incident	coccur when the designated the charge nurse shall notify orter. The designated reporter ent electronically to the Office omplaints (OHFC) a copy of submission to OHFC. To the Common Entry Point tonwan County Human them a copy of the OHFC on. If the incident involves g. assault, sexual assault, y), the CEP must be notified by a police department in cases the (e.g.) assault, sexual try, robbery, burglary etc.) of the incident. Occur while the designated the nurse in charge will described in 3a through 3d. The hard will document: ption of the incident in the each resident involved. The entified by their medical ter than name when mentioned s chart.	F 2	25			

* * *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/:	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CO 221 6TH STREET SOUTHWEST MADELIA, MN 56062	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
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 2	25		
F 226 SS=D	483.13(c) DEVELO ABUSE/NEGLECT		F 2	26		8/3/14
	policies and proced mistreatment, negle	evelop and implement written lures that prohibit ect, and abuse of residents on of resident property.				
	by: Based on interview facility failed to imp prohibition policy w administrator and o with State law throu (including to the Stagency) when there misappropriation of resident (R56) review missing from his wathoroughly investigated of 1 resident (R3) without staff knowled Findings include:  The facility policy for 1/16/2012, identified	or abuse prohibition, revised d maltreatment as physical buse, sexual abuse, verbal ploitation, financial		This Plan of Correction and responses to each F-Tag are maintain certification in the Medicaid programs and concredible allegation of complimentation of noncompliance agreement with any findings the F-Tags. The facility reset to dispute all findings and deany appropriate forum, incluindependent dispute resolution appealable remedies are suimposed, by timely appeal to Departmental Appeals Board F226  1) Situations that are identifications are suited as a suimposed of the process of	e submitted to Medicare and stitute a ance. The estitute an e or stated under erves its right eficiencies in ding in an ion, or, if bsequently to the d.	
	,	eporting such maltreatment		Abuse & Neglect Prevention R56, and every resident of L	Policy for R3,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245522	B. WING		06/26/2014		
	PROVIDER OR SUPPLIER  MEMORIAL HOME			22	TREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST IADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	was identified as fo (1.) Employees of mandated reporters situations that are cinjuries of unknown The Nurse in Charga. Immediately asset if any emergency trb. Notify the physicic. Notify the adminiand Social Services d. Fill out a Resider the type of incident suspected crime. (2.) Incidents that creporter is on site, the designated repowill:  a. Report the incide of Health Facility Commediately. Print ab. Report incident to (CEP) which is Wat Services by faxing the electronic submissic criminal activity (e.g. serious bodily injury telephone.  c. Notify the Madeli of a suspected crimassault, theft, forged. Notify the family (3.) Incidents that creporter is off duty, complete the steps (4.) The nurse in cla. A detailed descrimedical record of employed.	llows: Luther Memorial are s and must report any lefined as abuse, neglect or origin to the nurse in charge. ge will: ess the situation to determine eatment is required. an. strator, Director of Nursing s. at Incident Report, noting that is potential abuse or a  occur when the designated the charge nurse shall notify orter. The designated reporter ant electronically to the Office omplaints (OHFC) a copy of submission to OHFC. b the Common Entry Point conwan County Human them a copy of the OHFC on. If the incident involves g. assault, sexual assault, applice department in cases are (e.g.) assault, sexual try, robbery, burglary etc.)	F 2	2226	Specifically, the facility will report are future elopement incidents or allegator of misappropriation that are determed be suspected abuse or neglect to the state agency in accordance with the and procedure for reporting suspect abuse, neglect, or misappropriation property.  2) All residents have the potential of the profile of R3 and R56.  3) An all-staff inservice was held or 2, 2014. One of the agenda items focused on reviewing the procedure "reporting suspected abuse or negling residents", including the need to inful the Administrator and the requirement immediate reporting in compliance state law.  4) The Administrator and Director of Nursing will continue to be kept informational about incident reports and other typicallity reports, identifying instances cases should be reported to the Staff Agency (SA), which will be referred the future of this plan as the Office Health Facility Complaints (OHFC), interdisciplinary team will continue to 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 identifying reports of suspected about and neglect to OHFC. The Charge Nurses will continue to be responsible for conditional reports of the week. The Social Services Director or designee will continue to be responsible for conditional investigation and reporting the fit to OHFC. Staff will be trained	ations ined to he policy ted of fitting had been detected by the policy of the policy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245522	B. WING _		06/	26/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 221 6TH STREET SOUTHWEST MADELIA, MN 56062	<u> </u>		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 226	record number rath in another resident b. Notification of fa (5.) The investigat Administrator, Dires Services Director) incident reports recorigin, abuse, negliging resident property, a. The investigation staff, residents and incident b. The results of in the administrator of and to OHFC within report of incident.  The following documents were remedical record. The results of incident.  The following documents were resident as during the described as during the residence an invest (1) Progress note of described as during R3 had independent out of the facility, a facility. During intendesignee (SSD) or SSD stated R3 had gas station on 5/25 had contacted the location. Staff had back to the facility to be approximated on a busy street with facility to the store propel the wheelch	ner than name when mentioned	F 23	periodically on reporting neglect, or misappropria to the Administrator and accordance with state la Completion date: Augus	tion of residents immediately in w.		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245522	B. WING			06/	26/2014	
	PROVIDER OR SUPPLIER  MEMORIAL HOME			221 6TH	ADDRESS, CITY, STATE, ZIP CODE I STREET SOUTHWEST LIA, MN 56062	,		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 226	p.m., identified that to the facility at 7:00 located a block from record lacked any f the incident. An ass of R3 leaving the prevident in the record.  (3) Progress notes indicated the charg that R3 had been for blocks away, near to knew R3. According community member facility because it was reportedly stuck in community member facility because it was reportedly stuck in community member facility because it was unable to fire the recommunity member facility because it was unable to fire the	Inote, dated 5/28/14, at 9:06 R3 had again been returned 0 p.m. after having been in the facility. The medical urther documentation about sessment related to the safety remises unsupervised was not in d.  from 6/19/14, at 3:59 p.m. are nurse had informed the SSD bound in the alley a couple the house of someone who are to the documentation, their had assisted R3 back to the ras starting to rain. R3 was his wheelchair in the r's yard and needed his wheelchair. Documentation funity member had reported and his way back to the facility. It diacked a thorough the elopement.  6/23/14, at 10:19 a.m. R56 by had been taken from his aroom in January 2014. R56 ing two (2) \$20.00 bills, two r (4) \$5.00 bills and some afted he had reported the first stand and when he took it	F 2	26				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
	245522		B. WING _		06/	06/26/2014	
NAME OF PROVIDER OR SUPPLIER  LUTHER MEMORIAL HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 226	reported as missing searched R56's root the missing money documentation relamissing money, da R56 had reported awallet that was left room. The report fustaff were question and the family was not identify which is follow-up had occumoney. The SW is (FM)-A had been conformed by FM-A money reported waduring the interview been no reports to R3's elopements from the knowledge of staff him out. She was used a report filed for preliped money and would be money and would be money and would be money and would be mossing money it winvestigation had not missing money it winvestigation had not missing money it winvestigation of accordance with the plan. There was not notified the administration of the missing money it winvestigation that notified the administration of the missing money it winvestigation had notified the administration.	g from his wallet so she had om and questioned staff about. During review of the ated to the investigation of the ted 1/23/14, it indicated that around \$70.00 missing from his in his night stand drawer in his urther identified that nursing ared about the missing money notified. The investigation did staff were interviewed nor if any red related to the missing tated R56's family member ontacted and was the SW was that the amount of missing as questionable. Further, we the SW verified there had outside agencies related to form the facility. The SW facility campus without and without anyone signing unsure why there had not been oftential neglect related to R3's of the FM-A on 6/23/14, at 8:00 lieve him. He is very aware of know if it was missing."	F 22	6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	OATE SURVEY COMPLETED			
		245522	B. WING		06/26/2014	
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST IADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226 F 282 SS=D	p.m. it was verified any outside agencie money.	th the SW on 5/24/14, at 2:00 there was no report filed to es related to the missing	F 226 F 282		8/3/14	
	must be provided be accordance with eaccare.  This REQUIREMENT by: Based on observative review, the facility for services as directed plan for 1 of 1 resident.	ded or arranged by the facility y qualified persons in such resident's written plan of the NT is not met as evidenced the sion, interview and document ailed to provide care and do by the individualized care lents (R3) in the sample who bacco and required personal.		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	r	
	of cardiovascular aveakness), hyperte and depression.  R3's care plan, ider been initiated 4/3/1 behavior: Resident facility policy." The "Resident will rema	that included: aphasia, history ccident (CVA)-with right sided ension, aggressive behavior ntified a problem which had including: "Disruptive refuses to follow tobacco free goal was identified as: in clean," The interventions assist with cleaning of tobacco		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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/2	6/2014
NAME OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LUTUED	MEMORIAL HOME		2	21 6TH STREET SOUTHWEST		
LUINER	MEMORIAL HOME		ľ	MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	82 Continued From page 16		F 282			
	During observation 11:13 a.m., R3 was brown substance u also noted to have his face and hands soiled gray sweat p. During observation R3 was observed to has ide of his face, an wearing were observed to has ide of his face, an wearing were observed to has ide of his face, an wearing were observed in cake and drinking observation.  During observation R3 was observed schewing tobacco rumouth, chin and lef nurse (LPN)-A was	of R3's cares on 6/23/14 at sobserved to have a dark nder his fingernails. R3 was chewing tobacco smeared on and was wearing heavily	1 202	care plan will include notes to staff to successfully approach the situatiall staff.  2) All residents have the potential to their appearance marred by the preof food, drink, etc. on their faces, chands, etc. All residents' care plan address how ongoing grooming and cleanliness will be addressed throuday.  3) LMH will continue to support the philosophy of Person-Centered Care Personal preferences and approach be noted in each resident's care plaincluding instances whereby a residence may not be in agreement with another person's standards (e.g. personal cleanlines all staff inservice was held on July 2014. An agenda item focused on residents' grooming, cleanliness, and dignity. The importance of following care plan was emphasized along wimportance of informing the Charges.	on by c have esence othing, s will d gh the re. hes will an, dent's s). An 2, nd g the ith the	
	wash his face or ha have some staff tha nursing assistant (I	ands. LPN-A stated R3 did at he would let wash him, NA)-A who was working on the l as one of those NAs.		and other nursing administration who care needs improve/deteriorate to the level that the care plan needs to be revised. Care plans will continue to reviewed at least quarterly and will	nen he b be	
	at 5:00 p.m. on 6/2 multiple staff walke assistance with wa 5:03 p.m. dietary at to serve R3 his coff eye contact with rewith washing up or	bservations in the dining room 4/14, it was observed that d by R3 without offering him shing his hands or face. At ssistant (DA)-A was observed fee. DA-A was noted to make sident but did not assist him ask anyone else to assist him ay from table. At 5:07 p.m. the DM)		updated PRN.  4) The Director of Nursing and her delegates will continue to be responsor for ensuring that each resident's careflects as accurately as feasibly pot the problems, goals, and approach each resident. Care Plans will contibe developed with input from the refamily members/primary caregivers primary physician, and	nsible are plan assible es of tinue to asident,	

F 282  Continued From page 17 was observed to walk by R3 and communicate to him but did not offer assistance. It was clearly evident from a far distance there was brown substance all around R3's mouth.  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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
LUTHER MEMORIAL HOME  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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  STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062   PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EAC			245522	B. WING _		06/	26/2014
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 lit was clearly evident from a far distance there was brown substance all around R3's mouth.  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 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				STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST			
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  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	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	(X5) COMPLETION DATE
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 312	was observed to wahim but did not offe NA-H walked by the assistance. It was distance there was R3's mouth.  During interview with p.m. she stated R3 his clothes until the did let staff wash his approached in a major "pushy". NA-A st have periods of cordefinitely had certain than others.  On 6/24/14 at 5:50 serve R3 his evening pea salad, ham and oranges. R3 was all juice. When DA-E is continued to have be mouth, on his ching not offer to assist R face, nor did she rehim. R3 was observe substance (chewing left fingers while ea 483.25(a)(3) ADL CDEPENDENT RES  A resident who is undaily living receives maintain good nutri	alk by R3 and communicate to r assistance. At 5:09 p.m. e resident without offering any clearly evident from a far brown substance all around th NA-A on 6/24/14 at 5:12 would seldom let staff change end of the day but stated R3 s face sometimes if anner that was not threatening ated R3 was resistive but did impliance. NA-A stated R3 in staff he responded to better p.m., DA-E was observed to ing meal which consisted of dipotato, and mandarin so served coffee, milk, and served R3 his meal he prown substance around his and on his left hand. DA-E did its with washing his hands or equest any other staff to assist wed to have the brown grobacco) dripping from his ting. CARE PROVIDED FOR IDENTS		information/observations from the interdisciplinary care team. The D of Nursing and her delegates will implement a monitoring form for Ecleanliness before and after meall least one month with the option to the monitoring timeframe as need review of the care plans of those with goals specific to cleanliness a personal hygiene to ensure the canaddresses cleanliness and person hygiene as appropriate will also be conducted.  Completion date: August 3, 2014	Director  R3's s for a extend ed. A residents and ire plan hal	8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/2	26/2014
NAME OF PROVIDER OR SUPPLIER  LUTHER MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  221 6TH STREET SOUTHWEST  MADELIA, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 312	Continued From pa	age 18	F 312	2		
	by: Based on observareview, the facility from manner that promoresidents (R3) review assistance with dail Findings include: R3 had diagnoses cardiovascular acchemi-paresis), hyperand depression. R3's care plan, idea been initiated 4/3/1 behavior: Resident facility policy." The "Resident will remaincluded: "Offer to off face and hands. During observation 11:13 a.m. it was nearly substance under his noted to have chew face and hands and gray sweat pants.  During observation it was observed that the building. R3 haprior to leaving, when and drinking coffee was noted to have	that included a history of ident (CVA-with right sided ertension, aggressive behavior ntified a problem which had a including: "Disruptive refuses to follow tobacco free goal was identified as: iin clean," The interventions assist with cleaning of tobacco."  of R3's cares on 06/23/14, at oted that R3 had a dark brown is fingernails. R3 was also wing tobacco smeared on his did was wearing heavily soiled  of R3 on 6/23/14, at 3:11 p.m. at R3 exited the front door of ad been involved an activity just ich including consuming cake a. During this observation R3 cake frosting covering the right d in his beard. R3 also wore		This Plan of Correction and the responses to each F-Tag are submaintain certification in the Medical Medicaid programs and constitute credible allegation of compliance. Written responses do not constitute admission of noncompliance or agreement with any findings stated the F-Tags. The facility reserves it to dispute all findings and deficient any appropriate forum, including in independent dispute resolution, or, appealable remedies are subseque imposed, by timely appeal to the Departmental Appeals Board.  F312  1) R3's care plan was modified to his face and hands in the morning before and after meals as he allow care plan will include notes to staff to successfully approach the situat all staff.  2) All residents have the potential their appearance marred by the proof food, drink, etc. on their faces, on hands, etc. All residents' care plan address how ongoing grooming and cleanliness will be addressed through.  3) LMH will continue to support the philosophy of Person-Centered Carersonal preferences and approach be noted in each resident's care plincluding instances whereby a resident's care plincluding instances whereby a resident.	re and a The and I under s right cies in an if ently  Wash and s". The on how ion by o have esence clothing, as will dugh the ently in the series will an,	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	E SURVEY PLETED
		245522	B. WING _		06/:	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CO 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	During an observat R3 was observed shad chewing tobac sides of his mouth, practical nurse (LP 6/24/14, at 5:00 p.n to let staff wash his stated that R3 allow LPN-A indicated that who was working owho was able to as During observation 6/24/14, at 5:00 p.n staff walked by R3 with hand and/or fadietary assistant (DR3 his coffee and valerting staff to his the dietary manage was observed to wahim but failed to off that at 5:09 p.m. Nanot assist him. It was ubstance all arour During an interview stated R3 would second clothes until the enallow staff to wash approached in a ma or "pushy". NA-A s resistive at times, h compliance. NA-A staff he responded	ion on 6/24/14, at 4:59 p.m. eated in the dining room and co running down the both chin and left hand. Licensed N)-A was interviewed on an and stated R3 often refused face or hands. LPN-A also wed some staff to wash him. At nursing assistant (NA)-A and the shift, was one of the staff sist R3.  Is in the dining room on an it was noted that several without offering assistance cial washing. At 5:03 p.m. IA)-A was observed to serve walk from the area without grooming needs. At 5:07 p.m. In (DM) Is alk by R3, communicate with er assistance. It was noted A-H walked by resident and did as evident that R3 had brown	F 31	personal preference may not agreement with another personal standards (e.g. personal clear all staff inservice was held on 2014. An agenda item focus residents' grooming, cleanlindignity. The importance of focare plan was emphasized a importance of informing the eand other nursing administrational care needs improve/deterioral level that the care plan need revised.  4) The Director of Nursing and delegates will continue to be for providing ongoing training and enforcing the expectation services be provided to all repromotes personal hygiene, the area of daily grooming not birector of Nursing and her of implement a monitoring form cleanliness before and after least one month with the opt the monitoring timeframe as review of the care plans of the with goals specific to cleanling personal hygiene to ensure the addresses cleanliness and phygiene as appropriate will a conducted.  Completion date: August 3, 2	con's anliness). An In July 2, sed on ess, and ollowing the long with the Charge Nurse tion when ate to the sto be and her responsible g, education, in that the especially in eeds. The delegates will for R3's meals for a con to extend needed. A cose residents he care plan ersonal lso be	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		245522	B. WING _		06/26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 312	oranges. R3 was al juice. When served noted that R3 continuous substance (chewing on his chin and left assistance with was find another staff to observed to have the tobacco) dripping freating.  The facility failed to	d potato, and mandarin so served coffee, milk and the evening meal, it was nued to have a notable brown g tobacco) around his mouth, hand. DA-E did not offer R3 shing his hands or face nor offer assistance. R3 was ne brown substance (chewing om his left fingers while	F 31	2	
F 323 SS=J	that staff should as: face as needed. 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and		F 32	23	8/3/14
	by: Based on observate review, the facility for and appropriate into elopement off the faresident reviewed (elopement. The potential of the faresident reviewed).	ion, interview and document ailed to provide assessment erventions to prevent acility campus for 1 of 1 R3) who had a history of ential risk of serious harm or ed to place R3 in immediate		This Plan of Correction and the responses to each F-Tag are subm maintain certification in the Medica Medicaid programs and constitute credible allegation of compliance. written responses do not constitute admission of noncompliance or agreement with any findings stated	re and a Γhe e an

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245522	B. WING			06/2	26/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	3 0.12	
				22	21 6TH STREET SOUTHWEST		
LUTHER	MEMORIAL HOME			M	ADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	The IJ began on 5/himself to the Cene community member informed them of his summoned to bring was identified on 6/informed of the immage informed of the immage informed of the immage informed at the low D-isolated scope are indicated no actual than minimal harm jeopardy.  Findings include:  R3 had multiple includes includes includes includes includes includes includes including: 6/30/13 aware of R3's exit afailed to assess, minterventions to red R3.  R3 had been admithad diagnoses as including: history of (CVA) with right side aggressive behavior (CVA) with right side aggressive behavior (CVA) with traiting to illeting. The MDS ambulate but was including. The MIS ambulate but was included in the MIS ambulate but was included in the MIS ambulate i	25/14, when R3 wheeled ex gas station and a er had to contact the facility, is location and staff were gR3 back to the facility and (25/14. The administrator was mediate jeopardy (IJ) at 1:00 he immediate jeopardy was 4, but noncompliance wer scope and severity level of and severity level, which harm with potential for more that is not immediate  sidents of elopement off the ich was located on a busy (25/14, 5/28/14 & 6/19/14 and & 7/4/13). Facility staff were attempts; however, the facility onitor and provide luce the risk of elopement for ted to the facility on 10/2/01, dentified on the care plan facardiovascular accident led paralysis, aphasia,	F 3	323	the F-Tags. The facility reserves its to dispute all findings and deficience any appropriate forum, including in independent dispute resolution, or, appealable remedies are subseque imposed, by timely appeal to the Departmental Appeals Board.  F323  1) To address the concerns related hourly checks by nursing personne implemented in combination of add Code Alert to the wheelchair. Whe goes outdoors, he is supervised by member or volunteer who would be to summon assistance should it be needed. An Elopement assessment completed for R3 by the Social Ser Director (SSD) on 6/30/14. An Alle 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 licensed health care professionals determined that at this period of tim appropriate to maintain the interver that are currently in place (including described in this Plan of Correction primary physician's opinion would a with this decision as noted in her no 6/26/14.  2) All residents have the potential to affected because all residents are required to have their cognition assist least quarterly via the Minimum Eset Assessment (MDS).  3) Elopement Risk Assessments w	to R3, were ing n R3 a staff able nt was vice n strong those ). His gree otes on to be essed Data	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	, ,	E SURVEY IPLETED
		245522	B. WING		06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP COD 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	due to the CVA. Do the medical record comprehensive ass assessment of R3's abilities related to h the premises withor conducted.  During observation was observed to be the center of the sta of the facility. R3 was significantly forward lap. R3 was also ob wheeling his wheele leaning position, an upper and lower ex utilize only his left h wheelchair.  On 6/24/14, at 7:00 (LPN)-A was questi wherabouts of R3. R3 went outside bu of his location. LPN him, they should try There is not a spec whereabouts." LPN assistant (NA)-A ha shift.  During another obs p.m. R3 was observ wheelchair, sitting or road, in the staff pa to a busy street.	nication/speech capabilities cumentation was lacking in	F3	completed on all residents at a of "initial, annual, and PRN". I identified as at risk for elopem monitored with Code Alert and appropriate interventions will be implemented. Risk assessme conducted on a quarterly basis Primary caregivers, including f members, and primary physici consulted when interventions a successful. The ombudsman consulted as needed. An insee held on July 2, 2014 for all state agenda item focused on review definition of an elopement and person. The procedure for repsituations was reviewed, including review of CODE GRAY, and we reviewed periodically with all sidescribed in paragraph 4 below 4) The Administrator and Direct Nursing will continue to be residenting that procedures are for correctly for when an elopement person situation occurs. The I continue to be responsible for that the necessary assessment elopement assessment, safety assessments, other risk assessment elopement assessment, safety assessments, other risk assessments are completed and successful interventions are in place that safety and the resident's freed choice.  Completion date: August 3, 20	ndividuals ent will be other ents will be and PRN. amily ans will be are not will be rvice was f. An wing the missing porting such ding a sill be taff as w. etor of consible for aff, collowed ent/missing DON will ensuring ts (e.g., sments) coromote om of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245522	B. WING			06/:	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			2	TREET ADDRESS, CITY, STATE, ZIP CODE 21 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	supper but could not back and help the of get ready for bed." reported to any other unable to locate R3  On 6/24/14, at 7:20 interviewed and state himself. NA-A state unable to locate R3  The NAs stated that leaning position in the seated next to the seated ne	ted, "I looked for [R3] after of find him, then I had to get other residents so they could NA-A stated she had not er staff that she had been so.  p.m. NA-B and NA-C were sted R3 often went outside by d that at times they had been swhen they looked for him. It sometimes, due to R3's he wheelchair, he could be shrubs around the facility and be seen because the shrubs and NA-C both stated they is had left the facility campus in seen returned with the help of	F3	323			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245522	B. WING			06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			221	REET ADDRESS, CITY, STATE, ZIP CODE  1 6TH STREET SOUTHWEST  ADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323	campus when unsustated she was awaroad adjacent to the found lying in the stadministrator also whad experienced experienced experienced experienced about the whereabouts, the another resident ide would initiate their resure why staff did noted to be missing staff should know wand when his locati initiate a search.  During document rerecently left the fact 5/28/14 and 6/19/14 revealed the reside facility unsupervise following document resident's progress  (1) An entry dated findicated that during wheeled himself out documentation furth community member door and a NA had community member had fallen out of his the street next to the documentation indicated that draft the street. [The stream of the street on the first progress of the street on the first purpose of the street on the first progress of the street of the stree	pervised. The administrator are R3 had crossed the busy a facility and had also been areet in the past. The verified she was aware that R3 bisodes of getting stuck in his a facility grounds. When staff not knowing R3's dministrator stated, "If it were entified as missing, the facility missing person plan. I am not not do that when [R3] was grounds. The administrator stated where R3 is located at all times on is unknown, staff should eview it was noted that R3 had allity unsupervised on 5/25/14, 4. Further record review not had a history of leaving the don 6/30 and 7/4/13. The ration was noted in the notes:  6/30/13, at 10:50 p.m. grounds the development of the state of the supper. The ner indicated at 6:05 p.m. a result had a history of the facility answered the door to find six results standing around R3 who is wheelchair and was laying in		23			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245522	B. WING			06/:	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			2	TREET ADDRESS, CITY, STATE, ZIP CODE 21 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 PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	load/unload goods] the sidewalk curb a end, not even, or flate (2) Progress notes identified that R3 had facility by a couple of had stated R3 had the factory on the eR3 had been found street corner. [To go cross a busy road a environmental obstruneven pavement,  (3) Progress note of described as during R3 had independent out of the facility, ar facility. During interfacility. During interfacility. During interfacility. During interfacility. During interfacility. During interfacility as station on 5/25, had contacted the flocation. Staff had back to the facility. To be approximately on a busy street with facility to the store. propel the wheelch significant amount of (4) Another nurses p.m., identified that facility at 7:00 p.m. block from the facility ary further docume	here semi-trucks frequently . The nurse's notes described s uneven and raised at one	F3	23			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245522	B. WING		06/:	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 323	record.  (5) Progress notes indicated the charg that R3 had been for blocks away, near the knew R3. According community member facility because it was reportedly stuck in a community member assistance to free hindicated the comment R3 was unable to fire R3's medical recordinated investigation and assistance to free hindicated that with R3 the risk of community members as a lithough document p.m. indicated that with R3 the risk of community members and staff, R3 had found about to be funny." It that at that time distribution similar to life help if required. The had indicated that R3 hindicated t	from 6/19/14, at 3:59 p.m. e nurse had informed the SSD bund in the alley a couple he house of someone who ag to the documentation, the r had assisted R3 back to the ras starting to rain. R3 was his wheelchair in the r's yard and needed his wheelchair. Documentation nunity member had reported and his way back to the facility. It lacked a thorough seessment of the elopement.	F 323			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245522	B. WING _		06/	/26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 323	(RN)-A was intervieunaware if there had identify whether R3 the facility campus the care plan lacked to R3's elopements out of the facility. Respected R3's care interventions develored monitoring his wheelid not always makerisk for injury, and have conducted as due to R3's history.  During an interview SSD stated R3 had decisions but state awareness. The SSR3 regarding the more property, verified R situation was addrestated to the residuation was a nunaware of the ear R3 had experience care plan lacked pl R3's safety risks. Spoor judgement relas carefree.	are and stated she was ad been an assessment to a was capable of safely leaving independently. RN-A verified any guidance to staff related and/or safety abilities when and/or safety abilities and was at and/or safety/elopement assessment of elopements.  If on 6/25/14, at 12:50 p.m. the and/or ability and and/or assessment and and/or assessment and and/or assessments and fall and/or assessments and falls that and/or assessments and falls that and/or assessment and/or as	F 32	23		
	on 6/26/14, at 11:20 stated that R3 wou opportunity to be of The physician confi	with R3's primary physician 0 a.m., the primary physician ld not be safe if given the ff the premises unsupervised. irmed R3 should not leave the rised. The physician also				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED	
		245522	B. WING		06	/26/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	on 5/25/14 and 5/2  The immediate jeo was removed on 6 an IJ removal plan on one supervision documented hourly (missing person procate R3; aplication wheelchair frame to building; initiation or related to R3's cognitive had provided eduction reporting all reside tracking, assessmenter ventions were and licensed nursed determine whether responsibilities to relopements, and to the plan to assure administrator was 6/26/14 at 4:20 p.m. remained at the low a D, no actual harm to a physical safety and been thoroughly controlled to the following lemented for a 1. It is the response charge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises, or suspecharge nurse as so the safety and premises.	en unaware that R3 had eloped (8/14.)  pardy that began on 5/25/14 /26/14 when the facility initiated which included: providing one of for R3 while awake; ye checks with Code Gray (1000) initiation if unable to on of a code alert to the of an elopement assessment initive status; and when they ation to all staff regarding intelopements to ensure ent, monitoring and implemented; Direct care staff is were interviewed to they were aware of their monitor and report resident to ensure they were aware of the safety of R3. The motified the IJ was removed on in., but the noncompliance wer scope and severity level of in with a potential for no more in isolated because a sessment related to R3's discognitive abilities had not completed.  Elopement, dated 1/2003, wing procedures to be missing resident: insibility of all personnel to the attempting to leave the exted of being missing, to the	F3	23		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245522	B. WING		06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 221 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	leaving the premise a. Attempt to previous a. Attempt to previous. Obtain assistar in the immediate vice. Instruct anothe charge nurse or diresident has left the 3. Upon return of director of nursing a. Examine the reb. Contact the attempt of the incident of the inciden	rent departure; rice from other staff members cinity, if necessary; r staff member to notify the ector of nursing that the expremises. The resident to the facility ' the for charge nurse should: sident for injuries; ending physician and report al representative and inform t file an incident report; and ate notations in the resident 's loyee discover that a resident facility, he/she should: er resident is out on an pass. If not: gh search of the building and ated: nistrator and the director of for first if unable to reach the for nurse manager on duty; ents legal representative ding physician; rement officials otify volunteer agencies-law ake that determination; teams with resident	F3	23		
F 497 SS=E	483.75(e)(8) NURS REVIEW-12 HR/YF	E AIDE PERFORM R INSERVICE	F 4	97		8/3/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245522	B. WING		06/26/2014	4
	PROVIDER OR SUPPLIER  MEMORIAL HOME		2	TREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST MADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D BE COMPLÉTION	
F 497	of every nurse aide months, and must peducation based or reviews. The in-set sufficient to ensure nurse aides, but must per year; address a determined in nurse and may address that as determined by that aides providing sere cognitive impairment the cognitively impairment the cognitively impairment the cognitively impairment the facility failed to ensure evaluations were concept (E1, E2, E3, E4 & Eat the facility for great the facility for great the facility for great the ability to affacility.  Findings include:  Review of employee employee performation completed annually (1) E1 had been en 7/16/83. E1's last pedated 7/21/11 (3yrs (2) E2 had been en 12/16/97. E2's last dated 12/15/05 (7 yr (3) E3 had been en 12/15/05 (7 yr (3) E3 had been en 12/15/05 (7 yr (3) E3 had been en 12/15/15/15/15/15/15/15/15/15/15/15/15/15/	at least once every 12 provide regular in-service in the outcome of these rvice training must be the continuing competence of ust be no less than 12 hours areas of weakness as a aides' performance reviews he special needs of residents he facility staff; and for nurse vices to individuals with hits, also address the care of aired.  NT is not met as evidenced or and document review, the fure annual performance conducted for 5 of 5 employees been active and the service of the service	F 497	This Plan of Correction and the responses to each F-Tag are submit maintain certification in the Medicare Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute a admission of noncompliance or agreement with any findings stated at the F-Tags. The facility reserves its to dispute all findings and deficiencies any appropriate forum, including in a independent dispute resolution, or, if appealable remedies are subsequer imposed, by timely appeal to the Departmental Appeals Board.  F497  1) Annual evaluations of nursing assistants will be completed in the mof their employment anniversary. The	e and ne an under right es in an utly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING  (X3) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE			(X3) DATE SURVEY COMPLETED				
		245522	B. WING			06/	26/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME			221 6TH	ADDRESS, CITY, STATE, ZIP CODE I STREET SOUTHWEST LIA, MN 56062	, 55.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 497	9/6/01. E4's last pedated 10/10/11 (2 1 (5) E5 had been en 8/1/91. E5's last pedated 1/26/12 (1 1/2 During interview on director of nurses v (E1, E2, E3, E4 & E	le. Inployed by the facility since erformance evaluation was /2 yrs). Inployed by the facility since erformance evaluation was	F4	emp have Aug 2) T Adn assi Dire com with findi polic eval 3) T for e	ployees identified in the surve their evaluations completed gust 3, 2014. The Director of Nursing and ministrator will update the nursistant annual evaluation form. ector of Nursing and her delegable the annual evaluation an each nursing assistant to distings, set goals, etc. The cy/procedure addressing empluations will be reviewed and The Administrator will be responsively that evaluations are appleted annually.  Impletion date: August 3, 2014	sing The lates will nd meet cuss the loyee revised. onsible	

PRINTED: 07/30/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/25/2014 245522 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 221 6TH STREET SOUTHWEST **LUTHER MEMORIAL HOME** MADELIA, MN 56062 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

**Electronically Signed** 

07/25/2014

(X6) DATE

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.

Facility ID: 00695

PRINTED: 07/30/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245522	B. WING			06/	25/2014
· · · · · · · · · · · · · · · · · · ·	PROVIDER OR SUPPLIER  MEMORIAL HOME			22	TREET ADDRESS, CITY, STATE, ZIP CODE 21 6TH STREET SOUTHWEST ADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	By eMail to: Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit  2. The actual, or pr  3. The name and/oresponsible for correct	RRECTION FOR EACH OF INCLUDE ALL OF THE DRMATION: what has been, or will be, done	K	0000	N.		
	follows: The original buildin one-story, has no be protected and is of The 1st addition was one-story, has no be protected and is of The 2nd addition was one-story, has no be protected and is of The 3rd addition was one-story, has no be protected and is of The facility has a find detection throughof ire alarm system is department notifical capacity of 71 beds time of survey.	g was constructed in 1958, it is pasement, is fully fire sprinkler Type II(000) construction; as constructed in 1973, it is pasement, is fully fire sprinkler Type II(000) construction; as constructed in 1993, it is pasement, is fully fire sprinkler Type II(000) construction. Type II(000) construction. as constructed in 2001, it is pasement, is fully fire sprinkler Type II(000) construction. Type II(000) construction.  Type II(000) construction.  Type II(000) construction.  Type II(000) construction.  Type II(000) construction.  Type II(000) construction.					

Event ID: LDWF21

PRINTED: 07/30/2014 FORM APPROVED OMB NO. 0938-0391

RS FOR MEDICARE	& MEDICAID SERVICES				IVID NO.	0930-039
OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
	245522	B. WING			06/	25/2014
PROVIDER OR SUPPLIER  MEMORIAL HOME			221	6TH STREET SOUTHWEST		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	) BE	(X5) COMPLETION DATE
NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved auton option is used, the a other spaces by sm doors. Doors are s field-applied protec 48 inches from the	reced by: FETY CODE STANDARD  construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and relf-closing and non-rated or tive plates that do not exceed bottom of the door are					8/3/14
Based on observations failed to provide several hazardous facility in accordance 101 (2000 edition) substitutes as smoke from the corridor multiple of the facility tour betwon 6/25/2014, it was room corridor side to openings, penetration and conduits not fire	tions and interview, the facility e proper protection from 1 of areas located throughout the ce with NFPA Life Safety Code section 19.3.2.1. This deficient at 25 residents, staff and from a fire in these rooms could making it untenable.  I ween 9:30 AM and 12:30 PM is observed that the boiler wall had (2) 3"x 3" round ons around sprinkler piping			piping and conduits will be fire cau accordance with 19.3.2.1.  The Director of Environmental Ser and Administrator will continue to be responsible for ensuring the correct completed and monitoring the situation.	lked in vices pe	
	PROVIDER OR SUPPLIER  MEMORIAL HOME  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa NOT MET as evide NFPA 101 LIFE SA  One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are s field-applied protec 48 inches from the permitted. 19.3.2  This STANDARD i Based on observat has failed to provide several hazardous facility in accordance 101 (2000 edition) s practice could affect visitors as smoke fi enter the corridor m  Findings include:  On facility tour betwoon 6/25/2014, it was room corridor side so openings, penetrati and conduits not fire	PROVIDER OR SUPPLIER  MEMORIAL HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with % 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	TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MURA BUILD 245522  B. WING 25 CONTROLL HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with %4 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. 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This deficient practice could affect 25 residents, staff and visitors as smoke from a fire in these rooms could enter the corridor side wall had (2) 3"x 3" round openings, penetrations around sprinkler piping and conduits not fire caulked in accordance with 1 piping and conduits not fire in accordance with Findings in accordance with not fire several hazardous areas could enter the corridor making it untenable.  (X2) PREFIX 1 purple A. BullDING B. WIND 1 provide proper protection Conduits and provide proper protection from 1 provide proper protection from 2 provide proper protection from 3 provide proper protection from 4 proper protection 2.3.2.1. 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.  PREFIX 221 MAM 222	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.  The penetrations around the spring plond good editor) section 19.3.2.1.  The penetrations around the spring plond of the torrigonal content of the corrigon 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 sprinker piping and condurist will be fire cause penetrations around sprinker piping and conduring the correction of the side penetrations around prevent a reoccurrence.	This STANDARD is not met as evidenced by: NPPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ½ hour early 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.  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 covered that the boiler room corridor side wall had (2) 3"x 3" round openings, penetrations around sprinkler piping and conduits will be situation to prevent a reoccurrence.  (X2) MULTIPLE CONSTRUCTION (A BUILDING 01 - MAIN BUI

Event ID: LDWF21

PRINTED: 07/30/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245522	В. 1	WING_			06/2	25/2014
	PROVIDER OR SUPPLIER  MEMORIAL HOME	3			221	REET ADDRESS, CITY, STATE, ZIP CODE 1 6TH STREET SOUTHWEST ADELIA, MN 56062		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE			
K 029		ice was verified by the		K 02	29	8		5
	-							
	.3							

Event ID: LDWF21



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

Luther Memorial Home July 15, 2014 Page 2

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, Program Specialist

Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Luther Memorial Home July 15, 2014 Page 3 Luther Memorial Home July 15, 2014 Page 4

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre- pursuant to a surve found that the defic herein are not corre- not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires or requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result fron orders provided that the Department with	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE	•	
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	you electronically. is necessary for State enter the word "correct. You must then State licensure proceompletion date, the corrected prior to elements of the Minnesota Departments. On 6/23/14, 6/24/14 surveyors of this Deabove provider and orders are issued. electronic plan of correviewed these ordered they will be completed. Minnesota Departments of the State Licensing federal software. The assigned to Minnesota Departments of the State Licensing federal software. The assigned to Minnesota Departments of the State Licensing federal software. The assigned to Minnesota Departments of the State Licensing federal software. The assigned to Minnesota Departments of the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of complete statements of the Suggested Tindings which are in after the statement, evidence by." Followare the Suggested Time period for Corpus PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA"	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health.  4, 6/25/14 and 6/26/14 epartment's staff, visited the the following correction Please indicate in your correction that you have ers, and identify the date when ted.  The of Health is documenting and numbers have been note state statutes/rules for the prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the state statute is not met as wing the surveyors findings method of Correction and rection.  ARD THE HEADING OF THE	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the findings are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the sumfindings are the Suggested Metho Correction and the Time Period For Correction.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT THE SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." the tute/rule ies" ply" nis s which after the s veyors d of or DING OF THIS O DN FOR	

Minnesota Department of Health

STATE FORM 6899 LDWF11 If continuation sheet 2 of 27

Minnesota Department of Health

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 00,2	9,2011
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	THIS WILL APPEA	R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fa services as directed plan for 1 of 1 resid	ent is not met as evidenced on, interview and document ailed to provide care and d by the individualized care ents (R3) in the sample who bacco and required personal.				
	Findings include:					
	of cardiovascular ad	chat included: aphasia, history ccident (CVA)-with right sided ension, aggressive behavior				
	been initiated 4/3/13 behavior: Resident facility policy." The "Resident will rema	ntified a problem which had 3 including: "Disruptive refuses to follow tobacco free goal was identified as: in clean," The interventions assist with cleaning of tobacco				

Minnesota Department of Health

STATE FORM 6899 LDWF11 If continuation sheet 3 of 27

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00695	B. WING		06/2	26/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	age 3	2 565			
	11:13 a.m., R3 was brown substance u also noted to have his face and hands soiled gray sweat p.  During observation R3 was observed to the right side of his also observed to haside of his face, an wearing were observed to had been decided to the resident had been decided to have a side of his face.	of R3's cares on 6/23/14 at a observed to have a dark observed to have a dark observed to have a dark observed to have a mand was wearing heavily earts.  of R3 on 6/23/14 at 3:11 p.m., o have cake frosting covering face and in his beard. R3 was ave frosting on the entire right d the pants and shirt he was rived to be heavily soiled. The observed at an activity eating coffee just prior to this				
	R3 was observed so chewing tobacco rumouth, chin and left nurse (LPN)-A was p.m., and she state wash his face or ha have some staff than ursing assistant (I shift, was identified During continued of at 5:00 p.m. on 6/2 multiple staff walke assistance with was 5:03 p.m. dietary as to serve R3 his coff eye contact with rewith washing up or prior to walking awadietary manager (D	of R3 on 6/24/14 at 4:59 p.m., reated in the dining room with unning down the sides of his it hand. Licensed practical interviewed on 6/24/14 at 5:00 at R3 often refused to let staff ands. LPN-A stated R3 did at he would let wash him, NA)-A who was working on the as one of those NAs.  bservations in the dining room 4/14, it was observed that d by R3 without offering him shing his hands or face. At assistant (DA)-A was observed fee. DA-A was noted to make sident but did not assist him ask anyone else to assist him ay from table. At 5:07 p.m. the pM) alk by R3 and communicate to				

Minnesota Department of Health

STATE FORM 6899 LDWF11 If continuation sheet 4 of 27

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00695	B. WING		06/2	6/2014
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	0,2011
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	NA-H walked by the assistance. It was distance there was R3's mouth.  During interview wit p.m. she stated R3 his clothes until the did let staff wash hi	r assistance. At 5:09 p.m. e resident without offering any clearly evident from a far brown substance all around th NA-A on 6/24/14 at 5:12 would seldom let staff change end of the day but stated R3 s 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.					
	serve R3 his evenir pea salad, ham and oranges. R3 was al juice. When DA-E s continued to have be mouth, on his chin anot offer to assist R face, nor did she re him. R3 was observed.	p.m., DA-E was observed to a meal which consisted of d potato, and mandarin so served coffee, milk, and served R3 his meal he prown substance around his and on his left hand. DA-E did 3 with washing his hands or quest any other staff to assist yed to have the brown g tobacco) dripping from his ting.				
	director of nursing of system to educate s system to ensure st directed by the writt	THOD OF CORRECTION: The or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care. The director nee could monitor for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JTHWEST			
0/0.15	CLIMMA DV CTA			DDOVIDEDIS DI AN OF CORDECTI	ON	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 5	2 830				
2 830	MN Rule 4658.0520 Proper Nursing Car	Subp. 1 Adequate and e; General	2 830				
	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.						
	by: Based on observati review the facility fa manner that promo	on, interview and document illed to provide services in a ted good grooming for 1 of 3 ewed who required extensive y grooming needs.					
	cardiovascular acci	hat included a history of dent (with right sided ertension, aggressive behavior					
	used chewing tobac assistance to wash section of the care wash R3's hands a	ed 9/27/13, identified that R3 cco and required staff his face. The grooming plan indicated staff should not face daily but did not y of refusing cares and					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00695	B. WING		06/2	26/2014
	PROVIDER OR SUPPLIER	221 6TH S	DRESS, CITY, S STREET SOU , MN 56062	STATE, ZIP CODE ITHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	grooming needs. Ron 6/23, 6/24 and 6 chewing tobacco or were noted to walk assistance with groom of the staff wash of the wash of the building. Roughly soiled pants.  During observation it was observed that the building. Roughly soiled pants and drinking coffee was noted to have do side of his face and heavily soiled pants.  During an observat Roughly soiled pants.  During an observation observation of his mouth, practical nurse (LPI 6/24/14, at 5:00 p.m. to let staff wash his stated that Roughly allow who was working on who was able to as.  During observations of 24/14, at 5:00 p.m. staff walked by Roughly with hand and/or fadietary assistant (Dietary assi	R3 was observed several times /25 with dried food and/or his face and clothing. Staff past R3 and not offer any oming needs.  of R3's cares on 06/23/14, at oted that R3 had a dark brown in fingernails. R3 was also or fingernails. R3 exited the front door of dispensively been involved an activity just chincluding consuming cake. During this observation R3 cake frosting covering the right lin his beard. R3 also wore and shirt.  ion on 6/24/14, at 4:59 p.m. eated in the dining room and corunning down the both chin and left hand. Licensed N)-A was interviewed on and stated R3 often refused face or hands. LPN-A also or fine staff to wash him. At nursing assistant (NA)-A in the shift, was one of the staff	2 830			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	7	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00695	B. WING		06/2	26/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	alerting staff to his at the dietary manage was observed to wahim but failed to off that at 5:09 p.m. Nanot assist him. It was ubstance all around During an interview stated R3 would se clothes until the end allow staff to wash approached in a major "pushy". NA-A stresistive at times, how compliance. NA-A staff he responded On 6/24/14, at 5:50 serve R3 his evening pea salad, ham and oranges. R3 was al juice. When served noted that R3 continguistance (chewing on his chin and left assistance with was find another staff to observed to have the tobacco) dripping freating.  The facility failed to accordance with R3 that staff should as face as needed.	grooming needs. At 5:07 p.m. r (DM) alk by R3, communicate with er assistance. It was noted A-H walked by resident and did as evident that R3 had brown and his mouth.  on 6/24/14, at 5:12 p.m. NA-A ldom let staff change his dof the day but stated R3 did his face sometimes if anner that was not threatening tated that although R3 was e did have periods of stated R3 definitely had certain to better than others.  p.m. DA-E was observed to be meal which consisted of dipotato, and mandarin so served coffee, milk and the evening meal, it was nued to have a notable brown of tobacco) around his mouth, hand. DA-E did not offer R3 shing his hands or face nor offer assistance. R3 was no brown substance (chewing nom his left fingers while	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	dependent resident personal care per f conduct audits to e provided as indicated.  TIME PERIOD FOR (21) days.  Based on observative review, the facility f and appropriate intelopement off the firesident reviewed (elopement without of serious harm or R3 in immediate jer Findings include:	their responsibility to provide is with assistance with accility policy. The DON could insure the care is being ed and take action as needed. R CORRECTION: Twenty-one ion, interview and document ailed to provide assessment erventions to prevent acility campus for 1 of 1 R3) who had a history of supervision. The potential risk injury was determined to place opardy.	2 830			
	facility campus, wh roadway (recent: 5/historically: 6/30/13 aware of R3's exit a no interventions im of elopement.  R3, a 79 yr. old res diagnoses as ident (MDS) that include accident (CVA) with aphasia, aggressive R3's quarterly Minir 3/10/14, identified to	idents of elopement off the ich was located on a busy '25/14, 5/28/14 & 6/19/14 and & 7/4/13). Facility staff were attempts; however, there were plemented to reduce the risk ident admitted on 10/2/01 had ified on the Minimum Data Set d: history of cardiovascular a right sided paralysis, e behavior, and depression.				
	toileting. The MDS ambulate but was i	nsfers, dressing, hygiene and identified R3 was unable to independent with mobility in the DS further identified R3 had				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
	00695	B. WING		06/2	26/2014
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
had limited commundue to a CVA (cereb Documentation was to indicate that a conhad included R3's prelated to his unsafe premises without state During observation of was observed to be center of the staff parallity. R3 was observed to has his wheelchair due the position and his righ lower extremities. R when he propelled the On 6/24/14, at 7:00 (LPN)-A was question wherabouts of R3. Let R3 went outside but of his location. LPN him, they should try There is not a specific wherabouts." LPN assistant (NA)-A had During another observed the facility in parking lot drive-way.  On 6/24/14, at 7:10 about R3. NA-A stat supper but could no and help the other reserved.	nce with decision making and nication/speech capabilities oral vascular accident). Iacking in the medical record omprehensive assessment hysical and cognitive abilities a practice of leaving the aff supervision.  on 6/24/14, at 6:35 p.m. R3 located in a wheelchair in the arking lot on the west side of erved to lean significantly shead near his lap. R3 was we some difficulty wheeling to the forward/right leaning at sided paralysis of upper and 3 utilized only his left hand	2 830			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10	2 830			
	to any other staff th	at she was unable to locate				
	interviewed and state himself. NA-A state unable to locate R3 him. The NAs state leaning position in the seated next to the state they would be unable shrubs are taller. Not they were aware the campus in the past the help of community on 6/24/14 at 7:30 frequently went out unaware of any spewhereabouts. LPN-	p.m., LPN-B stated R3 side of the building but was ecific plan to monitor R3's 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.					
	administrator verifice the facility and that campus multiple time community member R3 did not listen to make good decision she was aware R3 wheelchair while of The administrator in had crossed the buand had also been past. The administrator that R3 had episod	on 6/24/14 at 7:50 p.m., the ed R3 frequently went outside he had been found off nes and had been returned by rs. The administrator stated directions and did not always ns. The administrator verified had sustained a fall from his f campus when unsupervised. Indicated she was aware R3 sy road adjacent to the facility found lying in the street in the rator verified she was aware es of getting stuck in his e facility grounds. When				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00695	B. WING		06/	26/2014	
NAME OF PROVIDER OR SUPP	PLIER STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
LUTHER MEMORIAL HO	ME	STREET SOU A, MN 56062	THWEST			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES SIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
whereabouts the another reside would initiate the sure why staff noted to be mined to be mined a search of the sidewalk the street. [The busy street on moderate trafficacross the street of the sidewalk content of the sidewalk content of the sidewalk the street. [The busy street on moderate trafficacross the street of the sidewalk content of	t staff not knowing of R3's he administrator stated, "If it were nt identified as missing the facility heir missing person plan. I am not had not done that when [R3] was ssing". The administrator indicated ow where R3 is located at all times ocation in unknown, staff should h.  ent review it was noted that R3 had unsupervised on 5/25/14, 5/28/14 & the past on 6/30/13 & 7/4/13. The mentation was noted in the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	26/2014
NAME OF PROV	/IDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER ME	MORIAL HOME		STREET SOU A, MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
(3) ind aw soo 2:0 him cor info sur Ce one with sto wh am abordant was (5) had nur the soo me sta wh need to be soo me sta who need to be soo me soo me sta who need to be soo me soo me soo me sta who need to be soo me s	sy road and mar stacles (i.e. curb d small inclines)  On 5/25/14, du lependently wheray from the facilicial service designation of the Center	ne corner R3 had to cross a neuver many environmental is, vehicles, uneven pavement, is, iring the evening shift, R3 eled outside the facility, blocks lity. During interview with the gnee (SSD) on 6/24/14, at dicated that R3 had wheeled ex gas station and a er had contacted the facility and its location. Staff had been g R3 back to the facility. [The oted to be approximately the facility on a busy street cline from the facility to the limited ability to propel the d have taken a significant propel this distance]; er, a nurses' note dated m., identified that R3 was again a lity at 7:00 p.m. as he had ck from the facility. The ked any further documentation An assessment related to the g the premises unsupervised				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	00/2	.0/2014
			STREET SOL			
LUTHER	MEMORIAL HOME		, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 13	2 830			
	his way back to the lacked a thorough i	facility. R3's medical record nvestigation into the any assessment evident				
	7/9/13, at 4:25 p.m. had discussed with street unsupervised informing staff, R3 talking about to be indicated that a disc to R3 using a name available button sin summon help if req	though documentation dated indicated that social services R3 the risk of crossing the dand the importance of found "what this writer was funny". Documentation cussion had occurred related e card or the use of an inlar to life line so he could puired. Documentation kay 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.					
	(RN)-A was intervieunaware if there had identify whether R3 the facility campus the care plan lacke to R3's elopements out of facility. RN-A care plan should had eveloped which in whereabouts. RN-make safe decision RN-A stated SS should be a shou	are				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE	-	
INAME OF I	NOVIDEN ON SOLT EIEN		STREET SOL			
LUTHER	MEMORIAL HOME		, MN 56062	JIHWESI		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	`	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
2 830	Continued From pa	ge 14	2 830			
	- Continuou i ioni pu	90				
		0/05/44 4 40 50 41				
		on 6/25/14, at 12:50 p.m. the				
		a history of making poor				
		d R3 had some cognitive cated she instructed R3				
		to stay on the facility property				
		led when the situation was				
		firmed she had not conducted				
		nents related to this. The SS				
		a new employee so had been				
		pements and subsequent falls				
		reviously. The SS verified the				
		anned interventions related to				
		e further stated that R3 had				
	poor judgement rela	ated to safety, indicating he				
	was carefree.					
	5	0/00/44 4 44 00 34				
		6/26/14, at 11:20 a.m. with				
		sian, it was stated that R3 given the opportunity to be off				
		pervised and confirmed R3				
		e premises unsupervised. The				
		she had not been unaware				
		on 5/25/14 and 5/28/14.				
		ated 1/2003, Elopement,				
		ing procedures for missing				
	resident:					
	<ol> <li>It is the respons</li> </ol>	sibility of all personnel to				
		attempting to leave the				
		cted of being missing, to the				
	charge nurse as so					
		loyee observe a resident				
	leaving the premise					
	a. Attempt to prev					
		nce from other staff members				
	in the immediate vid	cinity, if necessary; r staff member to notify the				
		ector of nursing that the				
	resident has left the					
		the resident to the facility ' the				

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	ota Department of He					
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, S	STATE, ZIP CODE		
			TREET SOL			
LUTHER	MEMORIAL HOME	MADELIA	, MN 56062			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	director of nursing of a. Examine the reb. Contact the atte what happened; c. Contact the leg them of the incident d. Complete and fe. Make appropriamedical record.  4. Should an empis missing from the a. Determine if the authorized leave or b. Make a thoroug premises. If not locate. Notify the adminursing, social work director of nursing of	or charge nurse should: sident for injuries; ending physician and report al representative and inform tile an incident report; and ate notations in the resident 's loyee discover that a resident facility, he/she should: e resident is out on an pass. If not: gh search of the building and	2 830			
	g. If necessary, no enforcement will man h. Provide search identification inform i. Make an extension area.  SUGGESTED MET The DON or Degine for elopement. The conduct audits to elopement reassessed for have been implementare at risk for elopement are at risk for elopement.	cement officials offity volunteer agencies-law ake that determination; teams with resident ation; and sive search of the surrounding THOD FOR CORRECTION: ee could reassess all residents ee DON or Designee could resure that all residents have or elopement and interventions ented for those residents who				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7.1. 20.123.1.10.				
		00695	B. WING		06/2	6/2014	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 870	Continued From pa	ge 16	2 870				
2 870	MN Rule 4658.0520 Proper Nursing Car	O Subp. 2 H. Adequate & re-CleanClothing	2 870				
	proper care. The cadequate and proper H. Clean clot	hing and a neat appearance. dressed during the day					
	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.						
	been initiated 4/3/13 behavior: Resident facility policy." The "Resident will rema	ntified a problem which had 3 including: "Disruptive refuses to follow tobacco free goal was identified as: in clean," The interventions assist with cleaning of tobacco					
	11:13 a.m. it was no substance under his noted to have chew	of R3's cares on 06/23/14, at oted that R3 had a dark brown s fingernails. R3 was also ring tobacco smeared on his d was wearing heavily soiled					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00695	B. WING		06/2	6/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1	
LUTHER	MEMORIAL HOME		TREET SOL	JTHWEST		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	, <b>MN 56062</b>	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 870	Continued From page 17		2 870			
	it was observed that the building. R3 hat prior to leaving, white and drinking coffee was noted to have uside of his face and heavily soiled pants.  During an observat R3 was observed shad chewing tobacc sides of his mouth, practical nurse (LPI 6/24/14, at 5:00 p.n. to let staff wash his stated that R3 allow LPN-A indicated that	ion on 6/24/14, at 4:59 p.m. eated in the dining room and co running down the both chin and left hand. Licensed N)-A was interviewed on n. and stated R3 often refused face or hands. LPN-A also yed some staff to wash him. at nursing assistant (NA)-A n the shift, was one of the staff				
	6/24/14, at 5:00 p.n staff walked by R3 with hand and/or fa dietary assistant (D R3 his coffee and walerting staff to his the dietary manage was observed to wahim but failed to off that at 5:09 p.m. Not assist him. It was substance all around	alk by R3, communicate with er assistance. It was noted A-H walked by resident and did as evident that R3 had brown and his mouth.				
	stated R3 would se clothes until the end	on 6/24/14, at 5:12 p.m. NA-A ldom let staff change his d of the day but stated R3 did his face sometimes if				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF GORREOTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVII	LLILD	
		00695	B. WING		06/2	6/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 870	, , , , , , , , , , , , , , , , , , ,		2 870				
	or "pushy". NA-As resistive at times, h compliance. NA-As	anner that was not threatening tated that although R3 was be did have periods of stated R3 definitely had certain to better than others.					
	serve R3 his evenir pea salad, ham and oranges. R3 was al juice. When served noted that R3 conting substance (chewing on his chin and left assistance with was find another staff to observed to have the orange of the salad of t	p.m. DA-E was observed to any meal which consisted of dipotato, and mandarin leso served coffee, milk and if the evening meal, it was mued to have a notable browning tobacco) around his mouth, hand. DA-E did not offer R3 shing his hands or face nor coffer assistance. R3 was the brown substance (chewing from his left fingers while					
	accordance with R3	provide services in 3's care plan which indicated sist R3 to wash his hands and					
	The DON could ensire-inserviced as to dependent resident personal care per faconduct audits to elements.	THOD FOR CORRECTION: sure that staff are their responsibility to provide as with assistance with acility policy. The DON could nsure the care is being ed and take action as needed.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 4 Tuberculosis ntrol	21426				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. WING			
		00695	B. WING		06/2	26/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		TREET SOU , MN 56062	JIHWESI		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines distates Centers for Disease tion (CDC), Division of nation, as published in CDC's fality Weekly Report (MMWR). include a tuberculosis in that covers all paid and contractors, students, inteers. The Department of the technical assistance intation of the guidelines.	21426			
	by: Based on interview facility failed to imple program to ensure communicable dise conduct a two step employees (E5) rev pre-employment tul Findings include:  During review of the on 6/25/14 it was id schedule and worki	and document review the lement their infection control all employees were free of ase. The facility failed to tuberculin skin test for 1 of 5 riewed who required perculin skin testing.  The facility schedule for staffing entified E5 was on the ng with residents.  The employee medical files for culin skin tests (TST) it was				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	26/2014
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21426	4/28/14 and the res 5/14/14, E5 had the documentation was had been read.  During interview wit on 6/25/14, at 2:15 no evidence the 2nd The DON stated up skin test, document the nurses station us and then the documemployee health reform lacked documbeen completed and the facility policy for Tuberculin test and identified the following. A week later the Mantoux test do 48-72 hours. A negative PPD weemployees begin or done before employees begin or done before employees. A week later the Mantoux test do 48-72 hours. A negative PPD weemployees begin or done before new employees. A list of employees the first week of the bethe responsibility PPD in the month renot done in the mor disciplinary action weeks.	e step TST conducted on ults were read on 4/30/14. On a 2nd step administered but lacking to indicate the results the had been read for E5. On completion of a tuberculing ration of the finding is kept at antil both steps are completed nentation is transferred into the cord. The DON verified the entation to indicate it had denad.  For Employee PPD (Mantoux) or Chest X-ray, dated 3/2004 ing procedures:  Will be required before new rientation. PPD test must be yeard and read within 48-72 the employee is to again have one and read by the nurse in active PPD will be required be begins orientation.  The serequiring a PPD or chest on the door by the time clock amonth they are done. It will to of staff members to get their equired. If the PPD or X-ray is in this is required, some form of will be taken.	21426			
		HOD OF CORRECTION: sing (DON) or designee could				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00695	B. WING		06/2	26/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER MEMORIAL HOME 221 6TH STREET SOUTHWEST  MADELIA, MN 56062						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	monitoring TB statu current standard for designee could peri status of new emplo	es responsible for giving and as of new employees the r giving TB. The DON or form audits to assure the TB	21426			
21990	Subd. 4. Reportin immediately make a entry point. Use of for the deaf or othe considered an oral point may not requiextent possible, the content to identify the caregiver, the naturn maltreatment, any of maltreatment, the noreporter, the time, of incident, and any of reporter believes must the suspected maltreporter may disclosin section 13.02, and section 144.335, to comply with this substitute of the suspected maltreporter may disclosin section 13.02, and section 144.335, to comply with this substitute of the suspected maltreporter may disclosin section 144.335, to comply with this substitute of the suspected maltreporter may disclosin section 144.335, to comply with this substitute of the suspected maltreporter may disclosin section 144.335, to comply with this substitute of the substitute	g. A mandated reporter shall an oral report to the common a telecommunications device r similar device shall be report. The common entry re written reports. To the report must be of sufficient ne vulnerable adult, the re and extent of the suspected evidence of previous ame and address of the date, and location of the sher information that the reatment. A mandated se not public data, as defined d medical records under the extent necessary to	21990			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00695	B. WING		06/26	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME	221 6TH S	STREET SOL	JTHWEST		
LOTTIEN			, MN 56062		T	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	Continued From pa	ge 22	21990			
	agency) when there misappropriation of resident (R56) review missing from his was thoroughly investigated of 1 resident (R3) without staff knowledge.	ate survey and certification e were allegations of resident money for 1 of 1 ewed who reported money allet and failed to report and ate elopement incidents for 1 who left the campus premises edge.				
	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.					
	was identified as fo (1.) Employees of mandated reporters situations that are or injuries of unknown. The Nurse in Charga. Immediately assif any emergency trb. Notify the physicic. Notify the adminiand Social Services d. Fill out a Resider the type of incident suspected crime. (2.) Incidents that or reporter is on site, the designated repowill:  a. Report the incide of Health Facility Commediately. Print a	Luther Memorial are and must report any defined as abuse, neglect or origin to the nurse in charge. ge will: ess the situation to determine eatment is required. an. strator, Director of Nursing s. In the Incident Report, noting that is potential abuse or a specur when the designated he charge nurse shall notify orter. The designated reporter ent electronically to the Office				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	LUTHER MEMORIAL HOME 221 6TH 1 MADELIA			THWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21990	(CEP) which is Wat Services by faxing the electronic submissis criminal activity (e.g. serious bodily injury telephone. c. Notify the Madelity of a suspected crimassault, theft, forged. Notify the family (3.) Incidents that creporter is off duty, complete the steps (4.) The nurse in ca. A detailed descrimedical record of e Residents will be id record number rath in another resident b. Notification of far (5.) The investigati Administrator, Director or incident reports regorigin, abuse, negler resident property, oa. The investigation staff, residents and incident b. The results of investigation of the administrator or and to OHFC within report of incident.  The following documelopements were not reported to there evidence an investigations and incident.	conwan County Human chem a copy of the OHFC con. If the incident involves g. assault, sexual assault, y), the CEP must be notified by a police department in cases are (e.g.) assault, sexual ry, robbery, burglary etc.) of the incident. occur while the designated the nurse in charge will described in 3a through 3d. harge will document: otion of the incident in the ach resident involved. entified by their medical er than name when mentioned is chart.	21990			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21990	away from the facil social service desig 2:00 p.m. it was inchimself to the Cene community member informed them of his summoned to bring Cenex store was not one-half mile from with a moderate incistore. Due to R3's wheelchair, it would amount of time to possible to the facility of the	ity. During interview with the gnee (SSD) on 6/24/14, at dicated that R3 had wheeled ex gas station and a er had contacted the facility and is location. Staff had been g R3 back to the facility. [The oted to be approximately the facility on a busy street cline from the facility to the limited ability to propel the d have taken a significant propel this distance]; er, a nurses' note dated m., identified that R3 was again lity at 7:00 p.m. as he had ck from the facility. The ked any further documentation	21990			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
VIND LEVIN	OF CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMP	1-0
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		221 6TH S	STREET SOL	JTHWEST		
LUTHER	MEMORIAL HOME	MADELIA	, MN 56062			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON NC	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIALE	DATE
				*		
21990	Continued From pa	ge 25	21990			
	\$1.00 bills. R56 sta	ated he had reported the				
		he nurse. R56 stated his left				
		nt stand and when he took it				
	out the money was	missing.				
	<b>D</b>	0/04/44 - 1.4.50 11				
		6/24/14, at 1:53 p.m. the indicated she had a written				
		ssing money that R56 had				
		stated that \$70 had been				
		from his wallet so she had				
		om and questioned staff about				
	the missing money.	During review of the				
		ted to the investigation of the				
		ted 1/23/14, it indicated that				
		round \$70.00 missing from his				
		in his night stand drawer in his irther identified that nursing				
	•	ed about the missing money				
		notified. The investigation did				
		taff were interviewed nor if any				
	_	rred related to the missing				
	money. The SW st	ated R56's family member				
		ontacted and was the SW was				
		hat the amount of missing				
	, ,	s questionable. Further,				
		the SW verified there had outside agencies related to				
		m the facility. The SW verified				
		campus without knowledge of				
		yone signing him out. She				
		ere had not been a report filed				
		t related to R3's elopement.				
	<b>D</b> 3	TNA A 0/00/44 0 00				
		th FM-A on 6/23/14, at 8:00				
		"If [R56] stated he had \$70.00 ieve him. He is very aware of				
		now if it was missing."				
	money and would k	now ii it was iinssilig.				
	During review of the	e incident report related to the				
		as noted that a thorough				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00695	B. WING		06/2	6/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LUTHER	MEMORIAL HOME		STREET SOU , MN 56062	JTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21990	investigation had no was lacking to indic misappropriation of accordance with the plan. There was no notified the adminis (CEP) or Office of the (OHFC) as directed.  During interview with p.m. it was verified any outside agencies money.  Suggested Method nursing (DON) could to ensure the abuse implemented as writing requirements, and the pool of the po	ot been completed. Evidence cate the potential money had been reported in e facility's abuse prohibition evidence the facility had strator, common entry point Health Facility Complaints	21990			

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