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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MFS8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00329

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245382**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON LUTHERAN HOME**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 08/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/24/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/11/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5382

August 24, 2015

Ms. Denise Becker, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

Dear Ms. Becker:

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, 2015 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 24, 2015

Ms. Denise Becker, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382024

Dear Ms. Becker:

On July 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On August 20, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on July 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015, effective August 3, 2015 and therefore remedies outlined in our letter to you dated July 8, 2015, will not be imposed.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245382	A. Building B. Wing	8/20/2015

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0412** Reg. # **483.55(b)** LSC	**08/03/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	**08/03/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GA/mm	08/24/2015	00329	08/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/25/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245382	A. Building B. Wing **01 - MAIN BUILDING 01**	7/24/2015

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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 Reg. # **NFPA 101** LSC K0056	Correction Completed **07/21/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** GS/mm	**Date:** 08/24/2015	**Signature of Surveyor:** 34764	**Date:** 07/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/24/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: MFS8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00329

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(L2) **134242800**

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(L4) **900 SECOND AVENUE**
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4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Tammy Williams, HFE NEII — 08/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 08/11/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
July 8, 2015

Ms. Denise Becker, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382024

Dear Ms. Becker:

On June 25, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 4, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 4, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 25, 2015 (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 25, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance.	F 000		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary dental services to meet the need of 1 of 3 residents (R20) identified as requiring dental services. Findings include: R20's quarterly Minimum Data Set (MDS) dated 5/1/15 identified R20 had schizophrenia, psychotic disorder and depression. The MDS identified R20 required assistance with eating, had coughing or choking during meals or with medications, and received a mechanically altered diet. However, the MDS did not identify R20 had	F 412	The facility will offer and make a dental appointment for Resident R-20 and arrange for transportation. The facility will work with the residents guardian to address dental needs. Resident¿s care plan was updated on 7/14/15. All residents with dentures have the potential to be affected by this practice. All residents with dentures will be assessed to determine need for denture evaluation and/or need for dental visit and at a minimum of quarterly thereafter. Care plans for residents with dentures will be reviewed/updated to reflect appropriately.	8/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/17/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 1 loose or ill fitting dentures. R20's care plan (CP) dated 2/21/14 identified R20 required total assistance with oral care to both upper and lower dentures. R20's CP also identified R20 had coughing, difficulty chewing and swallowing and required a pureed diet with honey thickened liquids. Review of R20's barium swallow study dated 3/10/15 identified R20 had decreased mastication(chewing) abilities due to only having upper dentures which contributed to her aspiration risk. Review of R20's dental evaluation dated 1/20/14 identified R20 had complained of ill fitting upper denture and did not wear her lower dentures. The dentist had included 3 options for R20 to chose from: 1-do nothing, 2-use adhesive to help retain denture adequately, 3-realign the upper denture. The dentist recommended an adhesive, and R20 chose to have a realignment. The dentist's office had faxed an estimate and plan for R20's alignment to the facility on 1/21/14. On 06/24/15, at 12:46 p.m. during interview R20 stated, " I don't have bottom dentures, they never fit right, they never worked, I didn't have to pay for them. My uppers are wearing out too, they don't fit." R20's mouth was observed to have loose fitting upper denture plate, which she held in place with her tongue and no lower denture plate in place. R20 stated she had been told she couldn't go to the dentist because she didn't have any money. R20 indicated she had seen the dentist greater than a year ago, and stated she wanted to have her dentures repaired.	F 412	The facility will arrange for timely dental care for any residents identified as wanting/needing this service. The Director of Nursing or designee will review and revise as necessary the policy related to dental care and the policy related to physician orders on or before August 3, 2015. The Interdisciplinary team will review dental needs at each care conference and ensure residents receive timely dental services. Education will be provided to nursing staff at July meetings related to carrying out physician orders. Education will be provided to the Interdisciplinary Team related to assessment of dental needs, documentation in the MDS, developing appropriate care plan interventions and ensuring timely provision of dental services. Chart review audits will be completed to ensure doctor orders are signed off and follow up is completed in a timely manner. Audits will be completed to review medical record documentation to ensure dental care is addressed in the care plan and reviewed at care conferences. These audits will be completed by the DON or her designee. Audits will be completed the following month for all residents who had a care conference in the previous month. Audit results will be monitored through the Quality Assurance Performance Improvement Committee. Audits will be done monthly for six months, then as needed until the QAPI Committee determines compliance has been	

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F 412	Continued From page 2 On 06/25/2015, at 2:42 p.m. during follow up interview, R20 was observed to hold her upper denture plate in place with her tongue. R20 did not have a lower denture plate in place. She stated she did not use adhesive on her dentures, and indicated she felt the adhesive was not effective. R20 stated she wanted an alignment of her dentures, and had money in the bank to pay for the realignment. R20 stated she unaware of the cost for the realignment, and facility staff or dental staff had not discussed the cost of realignment with her. On 06/25/15, at 3:09 p.m. during interview LPN-A stated R20 always complained she wanted more teeth. LPN-A indicated she felt R20 might be a choking risk for her to get different dentures, but wasn't sure. On 06/25/15, at 3:18 p.m. during interview nursing assistant, (NA)-C stated about 3 months ago R20 complained she wanted some new teeth. NA-C said she told R20 she had to check with the nurses to set up appointment if its possible.. On 06/25/15, at 3:26 p.m. during interview registered nurse, (RN)-A confirmed R20 wore dentures, and confirmed she had been seen by the dentist in the past. RN-A confirmed the lack of follow up after the dental appointment in the medical record. On 06/25/15, at 3:36 p.m. during interview the director of nurses, (DON) stated the usual facility practice was to follow up on recommendations from the dentist and stated "It fell through the cracks, it should have been the social worker and	F 412	sustained.	

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F 412	Continued From page 3 the care coordinator who followed up on this." She also stated the facility had issues in the past with getting residents downtown to the dentist. DON confirmed R20's current care plan lacked interventions for care of the ill fitting/missing dentures. Review of the undated facility Physician Order Procedure policy revealed the purpose of the policy was to carry out orders for a specific resident, received from a physician-written, verbal or by telephone and all orders would be noted off as the order was accomplished or appropriate follow through of detail of the order.	F 412		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		8/3/15

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F 441	Continued From page 4 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included surveillance and investigation of infections that occurred in the facility to determine interventions to prevent the spread of infections. This had the potential to affect all 59 residents currently residing the facility. Findings include: Review of the monthly log forms titled Infection Prevention Control Surveillance Log from March 2015 to June 2015 identified the log tracked only infections treated with antibiotics such as urinary, respiratory and eye infections. The logs lacked signs and symptoms of infections for residents who were not treated by antibiotics such as gastrointestinal, fungal, skin. During review of the facility's infection control	F 441	The Administrator, Director Nursing and Assistant Director of Nursing will review and revise as necessary the Infection Control program related to the surveillance of resident infections. All residents have the potential to be affected by this practice. Education will be provided to nursing staff during the July nurses meeting regarding the use of the infection surveillance forms. Nurses will be responsible to document symptoms of infections. Documentation will be reviewed by the designated Infection Control nurse. The Infection Control nurse will track resident symptoms and monitor for trends. The designated Infection Control nurse will complete an audit monthly to ensure	

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F 441	Continued From page 5 program on 6/23/15 at 6:37 p.m. with the assistant director of nursing (ADON), who was identified as responsible of the infection control program, there were components of the infection control program missing. The ADON verified treatment with an antibiotic had been the criteria used to track an infection on the infection control log. The ADON verified signs and symptoms of infections not treated by antibiotics were not tracked nor were they part of the report for the quality assurance (QA) meetings. The ADON indicated illnesses not treated with antibiotic with respiratory, fever, or gastro intestinal symptoms would not be on the infection control log. The ADON verified R54 had been treated with an antibiotic for a wound containing Methicillin-resistant Staphylococcus aureus (MRSA) (bacteria resistant to commonly used antibiotics). The ADON further verified although R54 ' s wound was not healed; the infection no longer was tracked on the infection control log, because the antibiotic treatment had been completed. The ADON stated " we are following contact precautions until the wound is healed. " The ADON further verified the physician had not ordered a post antibiotic wound culture " , we assume it is colonized because the resident is not symptomatic. " The ADON indicated a 72 hour tracking form had been in place at each nurse ' s station in order to follow infections not treated by an antibiotic; however it had not been followed through and the facility staff were no longer utilizing the form. During an interview on 6/24/2015, at 12:17 p.m. the ADON indicated seventy two hour tracking forms had been initiated to track the symptoms of infections not treated by antibiotics such as , respiratory, urinary, soft tissue, cellulitis, scabies,	F 441	nursing staff are documenting resident symptoms of infection. The Director of Nursing will audit the Infection Control Program Log to ensure the Infection Control nurse is monitoring for trends. Audit results will be reported to the Quality Assurance Performance Improvement Committee at the monthly meeting. Audits will be completed monthly for six months, then as needed until the QAPI Committee determines compliance has been sustained.	

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F 441	Continued From page 6 eye infections, fungal infections, GI, norovirus, C-difficile. The ADON verified the 72 hour tracking forms were no longer utilized in the facility and stated " the nurses kind of keep them in their heads. " The ADON verified the infection control program did not track or trend signs and symptoms of infections not treated with antibiotics. During an interview on 6/25/2015, at 2:20 p.m. the director of nursing (DON) verified the intent of the infection control program was to monitor trending of resident illness including coughing, fever, and diarrhea. The DON indicated logging of infections only that had been treated by an antibiotic would not meet the intent of the program. The facility provided policy was titled Employee Health, infection control revised 4/14. No other policy was provided.	F 441		

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2015**

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MADISON LUTHERAN HOME	**900 SECOND AVENUE** **MADISON, MN 56256**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 24, 2015. At the time of this survey, Madison Lutheran Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/17/2015

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Madison Lutheran Home is a 3-story building with partial basement, and is fully fire sprinkler protected. The original building was constructed in 1914 and was determined to be of Type I(322) construction. The 1952 addition was determined to be of Type I(332) construction. The 1968 addition was determined to be of Type II(111) construction. The 1977 addition was determined to be of Type II(111) construction. The 1991 addition was determined to be of Type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 65 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2015**

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation, and interview with the Director of Environmental Services, the elevator equipment room and the elevator pit in the basement was not protected with automatic fire sprinklers. This deficient practice could affect 25 of the 59 resident and staff and visitors. Findings include: During the facility tour on 06-24-15 between 7:45 AM and 2:00 PM it was observed that the elevator equipment room and the elevator pit was not protected with automatic fire sprinkler heads. All areas of a building shall be protected with sprinkler heads in accordance with LSC(00) Section 19.1.6 and 19.3.5.	K 056	1. Midwestern Mechanical Sprinkler Co has been contacted and will install a sprinkler head in the elevator mechanical room and the elevator pit. 2. Proposed completion date will be on July 21, 2015. 3. Paul Engesmoe, Director of Environmental Service, is responsible for correcting and continuous monitoring of the sprinkler system.	7/21/15

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	245382	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/24/2015**

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K 056	Continued From page 3 This deficient practice was confirmed with the Director of Environmental Services (PE) at the time of discovery and at the exit interview with the Administrator.	K 056		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 8, 2015

Ms. Denise Becker, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5382024

Dear Ms. Becker:

The above facility was surveyed on June 22, 2015 through June 25, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rule. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson (218) 332-5140 or email: gail.anderson@state.mn.us

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00329	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	**900 SECOND AVENUE MADISON, MN 56256**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00329	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 22nd, 23rd, 24th and 25th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary dental services to meet the need of 1 of 3 residents (R20) identified as requiring dental services. Findings include: R20's quarterly Minimum Data Set (MDS) dated 5/1/15 identified R20 had schizophrenia, psychotic disorder and depression. The MDS identified R20 required assistance with eating, had coughing or choking during meals or with medications, and received a mechanically altered diet. However, the MDS did not identify R20 had loose or ill fitting dentures.	21325	complete	7/28/15

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R20's care plan (CP) dated 2/21/14 identified R20 required total assistance with oral care to both upper and lower dentures. R20's CP also identified R20 had coughing, difficulty chewing and swallowing and required a pureed diet with honey thickened liquids.

Review of R20's barium swallow study dated 3/10/15 identified R20 had decreased mastication(chewing) abilities due to only having upper dentures which contributed to her aspiration risk.

Review of R20's dental evaluation dated 1/20/14 identified R20 had complained of ill fitting upper denture and did not wear her lower dentures. The dentist had included 3 options for R20 to chose from: 1-do nothing, 2-use adhesive to help retain denture adequately, 3-realign the upper denture. The dentist recommended an adhesive, and R20 chose to have a realignment. The dentist's office had faxed an estimate and plan for R20's alignment to the facility on 1/21/14.

On 06/24/15, at 12:46 p.m. during interview R20 stated, " I don't have bottom dentures, they never fit right, they never worked, I didn't have to pay for them. My uppers are wearing out too, they don't fit." R20's mouth was observed to have loose fitting upper denture plate, which she held in place with her tongue and no lower denture plate in place. R20 stated she had been told she couldn't go to the dentist because she didn't have any money. R20 indicated she had seen the dentist greater than a year ago, and stated she wanted to have her dentures repaired.

On 06/25/2015, at 2:42 p.m. during follow up interview, R20 was observed to hold her upper

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21325	Continued From page 4 denture plate in place with her tongue. R20 did not have a lower denture plate in place. She stated she did not use adhesive on her dentures, and indicated she felt the adhesive was not effective. R20 stated she wanted an alignment of her dentures, and had money in the bank to pay for the realignment. R20 stated she unaware of the cost for the realignment, and facility staff or dental staff had not discussed the cost of realignment with her. On 06/25/15, at 3:09 p.m. during interview LPN-A stated R20 always complained she wanted more teeth. LPN-A indicated she felt R20 might be a choking risk for her to get different dentures, but wasn't sure. On 06/25/15, at 3:18 p.m. during interview nursing assistant, (NA)-C stated about 3 months ago R20 complained she wanted some new teeth. NA-C said she told R20 she had to check with the nurses to set up appointment if its possible.. On 06/25/15, at 3:26 p.m. during interview registered nurse, (RN)-A confirmed R20 wore dentures, and confirmed she had been seen by the dentist in the past. RN-A confirmed the lack of follow up after the dental appointment in the medical record. On 06/25/15, at 3:36 p.m. during interview the director of nurses, (DON) stated the usual facility practice was to follow up on recommendations from the dentist and stated "It fell through the cracks, it should have been the social worker and the care coordinator who followed up on this." She also stated the facility had issues in the past with getting residents downtown to the dentist.	21325		

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21325	Continued From page 5 DON confirmed R20's current care plan lacked interventions for care of the ill fitting/missing dentures. Review of the undated facility Physician Order Procedure policy revealed the purpose of the policy was to carry out orders for a specific resident, received from a physician-written, verbal or by telephone and all orders would be noted off as the order was accomplished or appropriate follow through of detail of the order. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to providing timely dental services. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish an infection control program which included surveillance and	21375	complete	7/28/15

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21375	Continued From page 6 investigation of infections that occurred in the facility to determine interventions to prevent the spread of infections. This had the potential to affect all 59 residents currently residing the facility. Findings include: Review of the monthly log forms titled Infection Prevention Control Surveillance Log from March 2015 to June 2015 identified the log tracked only infections treated with antibiotics such as urinary, respiratory and eye infections. The logs lacked signs and symptoms of infections for residents who were not treated by antibiotics such as gastrointestinal, fungal, skin. During review of the facility's infection control program on 6/23/15 at 6:37 p.m. with the assistant director of nursing (ADON), who was identified as responsible of the infection control program, there were components of the infection control program missing. The ADON verified treatment with an antibiotic had been the criteria used to track an infection on the infection control log. The ADON verified signs and symptoms of infections not treated by antibiotics were not tracked nor were they part of the report for the quality assurance (QA) meetings. The ADON indicated illnesses not treated with antibiotic with respiratory, fever, or gastro intestinal symptoms would not be on the infection control log. The ADON verified R54 had been treated with an antibiotic for a wound containing Methicillin-resistant Staphylococcus aureus (MRSA) (bacteria resistant to commonly used antibiotics). The ADON further verified although R54 ' s wound was not healed; the infection no longer was tracked on the infection control log, because the antibiotic treatment had been	21375		

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completed. The ADON stated " we are following contact precautions until the wound is healed. " The ADON further verified the physician had not ordered a post antibiotic wound culture " , we assume it is colonized because the resident is not symptomatic. " The ADON indicated a 72 hour tracking form had been in place at each nurse ' s station in order to follow infections not treated by an antibiotic; however it had not been followed through and the facility staff were no longer utilizing the form.

During an interview on 6/24/2015, at 12:17 p.m. the ADON indicated seventy two hour tracking forms had been initiated to track the symptoms of infections not treated by antibiotics such as , respiratory, urinary, soft tissue, cellulitis, scabies, eye infections, fungal infections, GI, norovirus, C-difficile. The ADON verified the 72 hour tracking forms were no longer utilized in the facility and stated " the nurses kind of keep them in their heads. " The ADON verified the infection control program did not track or trend signs and symptoms of infections not treated with antibiotics.

During an interview on 6/25/2015, at 2:20 p.m. the director of nursing (DON) verified the intent of the infection control program was to monitor trending of resident illness including coughing, fever, and diarrhea. The DON indicated logging of infections only that had been treated by an antibiotic would not meet the intent of the program.

The facility provided policy was titled Employee Health, infection control revised 4/14. No other policy was provided.

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21375	Continued From page 8 SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to surveillance of the infection control program. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		7/28/15

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21426	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure an effective Tuberculosis infection control program for 1 of 6 residents (R56) who required a Tuberculin (TB) symptom screening completed; documentation of the interpretation of the Tuberculin Skin Test (TST) for 1 of 6 residents (R48), and for 1 of 5 employees (E1); a two-step TST was completed for 1 of 5 employees (E2) ; and the required pre-employment screening was completed for 1 of 5 employees (E3) who tested positive for TB with a blood test. Findings include: Review of resident tuberculin status evaluations revealed the following: -R56's medical record lacked evidence for completion of a TB symptom screening upon admission to the facility on 3/12/14. -R48's medical record lacked documentation of the resulting measurements of induration in millimeters, for the TST dated 6/18/14. Review of employee personnel records revealed the following: -E1 was hired by facility on 5/18/15, a TB screening completed on 5/12/15, and a first step TST with 0 millimeters(mm) of induration; however, the record lacked documentation of the resulting measurements of induration in millimeters, for the second step TST dated 5/22/15. -E2 was hired by facility on 2/2/15, a first step TST completed and documented 0 mm of induration; however, a second step TST had not	21426	complete	

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been administered.
-E3 was hired by facility on 3/18/15, a first step TST test was completed and documented with 0 mm of induration on 3/19/15, and a second step TST had been completed and documented to have a 13 mm induration. E3's record identified E3 had been seen at the clinic and completed a blood test for TB with positive results dated 4/6/15. No further documentation of E3's TB status or ability to work was found in E3's personnel file
During an interview on 6/24/15, at 1:53 p.m. Registered Nurse (RN)-A verified the routine practice of TB symptom screen, completion upon admission or readmission. RN-A verified R56 had a symptom screen in the paper chart; however none of the symptom questions had been completed. RN-A verified symptom screens were only completed on paper and not in the computerized record.
During an interview on 6/24/15, at 2:01 p.m. RN-B verified R48 did not have documented results of mm of induration for the second step TST. RN-B indicated the results should have been documented as mm of induration.
During an interview on 6/25/15, at 8:45 a.m. the assistant director of nursing (ADON) verified being responsible for the facility TB program. The ADON verified R56's TB symptom screening had not been completed; R48 and E1's TST had not been documented with the measurement of induration ; E2's two-step TST had not been completed ; and E3's personnel file had not contained follow up and work status regarding the positive blood test for TB.

During an interview on 06/25/2015, at 2:20 p.m. the director of nursing verified the following expectations: TB symptom screenings upon

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21426	Continued From page 11 admission to the facility; two step TST testing upon admission to the facility and new employee hire; documentation of TST results in mm of induration; second step TST to be administered two to three weeks after the first step; and documentation the employee is non-infectious for employees with history of positive TST. The DON indicated she was unaware the the results of further evaluation for TB and/or physician documentation of E3's ability to return to work, were not in E3's personnel file. The facility policy titled Tuberculosis Program, revised 5/15, indicated the facility was to screen residents upon admissions or readmissions for TB symptoms and they were to receive a two-step TST. The policy also indicated all employees, at the time of initial employment would be screened, have a first and second step TST, and if they are positive reactors, would have a chest x-ray. The policy included the following when an employee showed positive results with a TST: The HCW will be excluded from the workplace until diagnosis is established, treatment begun, and determination made that the HCW is non-infectious. SUGGESTED METHOD FOR CORRECTION: The administrator, director of nursing, could review and revise policies and procedures for TB surveillance. The administrator, director of nursing, could monitor resident and employee TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		